Report on an unannounced inspection visit to police custody suites in

Cambridgeshire Constabulary

by HM Inspectorate of Prisons and HM Inspectorate of Constabulary and Fire & Rescue Services

7–18 August 2017

Glossary of terms

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Any enquiries regarding this publication should be sent to HM Inspectorate of Prisons at Clive House, 5th floor, Petty France, London SW1H 9EX, 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

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Section 1. Introduction

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

We last inspected Cambridgeshire police custody in May 2011, when we found a more positive staff culture than before, and one that had led to improvements in the way that detainees were treated and the conditions they were held in. Our principal concerns were the weaknesses in staffing and management and the limited level of mental health support available.

Importantly, at this inspection we found that detainees in custody were held in reasonably good physical conditions. It was clear that the staff culture remained healthy and we were generally impressed with the care and attention that staff showed towards detainees.

The overall management arrangements for custody within the force were complex. Cambridgeshire Constabulary had entered into a formal collaboration with two other forces, under section 22A of the Police Act 1996, which meant that it did not have direct strategic responsibility for its own custody provision. The intention behind this collaboration was eventually to have a fully integrated and interoperable custody service across the three forces. The position in Cambridgeshire was further complicated because it had also entered into a separate agreement with the Norfolk force, to use facilities outside Cambridgeshire for some of its detainees. At the time of the inspection, it was difficult to see if any real benefit had yet been gained through any of these arrangements. Given the complicated governance structure, and because procedures were in a state of transition, we did not believe that Cambridgeshire had sufficient governance and control over its day-to-day custody function.

We were also concerned to find that minimum staffing levels within custody suites were not always complied with. Staff cover was sometimes not sufficient to ensure safe detention, and this could have had an adverse impact on detainees.

We were pleased to discover that data used within the force were generally managed well. Recently introduced quality assurance arrangements worked effectively and it was reassuring to find that the force was able to demonstrate that use of force was proportionate. Overall, the picture surrounding the use of force in custody was positive and, while it reflected what we expect to see, we do not often find this.

Since the previous inspection, improvements had been made in relation to mental health. There was effective partnership engagement in this area, and few detainees were held in custody under section 136 of the Mental Health Act as a place of safety. The liaison and diversion service also provided good support for vulnerable detainees, and worked well in partnership with custody and health care staff, providing a particularly effective link with wider mental health services in the community.

Overall, during the course of this inspection we found many positive features in the way that custody services operated, delivering good frontline outcomes for detainees in a number of key areas. However, at a strategic level we had concerns that the weaknesses identified in our 2011 inspection remained, and that, in practice, the collaborative arrangements for custody services did not provide sufficient accountability at senior officer level in Cambridgeshire Constabulary. Until this is addressed, we believe that this will remain a block to the custodial function in Cambridgeshire becoming even better.

We noted that, of the 21 recommendations made in our previous report after our inspection of 2011, 12 recommendations had been achieved, five had been partially achieved and four had not been achieved.

This report provides one recommendation to the force, and highlights 27 areas for improvement and one area of good practice.

Dru Sharpling CBE
HM Inspector of Constabulary

Peter Clarke CVO OBE QPM
HM Chief Inspector of Prisons

October 2017

Section 2. Background and key findings

2.1 This report is one in a series relating to inspections of police custody carried out jointly by HM Inspectorate of Prisons (HMI Prisons) and HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS).[1] 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 and HM Inspectorate of Constabulary and Fire & Rescue Services are two of several bodies making up the NPM in the UK.

2.2 The inspections of police custody look beyond the implementation of the Police and Criminal Evidence Act 1984 (PACE) codes of practice and the College of Policing's *Authorised Professional Practice - Detention and Custody* at force-wide strategies, treatment and conditions, individual rights and health care. They are also informed by a set of *Expectations for Police Custody*[2] about the appropriate treatment of detainees and conditions of detention, developed by the two inspectorates to assist best custodial practice.

2.3 A documentary analysis of custody records was conducted as part of the police custody inspection. The custody record analysis (CRA) was carried out on a representative sample of the custody records, across all of the suites in that area, opened in the week prior to the inspection being announced. Records analysed were chosen at random and a robust statistical formula provided by a government department statistician was used to calculate the sample size required to ensure that our records analysis reflected the throughput of the force's custody suites during that week.[3] The analysis focused on the legal rights and treatment and conditions of the detainee. Where comparisons between groups or with other forces are included in the report, these differences are statistically significant.[4] A total sample of 113 records were analysed.

2.4 A data collection template was completed by the force during the inspection and was based on police custody data for the 36 months prior to inspection. The template requested a range of information, including data on the demographics of the custody population, the number of voluntary attendees[5] and the average length of time in police detention.

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1 On 19 July 2017, 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.

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

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

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

5 Where individuals attend a police station by appointment to be interviewed, avoiding the need for arrest and subsequent detention.

Custody suites	Number of cells
Huntingdon (contingency suite)	10
King's Lynn	8
March (contingency suite)	11
Parkside	12
Thorpe Wood	29

Leadership, accountability and partnerships

2.5 Cambridgeshire Constabulary had entered into a formal collaboration with two neighbouring forces, and each force had an area of business for which it was accountable. Responsibility for custody services lay with Hertfordshire Constabulary. Cambridgeshire Constabulary did not have direct strategic responsibility for its custody provision, but the overall governance arrangements provided clear accountability for this function.

2.6 Collaboration between the forces in relation to custody was underdeveloped and there were acknowledged gaps in engagement and scrutiny at senior officer level between Cambridgeshire and Hertfordshire Constabularies. Improvements were planned and it was hoped that a fully integrated service could eventually be achieved. However, at the time of the inspection, we were not confident that Cambridgeshire Constabulary had sufficient scrutiny over its own custodial function.

2.7 Custody policy dictating minimum staffing levels within custody suites was not always complied with. Staff cover was not always sufficient to ensure safe detention.

2.8 The force had also entered into a contractual arrangement with Norfolk Constabulary to use the Police Investigation Centre (PIC) in Kings Lynn. This meant that detainees arrested in Cambridgeshire, could be detained in a custody facility in Norfolk. This arrangement was outside of the tripartite collaboration, and any influence by Cambridgeshire over procedures or practices at the PIC had to be negotiated. The force did not have sufficient monitoring and scrutiny of the PIC to assure itself that detainees held there, for whom it was responsible, were dealt with properly.

2.9 The collation and monitoring of performance data relating to custody were generally good, relevant data were available and most areas of performance were well understood.

2.10 In general, data were managed well. Recently introduced quality assurance arrangements worked well and the force was able to demonstrate that the use of force was proportionate.

2.11 Although the understanding and recording of the code G necessity test were good, the force did not always comply with PACE and code C.

2.12 The force was unable to demonstrate how it was meeting its obligations under the public sector equality duty. We were advised there was little collation or analysis of data relating specifically to custody. Equality action plans were in place but they did not offer assurance against disproportionate outcomes for detainees from minority groups. We were also advised of a diversity and equality audit in July 2017 which identified poor governance and

monitoring of diversity and equality across the force, which was a weakness that could lead to the diminution of this important area of work. There were significant weaknesses in the gathering, analysis and use of equality data specifically relating to custody. Equality and diversity training for custody staff was inadequate.

2.13 The force had a strong focus on protecting and diverting vulnerable people from custody, together with effective partnership engagement. However, statutory partners did not always have sufficient capacity or capability to ensure that this aspiration was achieved successfully.

2.14 In spite of a commitment in principle, local authority partners had not signed the Children's Concordat. There was effective monitoring of data relating to children in custody; however, too many children who were charged and had bail refused were detained in custody overnight because of an absence of suitable alternative accommodation.

2.15 There was effective partnership engagement in relation to mental health, and few detainees were held in custody under section 136 of the Mental Health Act[6] as a place of safety.

Pre-custody: first point of contact

2.16 Frontline officers had a good understanding of vulnerability and generally felt confident in dealing with people who could be at risk. There was a strong focus on avoiding custody for children wherever possible. In general, frontline officers received relevant information from call handlers when responding to incidents, helping to inform their decision making.

2.17 Dealing with people with mental ill health remained challenging. The mental health staff based in the control room were seen as invaluable in providing advice and assistance to frontline officers, assessing people over the telephone and liaising with health services when needed. Although, in line with force policy, those detained under section 136 should have been transported by ambulance, in practice long waits often resulted in officers resorting to arranging police transport.

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

2.18 Overall, detainees held in custody were treated well. We found some differences in treatment between the suites. At Thorpe Wood, standards were very high and detainees were treated with considerable decency and respect. At Parkside, while detainees were still dealt with well enough, some staff we observed adopted a less empathetic approach.

2.19 Detainees' privacy during booking-in was mainly poor, with the exception of the King's Lynn and March custody suites. However, most cell toilet areas were appropriately obscured on closed-circuit television (CCTV) monitors.

2.20 The needs of female detainees were largely well met. There was limited training on equality and diversity. Provision for religious observance was poor. The force was unable to provide data on the length of time that immigration detainees were kept in custody.

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

2.21 Provision for detainees with a disability was mixed. Staff did not always know about, or were not sufficiently confident to use, the specialist facilities that were available. There were no specially adapted cells, toilets or showers in any of the suites, with the exception of one adapted toilet at King's Lynn, and there were problems with step access at both of the main Cambridgeshire suites.

2.22 As part of the tripartite collaboration, a new custody-themed intranet site had been introduced which included advice and guidance on a range of detainee welfare issues, including cultural and diversity considerations. However, this promising initiative had only recently been introduced and was not yet widely known about by custody staff.

2.23 Initial risk assessments were thorough. Detainee care plans were adequate and observation levels were adhered to. Most staff had a reasonable awareness of self-harm and appeared confident in the way they dealt with vulnerable detainees. Decisions to withhold items of clothing from detainees were based on individual risk assessments. Anti-ligature knives were not carried routinely by all custody staff.

2.24 Staff carried out rousing efficiently and the staff handovers we observed were thorough.

2.25 The grounds for detention were generally well recorded on the custody record and appropriately authorised. Good explanations were given to detainees about their legal rights and entitlements, and special arrangements were made for those who might have had difficulty in understanding the standard format. Detainees did not have access to up-to-date PACE booklets.

2.26 The total length of time that detainees were held in custody was longer than we normally find.

2.27 The voluntary attendance system worked well, and records over the previous three years showed a welcome increase in its use.

2.28 The quality of PACE reviews of detention was inconsistent. We found evidence that reviews were often conducted too early, and when a review had taken place while detainees were asleep, they were not always informed. Some reviews of detention for children and vulnerable people were carried out by telephone.

2.29 Following the introduction of new legislation, there had been a considerable decrease in the number of detainees being released on either conditional or unconditional bail, from approximately 32% to around 7%, which meant that far fewer detainees were on police bail during investigations.

2.30 Between 3 April and 9 August 2017, almost a third of detainees had been released under investigation (RUI). There was no systematic oversight of these cases. This meant that detainees could be RUI for long periods without knowing the outcome of their case.

In the custody cell, safeguarding and health care

2.31 Overall, physical conditions in the custody suites were reasonably good. We found little graffiti in any of the cells we inspected. There were few ligature points and those that we identified were addressed during the course of the inspection. Hand-washing facilities were not available in all cells.

2.32 Daily cell checks carried out by detention officers were comprehensive, and cleaning arrangements were mostly good. There were effective procedures for ensuring that repairs were carried out in the suites.

2.33 Staff awareness of the emergency evacuation procedures was mostly good.

2.34 Overall, the picture surrounding the use of force in custody was a positive one and reflected our expectations. The level of staff training was good and, based on what we observed, staff dealt with challenging detainees patiently and generally only deployed force that was proportionate to the risk or threat posed. Most of the cases we examined in depth had been managed well. Handcuffs were not applied routinely and the number of strip-searches was comparatively low, and those we saw were appropriate.

2.35 The selection of food and drink available to detainees was basic but adequate. The use of showers was not promoted actively enough. The supply of reading materials available was poor but there was a wide range of replacement clothing and toiletries.

2.36 Staff generally showed a good understanding about safeguarding. Specialist training in this area had been provided and custody staff were well supported by health care professionals and liaison and diversion service (LADS) workers in this field.

2.37 Children were well cared for in custody, and the risk assessments they were subject to during their time in custody were mostly good. The appropriate adult (AA) scheme worked well and provided children with reliable and timely support. There was a strong focus on minimising the length of time that children spent in custody, and in particular avoiding overnight detention. Although custody staff made considerable efforts to provide alternative accommodation for children who had been charged and refused bail, very often this did not result in children being moved.

2.38 Custody staff spoke positively about the standard of health care input. Regular contract review meetings with police and G4S Forensic and Medical Services ensured appropriate oversight of the service, and good relationships at a local level enabled quick resolution of any emerging issues.

2.39 G4S governance processes were reasonably good. However, there was no mechanism for detainees to make confidential complaints outside of the police complaints process, which was inappropriate.

2.40 Individual health care was generally good and underpinned by comprehensive, professional assessments. However, the clinical rooms were not clinically clean and were inappropriate for forensic sampling.

2.41 Detainees had appropriate access to medication while in custody, including symptomatic relief for alcohol and opiate withdrawal. However, medications were not sent with them to court, which presented a risk to their health.

2.42 Although there were no specific services for drug and alcohol located directly within police custody, they were readily available in the community. Links were good and appropriate referrals were made via LADS.

2.43 LADS provided a good resource for vulnerable detainees and worked well in partnership with custody and health care staff, providing a particularly effective link with wider mental health services.

2.44 Few people were detained in police custody under section 136. Custody staff believed that the introduction of mental health nurses in the control room had been helpful in maintaining this.

Release and transfer from custody

2.45 The quality of pre-release risk assessments was variable. While we observed high-quality pre-release arrangements being carried out in practice, some custody records did not reflect this. Custody sergeants routinely asked detainees how they were planning to travel home after release, and vulnerable detainees and children were transported home by police officers.

2.46 Custody sergeants regularly referred detainees to LADS. Most detainees were offered an information leaflet before their release; however, this material was not available in other languages or formats.

2.47 Person escort records did not always include detailed and up-to-date risk information. Some had loose-leaf confidential medical information attached, which was inappropriate.

2.48 We were told that detainees were generally accepted in local courts until 2pm. However, during the inspection two detainees, including a child, were turned away from the court before 10am. Owing to the tenacity of a custody sergeant at one site, these detainees were moved to court later in the day, avoiding the need for an unnecessary overnight stay in police custody.

Area of concern and recommendation

2.49 **Area of concern:** The collaboration arrangements with Hertfordshire and Bedfordshire had resulted in a lack of accountability and scrutiny for custody services at senior officer level in Cambridgeshire Constabulary.

Recommendation: The force should take clear accountability for the delivery of custody services to Cambridgeshire detainees, with effective scrutiny and oversight to ensure safe and respectful outcomes for detainees.

Section 3. Leadership, accountability and partnerships

Expected outcomes:
There is a strategic focus on custody, including arrangements for diverting the most vulnerable from custody. There are arrangements to ensure custody-specific policies and procedures protect the wellbeing of detainees.

Leadership

3.1 Cambridgeshire Constabulary delivered its policing services with two neighbouring forces – Bedfordshire and Hertfordshire – under a tripartite collaboration under section 22A of the Police Act 1996. Each force had a strategic area of business for which it was accountable. Hertfordshire Constabulary was responsible for operational support, which included custody services for all three forces.

3.2 As a result of the collaboration arrangements, Cambridgeshire Constabulary did not have direct strategic responsibility for its custody provision. Nevertheless, the governance structure for the three forces was able to provide a clear framework for accountability for the safe delivery of custody.

3.3 However, the operational support strand of the collaboration, which included custody services, was not sufficiently well established to provide effective strategic oversight of all activities. There were gaps in engagement and scrutiny at senior officer level between Cambridgeshire and Hertfordshire Constabularies, and many of the strategic issues that we had identified in our previous inspection had not been addressed. A review of the governance and meeting arrangements had introduced changes to improve the position. However, at the time of the inspection we were not satisfied that Cambridgeshire Constabulary had sufficient scrutiny at senior level over its own custody services (see area of concern 2.49).

3.4 The intention of collaborating the custody services was to have a fully integrated and interoperable service across the three forces. The success of this was predicated partly on the introduction of the Athena custody computer system, which was not likely to be in place until May 2018. To ensure the successful move to an integrated service, operating procedures across the three forces needed to be aligned, and we were not confident that sufficient progress was being made to achieve this.

3.5 The resourcing of custody suites was the responsibility of the force, and its custody policy set clear minimum staffing numbers for each suite. However, these were not complied with at all times during the inspection, and on occasion staff were clearly stretched, which had an impact on the effective and efficient delivery of custody services.

3.6 Custody sergeants and detention officers received comprehensive training before undertaking custody duties. All staff were accredited to perform the role, and received a period of mentoring by more experienced staff before their accreditation was validated. Staff also received five additional training days annually to maintain their continuing professional development.

3.7 The force had also entered into a contractual arrangement with Norfolk Constabulary to use the Police Investigation Centre (PIC) in King's Lynn. This meant that detainees arrested in

Cambridgeshire could be detained in a custody facility in Norfolk, staffed by Norfolk custody and detention officers. This arrangement was outside of the formal collaboration; therefore, for Cambridgeshire Constabulary to have any influence over procedures or practices at the PIC, this had to be by negotiation with Norfolk Constabulary rather than direct governance responsibility. The force did not have sufficient monitoring and scrutiny of the PIC custody services for Cambridgeshire detainees to assure itself that standards of care and outcomes for detainees were of a good standard and consistent with those received in its own custody suites.

3.8 The force had adopted the College of Policing's *Authorised Professional Practice - Detention and Custody*. This was complemented by a comprehensive standard operating procedure providing additional guidance in specific areas. Staff were generally knowledgeable in relation to processes and procedures but not all the processes and practices we observed were compliant with the written policy.

3.9 Leadership in clinical governance, strategic oversight and monitoring of health services were generally good and resulted in effective operational working in the custody suites. This was well supported by a fully integrated LADS, which provided good support to detainees on release.

Area for improvement

3.10 The force should assure itself that its resourcing and staffing levels in custody suites are sufficient to ensure safe detention and the effective and efficient delivery of custody services.

Accountability

3.11 The collation and monitoring of performance data relating to custody were generally good and most areas of performance were well understood and supported by a wide range of data.

3.12 Regular quality assurance processes had recently been introduced and were sufficiently focused to identify poor performance, and there were effective mechanisms to ensure that trends could be identified and used to inform learning and improve staff performance.

3.13 The force collated comprehensive data in relation to the use of force in custody and was able to provide the data sets required for the Home Office Annual Data Return (HOADR), as recommended by the National Police Chiefs Council (NPCC). The force also published these data externally.

3.14 The force had satisfactory mechanisms to assure itself, the Police and Crime Commissioner and the public that the use of force in relation to detention and custody was safe and proportionate.

3.15 The overall quality of custody records was good, with sufficient focus on safe detention. Narrative entries were comprehensive and provided context to decision making. Officer understanding and recording of the code G necessity test was particularly good. However, the force did not always comply with PACE and code C[7] of the code of practice for the detention, treatment and questioning of persons by police officers, particularly in relation to

[7] Police and Criminal Evidence Act 1984 (PACE) code C is the code of practice for the detention, treatment and questioning of persons by police officer.

reviews of detention and the versions of the codes of practice held in the suites (see paragraph 5.23, the section on PACE reviews and recommendations 5.28 and 5.34).

3.16 The force was unable to demonstrate how it was meeting its obligations under the public sector equality duty. Custody staff across the force were required to complete basic online equality training during their induction to the role. However, there had been no specific Equality Act training for custody staff in the previous 12 months, and an internal force audit conducted in July 2017 identified that refresher training was not provided to staff following induction. Equality and diversity training was not included within the force's equality objectives for the next four years.

3.17 While custody data were monitored by age, gender and other protected characteristics, it was unclear whether a regular systematic review of these data took place to identify any disproportionate outcomes for detainees. The force was unable to provide any equality impact assessments relating to its custody policies.

Areas for improvement

3.18 The force should ensure that staff comply with code C of the codes of practice relating to the detention, treatment and questioning of detained persons by the police.

3.19 The force should ensure that staff understand their responsibilities under the Equality Act, and that it is meeting its obligations under the public sector equality duty.

Partnerships

3.20 The force had a clear strategic focus on protecting and diverting vulnerable people from custody, together with effective partnership engagement. However, statutory partners did not always have sufficient capacity or capability to ensure that this priority led to improved outcomes for detainees.

3.21 The force was engaging with partners to improve outcomes for children, and monitored data relating to children in custody effectively. It was working to the principles of the Children's Concordat but the two local authorities had not agreed to sign, and the force told us that they lacked the capacity to meet their statutory obligation to provide alternative accommodation for children. As a result, too many children who were charged and had bail refused were detained in custody overnight (see section on safeguarding).

3.22 There was effective partnership engagement in relation to mental health, and few detainees were held in custody under section 136 of the Mental Health Act as a place of safety (see paragraph 6.67). There were also some good partnership arrangements to divert people with mental ill health arrested for offences away from custody for mental health support or assessment, or arranging this as a priority if they were in taken into custody.

3.23 Wider diversion schemes to reduce offending and prevent criminalisation were limited. However, there was joint working with the youth offending service to find the right solutions for children and avoid their criminalisation.

Section 4. Pre-custody: first point of contact

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

Assessment at first point of contact

4.1 Frontline officers had a good understanding of vulnerability. The force had no specific definition of vulnerability but officers made their own assessments based on a range of factors, such as mental health, learning disabilities, alcohol and drug use, as well as taking account of a person's situation or circumstances.

4.2 There had been some training around recognising and addressing the needs of vulnerable people, including some mental health training. However, there was an over-reliance on e-learning, which officers did not find helpful, and other training had not been consistently delivered to all officers. Officers determined whether a person was capable of making their own decisions, in discussion with health professionals where possible. It was clear from discussions with officers that they felt confident when dealing with vulnerable people and deciding on the most appropriate action to take.

4.3 In general, frontline officers felt that they received relevant information from call handlers in the control room when responding to incidents. This depended on how busy control room staff were, so the amount and quality of the information could sometimes be variable. Officers could access information on their hand-held tablet devices and carry out their own checks on people involved in incidents. This meant that, in most cases, they had sufficient information on which to base their decisions about the course of action to take at the scene.

4.4 Mental health professionals in the control room offered good support to frontline officers during the day, and were highly valued. They provided advice and assistance, spoke to and assessed individuals involved in incidents by telephone if needed, and liaised with health services to arrange support for a vulnerable person or, if required, access to a health facility, thereby helping to avoid taking people with mental ill health into custody.

4.5 Frontline officers only took people detained under section 136 of the Mental Health Act into custody as a place of safety when they had not been accepted by health services because of violent behaviour and/or intoxication. As there was only one health-based place of safety in the force area, officers took detainees to hospital, often remaining with them for many hours until they were assessed by mental health professionals. This was poor use of police time and could have had an adverse impact on detainees in a distressed condition.

4.6 There was a strong focus on diverting children away from custody. Frontline officers made sure that they had robust grounds for detaining children and could justify these to the custody sergeant. They actively explored alternatives such as taking the child home and interviewing them there with their parents, or using restorative justice and community resolutions[8] to resolve incidents. There had been increasing use of voluntary interviews for children. Data provided by the force for the period 1 August 2016 to 31 July 2017 showed

[8] The resolution of a less serious offence or antisocial behaviour incident involving an identified offender (both youth and adult), through informal agreement between the parties rather than progression through the criminal justice process.

that children made up 17% of all voluntary attendees, but only 7% of total custody throughput (see also section on safeguarding).

4.7 The decision on how to transport detainees to custody was based on a risk assessment. Police vans were used as the preferred option but there could be delays while waiting for these, so officers also used their police cars. Ambulances were called to transport detainees held under section 136, in line with force policy. However, in practice, long waits for ambulances often led to officers seeking an inspector's authority to use a police car.

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

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

Respect

5.1 Overall, we found that detainees were treated well. However, we identified some cultural differences between the two main custody suites. Detainees at Thorpe Wood were treated with considerable courtesy, compassion and care. For example, we observed one female detainee who had been placed in anti-rip clothing for her own safety. After she had been given her own clothing back, the custody sergeant ensured that she also received the additional protective coverings she had worn over historic self-harm scars when coming into custody, being mindful of the detainee's obvious sensitivities about this. At Parkside, while detainees were treated adequately, with their individual needs taken into account, some staff we observed adopted a less empathetic, more withdrawn and functional approach.

5.2 The levels of privacy afforded to detainees during booking-in were generally poor, with the exception of the King's Lynn and March custody suites. Although the booking-in areas varied in design, the concerns were broadly similar, including being cramped, with poor spacing between desks; the use of multiple desks simultaneously, making the area too congested; high noise levels; and the routine passing through of solicitors, cleaners, custody and non-custody staff while detainees were present. Despite having a separate desk available at Thorpe Wood to mitigate against these issues, staff acknowledged that this was not used regularly, and not used specifically when sensitivities about alleged offences and personal circumstances were likely to be discussed. There was poor privacy for detainees in some shower areas, an issue highlighted in our previous report, with the facilities at Thorpe Wood and Huntingdon offering insufficient screening. However, cell toilet areas were obscured on all CCTV monitors.

5.3 The needs of female detainees were generally well met. During booking-in, they were routinely asked if they wished to speak to a female officer or needed sanitary products. The range of sanitary products available was very good at all suites, except King's Lynn. However, we found little evidence of consideration being given to placing women away from male detainees in custody suites, and there were no designated 'female' cells in any of the suites in regular use.

5.4 The lack of equality training (see paragraph 3.16) meant that custody staff were not sufficiently prepared to deal with the wide range of individual backgrounds and needs of the detainees they encountered. As part of its strategic tri-force collaboration (see section on leadership), a new custody-themed intranet site had been introduced for use by Cambridgeshire Constabulary staff, which included some detailed advice and guidance on a range of detainee welfare issues, including various cultural and diversity matters. However, this resource was not yet fully established, with much of the content still incomplete, and custody staff were not yet familiar with, or aware of, it.

5.5 The provision for religious worship was generally poor, with all suites containing inadequate supplies (except Thorpe Wood) or inappropriately stored materials, including unwrapped copies of Qur'an texts. The direction of Mecca was clearly marked on cell ceilings, to assist Muslim detainees in their daily prayers (although those at March were inconsistent and likely to offer some detainees misleading information). However, these were not supported by supplies of other Muslim worship aids, and texts for some other religions (Hinduism, Judaism) were absent entirely. Some valuable guidance for staff on religious dietary requirements that we found at Thorpe Wood was not available at the other suites.

5.6 During the inspection, we did not see any immigration detainees being booked into any of the custody suites. However, there was guidance on dealing with immigration detainees, and custody staff were acquainted with it. Force data showed that 233 immigration detainees had been held in the year to 31 July 2017, which was far fewer than in the previous year (622). The force provided no data on the average length of time that these detainees had remained in police custody before being transferred to an immigration removal centre following service of an IS91 warrant of detention,[9] making it difficult to assess how well these arrangements were working.

5.7 The custody suites were generally not sufficiently prepared to deal with detainees with sight, hearing or mobility impairments, although it was positive to find some blue-band visual aid markings in some cells at Parkside. There were no specifically adapted cells, toilets or showers in any of the suites used by the force, with the exception of one adapted toilet at King's Lynn. In cells, benches were generally of the same standard height (or lowered), which could have caused those with limited mobility some difficulties. This was compounded by the lack of suitably lowered call bells, to enable detainees to alert staff from their bench position. However, supplies of extra-thick mattresses were generally good in all of the suites, and staff confirmed that these could be issued in multiples where deemed necessary. Wheelchairs were only available at Parkside, and showers generally had step access, with no handrail support, making these facilities unsuitable for those with a mobility difficulty. However, we saw evidence of staff being mindful of these issues, and taking steps to mitigate them where possible. This included several occasions where detainees were allowed to sit on a chair during booking-in, and one example where a detainee (at Thorpe Wood) was allowed to retain their crutches in their cell, despite concerns about their levels of aggression and behaviour en route to custody.

Areas for improvement

5.8 Booking-in desks should allow effective and private communication between detainees and staff. The discrete facilities at Thorpe Wood should be fully utilised when dealing with sensitive cases and/or involving vulnerable detainees.

5.9 All custody staff should receive the same training opportunities specifically relating to better understanding diverse needs, including mental health, vulnerabilities and protected characteristics.

5.10 The force's own custody policy minimum requirements for detainees with disabilities, and religious and cultural needs should be met in all custody suites. A full range of religious worship texts and materials should be available and stored appropriately in all custody suites, with relevant guidance on observance and dietary considerations available to staff.

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

Communication

5.11 The force had provision for the use of professional telephone interpreting services for detainees who required this service, and there were telephone systems to enable custody staff and detainees to have three-way conversations.

5.12 We found Braille versions of the rights and entitlements document for sight-affected detainees at March and Thorpe Wood but copies were not available at any other suites, even though this was required by the force custody policy (and the Equality Act 2010). A sign language version of this document was available on the new tri-force intranet (see paragraph 5.4) but staff were not yet familiar with this tool. We found hearing loops at Thorpe Wood but not all staff were confident in how to access or use them.

Risk assessments

5.13 All detainees were risk assessed on arrival, mostly by custody sergeants, who asked questions set out in a standardised electronic template on the national strategy for police information systems (NSPIS) computer system. The risk template included a wide range of appropriate and in-depth questions to ensure that action was taken to safeguard detainees while in the custody suite. In addition, staff took time to focus on the identification of risk during the booking-in process, using a dynamic assessment of the demeanour and physical presentation of detainees. Sergeants also accessed historical data from the police national computer and previous custody records, to provide additional information with which to assess potential risk further. We observed non-compliant detainees placed on constant and 15-minute observations until they were compliant enough to be risk assessed.

5.14 Most of the care plans in the CRA and in the custody records we examined during the inspection had been completed in detail and included a clear justification for the agreed level of observations, and these were amended dynamically as required. The set frequency of observations carried out by detention officers visiting detainees placed in cells was adhered to in most cases. There was good use of close proximity and constant watch, and CCTV was used appropriately, although was not available in all cells.

5.15 We observed good levels of care and concern from custody staff about the most vulnerable detainees. Staff awareness of self-harm and how to support detainees who were most at risk was reasonably good. Detainees were allowed to keep their clothes, and were not issued with replacement police-issue clothing before they were placed in a cell. The decision to withhold items of clothing was based on an individual risk assessment, and we saw examples where detainees were allowed to keep items such as scarves, which was a proportionate and sophisticated response to the management of risk. Most staff were confident in how to assess risk while maintaining the dignity of detainees, especially those who were vulnerable.

5.16 Anti-ligature knives were not carried routinely by all custody staff in the suites we visited, which compromised safety and increased the risk of harm to detainees.

5.17 Rousing practice was mostly good, and in the custody records we looked at, these incidents were documented by staff in sufficient detail. Staff knowledge of the importance of rousing for detainees who were at particular risk, such as those detoxifying from alcohol, was good and posters offering guidance on detainee rousing were prominently placed in all suites.

5.18 Shift handover arrangements were mostly good. Handovers were led by sergeants, and those we observed were well conducted and focused appropriately on detainee risk, welfare and case progression, and included all relevant police custody staff.

Area for improvement

5.19 All staff in custody suites should carry anti-ligature knives.

Individual legal rights

5.20 Detention was authorised appropriately by custody sergeants. Good explanations for the reasons for arrest were given by arresting officers, in compliance with the statutory code of arrest set out in the Police and Criminal Evidence Act 1984 (PACE). The grounds for detention were mainly well recorded on the custody record, and our observations and case audits showed that custody sergeants ensured that these were fully justified; if they were not satisfied that this was the case, detention was refused, and we found some examples of this happening.

5.21 Waiting times for detainees to be booked into the custody suites were relatively short. Our CRA showed an average waiting time of 18 minutes between arrival at custody suites and detention being authorised. In general, arrival times were recorded accurately. Detention officers at Thorpe Wood noted the time on the whiteboard when detainees arrived in the holding area, to ensure accurate recording, which was a good initiative that could be introduced at other suites. However, we were told by frontline officers, and we observed, that detainees sometimes had long waits, particularly at shift handovers or when staffing levels in the suites were stretched.

5.22 Good explanations were given to detainees about their legal rights and entitlements. The leaflets they were given were legible and easy to read. For detainees who might have had reading difficulties, custody sergeants offered an 'easy read' booklet with illustrations to help them to understand their rights and entitlements. Pre-printed rights and entitlements were also available in various languages, to assist those for whom English was not their first language, and custody officers were aware of how to access the government website, where this document was available in further languages if required.

5.23 PACE booklets, which included code C, were out of date at both Thorpe Wood and Parkside. At King's Lynn, up-to-date versions were in the suite in plentiful supply.

5.24 Those wishing to speak to their solicitors, or other people, on the telephone could not do so in private as the telephones used for this purpose were located at the side of the booking-in desk in Thorpe Wood and behind the custody desk at Parkside, allowing any conversations to be easily overheard.

5.25 The force had made good use of voluntary attendance as an alternative to custody. There had been an impressive overall rise of 20% in its use over the previous three years, with 4,165 voluntary attendees between 1 August 2016 and 31 July 2017. Voluntary attendance interviews took place outside of the custody suites.

5.26 The total length of time that detainees remained in custody was too long; our CRA showed an average detention time of 17 hours and 19 minutes, which was substantially higher than for the other police forces we have inspected since March 2016. Our observations and discussions with staff corroborated this, with delays occurring in progressing investigations and waiting for Crown Prosecution Service decisions.

5.27 Arrangements for dealing with DNA samples were satisfactory. These were kept away from other samples and were collected regularly.

Areas for improvement

5.28 The force should ensure that up-to-date versions of the PACE codes of practice are available for detainees at all the custody suites.

5.29 There should be sufficient privacy for detainees to speak to their solicitors.

5.30 Investigations should be progressed expeditiously, to ensure that detainees are not kept in custody for longer than necessary.

PACE reviews

5.31 The quality of PACE reviews of detention was inconsistent. We observed some good PACE reviews carried out in person, with clear explanations and information given to detainees, along with checks in relation to their care needs. However, in other reviews, there was limited interaction with detainees. The level of detail recorded in custody records also varied considerably. Our CRA and case audits showed that reviews were often conducted early, seemingly for the convenience of inspectors carrying them out, rather than for the benefit of detainees. In our CRA, 22 of the 84 first reviews had taken place early; when a second review had been required, 15 out of 39 had been early.

5.32 Our review of cases also showed that when a review had taken place while detainees were asleep, they had not been routinely reminded that this had occurred, or informed about the decision for continued detention – even though in some cases they had been spoken to by custody sergeants once they were awake; this contravened PACE code C.

5.33 Many of the reviews conducted by telephone did not contain adequate details of the rationale for the inspector not attending in person; again, this was not compliant with PACE code C. Some reviews of detention for children and vulnerable people were carried out by telephone, with insufficient efforts made to arrange these in person, which was poor practice (see area for improvement 3.18).

Area for improvement

5.34 The force should ensure that when reviews of detention have taken place while a detainee is asleep, the detainee is informed of the review as soon as practicable. This should be recorded on the custody record.

Access to swift justice

5.35 The force had adopted the College of Policing's *Authorised Professional Practice - Detention and Custody*. This was complemented by a comprehensive standard operating procedure where additional guidance was provided regarding pre-charge bail.

5.36 There were two custody sergeants with responsibility for managing the pre-charge bail process. They sent out reminders to investigating officers before the detainee answered bail, to progress the case and avoid extending bail unnecessarily. In the custody records, we also saw some cases where bail had been amended and notifications sent to the detainees to attend the police station prior to the date they were initially bailed to because their investigation had already been finalised, which reduced the periods that detainees were kept on bail. However, our case audits showed that when bail had been extended, no details about the reasons for this had been recorded either on the custody record or the bail form.

5.37 Since the Police and Crime Act 2017 had come into effect, in April 2017, the force had seen a considerable reduction in the number of detainees released on either conditional or unconditional bail, from approximately 32% before the Act to around 7%, which meant that far fewer detainees were on police bail during investigations.

5.38 Between 3 April and 9 August 2017, a total of 799 detainees had been 'released under investigation', with no obligation to return to police stations; this represented 29% of the total number of detainees held during this period. There was inconsistent oversight by supervisors to ensure that these cases were finalised appropriately in a timely way. This meant that there was no assurance that these individuals had access to swift justice.

Area for improvement

5.39 The force should establish a robust system to monitor the progress of investigations for detainees released under investigation, to ensure that there are no unnecessary delays and that cases are expedited.

Complaints

5.40 Custody staff consistently told us that if a detainee wished to make a complaint, they would take the details and refer them immediately to the custody inspector, who in turn would try to address the detainee's concerns while they remained in custody. We saw an example of this at Thorpe Wood, where a serious allegation of sexual and physical assaults against arresting officers, made by a detainee on arrival, was referred immediately both to custody and investigating inspectors, with appropriate additional steps taken promptly. However, Cambridgeshire detainees who were taken to the King's Lynn custody suite and wanted to complain formally received less favourable treatment, as a result of the lack of Cambridgeshire staff involved in their detention. Their complaints were referred back to inspectors in the Cambridgeshire area to resolve, with the expectation that this would take place after the detainee had left custody and returned to the county. This failed to provide such detainees with any immediate recourse for their concerns and was inconsistent with the good practice elsewhere.

5.41 No information on how to submit a complaint was displayed in the custody suites or given to detainees during the booking-in process. In addition, there was no separate process available for detainees who wanted to complain about the clinical care they received from G4S, which the force did not have the appropriate powers to deal with (see also paragraph 6.44 and recommendation 6.50).

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

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

Physical environment is safe

6.1 Overall cleanliness across the custody suites was good. At King's Lynn and Thorpe Wood, the communal areas and cells were clean and well maintained. By contrast, at Parkside some of the older cells had ingrained dirt on the benches, some of the cell floors were dirty and worn, communal areas were grubby and some in-cell toilets were stained and in need of a deep clean. There was little graffiti in any of the cells we inspected. We found few in-cell potential ligature points; we reported those we identified at Thorpe Wood and Parkside to the on-site caretakers (see below), who addressed most of them during the inspection. We found potential ligature points in seven of the cells we inspected at the contingency suite at March. There were in-cell hand-washing facilities in all cells at King's Lynn and Thorpe Wood, but in only two cells at Parkside.

6.2 Daily cells checks were carried out in all suites by detention officers, who used a comprehensive checklist (which included potential ligature points), recorded on an electronic system; any defects found were reported daily. At Thorpe Wood and Parkside, on-site caretakers visited the suites promptly to carry out repairs, and staff told us that few cells were taken out of use for long periods. Cleaning arrangements were mostly good, with cleaners visiting each site daily.

6.3 During the inspection, most cell call bells were answered promptly by detention officers. We observed sergeants explaining the use of these to detainees during the booking-in process, and detention officers usually explained the system again before placing detainees in their cells. Cell call bells could be muted at Parkside and Thorpe Wood, and during busy periods we saw this happen; this was inappropriate and could have put detainees at risk.

6.4 The in-cell ventilation systems at Parkside and Thorpe Wood were not efficient. Staff said that some cells were too cold in the winter and could overheat during hot weather. This was mitigated by giving detainees blankets, or drinking water and access to the exercise yards. However, during busy periods it was difficult for staff to manage the poor in-cell ventilation.

6.5 All custody suites displayed fire evacuation plans, which staff were aware of, and fire evacuation drills took place regularly. However, the level of recording of these drills was variable. Fire alarm systems were tested weekly, and there were sufficient sets of handcuffs in the emergency evacuation packs in custody suites to evacuate the cells safely if required.

Areas for improvement

6.6 All cells and communal areas should be cleaned and maintained adequately.

6.7 Fire drills should be recorded and documented accurately.

Safety: use of force

6.8 Overall, the use of force by Cambridge Constabulary broadly reflected our expectations. In general, accurate data on the use of force in custody were collected, which was better than we often see. There was some analysis of these data, and this was published on the force's website, and there was some managerial oversight. Information provided by the force showed that most custody staff were up to date with their safety/personal protection training.

6.9 The force custody policy placed a strong emphasis on de-escalating situations in the controlled custody environment. However, there was no guidance on the equipment that custody sergeants were expected to carry, and we found inconsistencies at both Parkside and Thorpe Wood: some carried irritant/incapacitant spray (PAVA), batons and handcuffs, while others carried a combination or none of these.

6.10 Through our case audits, CRA and observations, we identified 12 cases in which force had been used in custody, which we reviewed in depth, including cross-referencing them against CCTV. Individual use of force forms were submitted, which was positive. Detention logs generally contained reasonable information about the incident, to justify why force had been used.

6.11 Although we identified a range of learning points in half of the cases we reviewed, three-quarters of the incidents had been managed well overall. There had been considerable efforts to de-escalate situations, the force used had been mostly proportionate to the risk posed and there had been good attention to maintaining detainees' dignity, and we referred no cases back to the force. However, concerns from the CCTV footage included: a lack of proportionality and appropriateness of the drawing and use of PAVA at Parkside, particularly to gain compliance; some poor use of techniques; and some uncoordinated and uncontrolled situations, sometimes involving too many staff.

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

6.13 Detainees did not arrive in custody routinely wearing handcuffs. We observed a minority of cases where handcuffs remained in place on compliant detainees for too long, which was disproportionate to the threat posed in the controlled custody environment.

6.14 Force data showed that 3% of detainees had been strip-searched in custody in the previous 12 months, which was low. We saw few strip-searches authorised during the inspection. The rationale to justify these was adequate, and the records we examined indicated the specific grounds and justification for strip-searches, which was appropriate.

Area for improvement

6.15 Cambridgeshire Constabulary should review the personal safety equipment that staff carry in custody. They should ensure that irritant/incapacitant spray and spit hoods are used appropriately and proportionately, and that all uses are recorded accurately.

Good practice

6.16 *The use of force broadly reflected our expectations, with accurate records maintained, individual use of force forms submitted, managerial oversight and analysis, a strong emphasis on de-escalating situations, and good attention to maintaining detainees' dignity when required.*

Detainee care

6.17 A selection of hot drinks and water were available on request, although detainees at King's Lynn could access drinking water in their cells. Food preparation areas were clean. Breakfast consisted of cereal bars, and a limited range of long-life microwave meals was stocked, including vegan, halal and other diet-suitable options (with the exception of Kosher, which contravened the force's custody policy). Food was not stocked at either of the contingency suites; the expectation was that this would be sourced from one of the two operational suites when the facilities were required. Highly detailed guidance on each meal's dietary suitability was located at the contingency suite at March, with an alternative (but less detailed) version found at Thorpe Wood, but there was none at Parkside. Not all custody staff were familiar with the guidance; they said that they would discuss such issues with the detainee, which could have posed difficulties with non-English-speaking detainees. Detainees were not allowed to have food brought in for them by friends and family but there was no contingency policy if the foods stocked were not suitable for the individual.

6.18 Meals were usually served to detainees at consistent times (early morning, lunchtime and late afternoon to early evening). However, from our observations, speaking to staff and the results of our case audits and CRA, we were satisfied that detainees also received food more often, and were regularly offered it. In our CRA, in 104 of the 113 cases (92%) we looked at, the detainee had been offered food and drink, including all 21 detainees who had been held for over 24 hours. We also saw detainees being asked if they wanted something to eat or drink when being booked into custody, and detention officers told us that they would also check this when taking detainees to their cell for the first time.

6.19 We found that detainees, particularly those at Thorpe Wood, were regularly informed of their rights to access various care provisions (reading materials, outside exercise, washing facilities, food and drink), including while they were being booked into custody, on induction to their cells by detention officers and also during suite 'walk around' introductions by new shift staff; this was extremely positive, and indicative of a caring, mindful approach to detainees' welfare needs. However, staff said that they were not always able to fulfil any such requests, depending on the number of detention officers available to facilitate this, which was said to vary considerably.

6.20 Force policy also required custody staff to remove waste food and drink items from cells immediately, to prevent their use to cause damage or injury. However, we found that this did not happen regularly, and staff confirmed this; for example, we saw food items issued at breakfast time remaining in cells when lunch was served. This suggested that insufficient staffing levels might have been having a negative impact on detainees' standards of care.

6.21 Mattresses and pillows were in generally reasonable condition and were routinely provided in all cells, with back-up supplies also available, including a good number of extra-thick mattresses to offer those requiring additional physical support. However, bedding materials were not cleaned between uses, unless staff had particular concerns about a detainee's hygiene or health, in which case they applied disinfectant spray before the cell was allocated to a new detainee. Supplies of blankets were also freely available and could be issued in multiples if detainees requested this (see also paragraph 6.4).

6.22 In our CRA, 34 out of 113 (30%) detainees reviewed had been offered outside exercise; 33 (29%) had been offered a shower and 22 (20%) had been offered something to read; these figures dropped considerably for detainees held over 24 hours, although were far higher than the average figures for the forces we have inspected since March 2016. For detainees going to court, staff said that they would always try to offer access to shower or washing facilities, but that this was not always possible to facilitate, depending on the numbers of detainees and staff (and their gender mix) present.

6.23 Cotton towels were available in all suites, along with a reasonable selection of toiletries such as toothbrushes and shower gel, all of which were in good supply. The variety and supplies of female hygiene products were good. Replacement clothing (tracksuit bottoms, T-shirts and sweatshirts), shoes (plimsolls and foam slippers) and underwear (both male and female) were widely available in various sizes.

6.24 Exercise facilities were also generally poor. For example, the exercise areas at both Thorpe Wood and Huntingdon were primarily intended for use by docking vehicles transporting detainees in and out of custody, and therefore could not be used during these times, and were also inappropriate facilities. The exercise yard at the March contingency facility, although rarely used, presented significant ligature point concerns, as we had identified in our previous report, requiring close and constant supervision by staff to ensure detainees' safety.

6.25 Stocked reading materials consisted of a variety of magazines and books, and relied on staff bringing items in, or public donations. The supplies were of mixed quality and variety, with mostly poor provision for children and few items in languages other than English. The reading materials at King's Lynn were impressive, and included materials in a range of different languages.

6.26 Of the two main suites, only Thorpe Wood had visits facilities. Staff said that these would be used only for those held for long periods, such as foreign nationals, but we found no evidence of this occurring during the inspection. By contrast, bespoke visits facilities at the contingency suite in King's Lynn were excellent, with two rooms available, including one suitable for wheelchair access, and we found examples of recent use.

Areas for improvement

6.27 The force's policy for, and staff's awareness of, arrangements for securing alternative meals for detainees should be clarified.

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

6.29 All custody suites should have appropriately sized and located exercise facilities, to provide detainees with access to natural light and outside air, at all times.

6.30 Detainees held for longer periods should be offered the opportunity for family visits in all suites.

Safeguarding

6.31 Officers on the frontline and in custody had a good understanding of safeguarding children and vulnerable adults. They had received training in this area – for example, in child abuse and people trafficking issues. Safeguarding was seen as everyone's responsibility, and all of the officers we spoke to knew how and when to make safeguarding referrals to other agencies.

6.32 Arresting and investigating officers took primary responsibility for identifying safeguarding concerns and making referrals, and there were supervision arrangements to ensure that these took place. Custody officers were also focused on addressing safeguarding issues, and they were well supported by health care professionals and LADS teams in custody in identifying concerns and putting support measures in place. We observed some good discussions in custody between officers and other professionals about the actions that needed to be taken to ensure that vulnerable adults and children were safeguarded adequately.

6.33 There were effective arrangements to ensure that children and vulnerable adults received support as early as possible from AAs. Parents or family members were sought in the first instance but when it was not possible to establish early contact, custody sergeants made arrangements through the AA scheme. The two local authorities provided the daytime scheme, through either their own staff or volunteers, and there was an on-call scheme overnight across the force area both for children and vulnerable adults. Through our case audits and observations, we found that, in general, early requests were made and AAs arrived promptly, during both the day and night. This meant that detainees received their rights and entitlements in the AA's presence and benefited from their advice and support early on in detention.

6.34 Custody sergeants regarded the AA service as good. From our observations in the suites, it was clear that AAs from the scheme had a good understanding of their role, and we saw several positive interactions with detainees, and a clear focus on ensuring that they understood what was happening to them. For AAs who were family members and perhaps not familiar with role, guidance was available and issued.

6.35 However, our CRA showed that there had sometimes been long waits before an AA had arrived. The average waiting time in our sample of cases was six hours and 34 minutes, varying between one and 18 hours. We also found some cases where AAs had not been called when they should have been, or had not arrived after being called. Recording was not always clear, and in some cases the record of rights had not been completed with the AA, despite the AA being in the suite dealing with other parts of the custody process. The force did not monitor the AA service, which would have enabled them to identify and address any areas of concern.

6.36 Children in custody received good care and attention. Custody sergeants told us that they would prioritise children for booking-in, and provide as much privacy as possible at the booking-in desk. Although there were no dedicated cells or rooms for children, thought was clearly given to where they could be best placed, mainly by making use of the cells for vulnerable detainees. We did not see any girls being booked into custody but were told that they would be offered a female officer to care for their welfare needs, in line with legislation and force policy.

6.37 Risk assessments for children were carried out well, and health professionals were involved as necessary. The LADS team visited all children in custody, to try to engage with them and provide support. However, in some cases the reviews of detention were carried out by telephone, which was poor practice (see also paragraph 5.33). Care was taken when releasing children, to ensure that any safeguarding concerns were met and that they were

returned home, or to a suitable address, safely. Custody sergeants were aware of the importance of trying to avoid the criminalisation of children, and referred them to the youth offending services for disposal decisions.

6.38 There was a good focus on minimising the length of time that children spent in custody, and in particular avoiding overnight detention. Between 1 August 2016 and 31 July 2017, 873 children had entered custody, representing 7% of throughput. Information provided by the force suggested that approximately 10 children a month were held overnight. When an overnight detention was being considered, the custody sergeants discussed the case with an inspector and were required to provide robust justification. All children held overnight both pre- and post-charge were closely scrutinised by senior officers on a daily basis and assessed as to whether this could have been avoided.

6.39 There was joint working between the force and local authority partners for the provision of alternative accommodation for children who had been charged and refused bail. Local authorities have a statutory responsibility to provide accommodation for a child in these circumstances, to avoid them remaining in custody overnight. Information on children detained overnight had also been reported to the local safeguarding children's boards. However, despite this joint working and oversight, this had not resulted in improvements. Data provided by the force showed that between 31 July 2016 and 1 August 2017, 55 children had been charged and had bail refused; 42 requests for alternative accommodation had been made but only two children had been moved. There were no escalation procedures in these cases, and we were told that because there was no secure accommodation within reasonable travelling distance, and very limited other accommodation, such procedures would achieve little. Outcomes for children were poor, with most remaining in a cell overnight.

Areas for improvement

6.40 The force should assess the effectiveness of the appropriate adult service through robust monitoring arrangements, and ensure that custody records consistently capture all relevant information to enable this.

6.41 The force should strengthen its joint working with local authority partners, to ensure that children charged and refused bail are moved to appropriate alternative accommodation and not held in custody overnight.

Governance of health care

6.42 G4S Forensic and Medical Services (G4S) had provided physical health care services since 1 April 2015. In line with the tri-force collaboration arrangements (see paragraph 3.1), the contract was led and overseen by Hertfordshire Constabulary. The original three-year contract had recently been extended until 31 March 2019.

6.43 Regular contract review meetings with police and G4S Forensic and Medical Services took place and appropriate data were analysed, and informed discussion. Internal G4S governance processes were in place, including weekly audits of infection control, medication stocks and emergency equipment.

6.44 Operational oversight was satisfactory, through monthly meetings with clinical leads. Regular contact between the clinical lead and police inspectors enabled the quick resolution of any emerging concerns. There was a clear incident reporting process for staff, but there was no mechanism for detainees to make confidential complaints outside of the general police

complaints system, which was inappropriate. The 12 complaints that had been received in the previous year had been from the police, and had been about health care professional (HCP) and forensic medical examiner (FME) cover.

6.45 The service provided 24-hour cover, through two 12-hour shifts, with an embedded HCP (nurse or paramedic) in each custody suite, and access to an on call FME. Custody staff were complimentary about the embedded HCPs, and detainees we spoke to were satisfied with their treatment.

6.46 The professional credentials of all staff were recorded, and reminders sent to practitioners about revalidation dates. While ad hoc support was readily available, G4S HCPs did not receive formal clinical supervision.

6.47 Only one member of G4S staff was out of date with their life support training, but this was immediately rectified when managers were alerted to this. Ongoing training opportunities were available and induction for new staff was comprehensive. There were adequate arrangements for checking emergency equipment; however, we found discrepancies with some minor out-of-date stock.

6.48 HCPs told us that professional telephone interpreting services were used, and all staff we spoke to were aware of their responsibilities regarding appropriate information sharing. Formal protocols were in place where appropriate.

6.49 Each of the suites had one clinical room which was used both for medical assessments and forensic sampling. Despite a weekly infection control audit, rooms were dusty; sinks in the clinical room at both Thorpe Wood and Parkside needed cleaning; and the grimy floors did not meet current infection control standards. There were no cleaning schedules. Clinical sharps waste bins in both suites were not dated or appropriately secured. Both rooms were small and cluttered. At Thorpe Wood, medical consumables were not well organised and stock control was ineffective. There were no supplies to clean wounds, which was poor.

Areas for improvement

6.50 A confidential clinical complaints process should be available to detainees, and this should be advertised and easy to access.

6.51 All health care professionals should receive formal clinical supervision.

6.52 There should be robust infection control procedures for all the clinical rooms, supported by regular audits of infection control. (Repeated recommendation 6.8)

Patient care

6.53 In our CRA, 51% of detainees had required a health assessment while in custody. Response times reported between April and July 2017 were satisfactory, with over 97% compliance for both sites.

6.54 Clinical assessments were conducted professionally, in private, with appropriate interventions and onward referrals. We observed a request by G4S for joint assessment with the LADS team, which subsequently proved useful in linking community psychiatric services to detainee care.

6.55 The standard and storage of clinical records were satisfactory. HCPs had access to the NHS Summary Care Record, which informed health assessments and confirmed medication. HCPs entered information directly into the detainee custody record on NSPIS, which helped to ensure ongoing care. The clinical lead carried out audits of all HCP records twice a year, with the most recent audits scoring 90% and 95% compliance, respectively. Feedback to practitioners was good, and supported by development plans. HCPs were not directly involved in any risk assessment for person escort records (PERs); only loose-leaf confidential medical information, printed from the custody record, was attached to the PER, which was inappropriate.

6.56 Detainees could continue with prescribed medication while in custody, including opiate substitution medication, and police officers could collect methadone from a pharmacy if required. Those experiencing withdrawal symptoms from opiates or alcohol received symptomatic relief following a comprehensive HCP assessment. However, medication was not sent to court with detainees, which could have presented a risk to their health.

6.57 Medicine storage in clinical rooms complied with professional standards, and medication stocks were checked regularly. Appropriate patient group directions (to enable nurses to supply and administer prescription-only medicine) were in place and medication was administered by custody staff appropriately. Nicotine replacement therapy was widely available if needed. Unused medications were disposed of satisfactorily.

6.58 Custody staff had access to a limited range of over-the-counter medication, which could be given following a telephone consultation with an HCP, if there were none on site. No record of this stock was kept at Parkside.

Area for improvement

6.59 All medication that is due while a detainee is at court should be sent with them, with clear instructions for administration.

Substance misuse

6.60 There was a force-wide substance misuse demand strategy in place, which identified effective partnership working and wider activity to support those in contact with police services. This included close police involvement in the integrated recovery offender programme (IROP) in Peterborough, to provide intervention support to those who frequently attended police custody.

6.61 In Cambridge, adult substance misuse support was provided by Inclusion, and young people's services by Cambridge Child and Adolescent Substance Abuse Service (CASUS). In Peterborough, Aspire provided a service for adults and young people alike. Although no services were present in the custody suites, there were good links with G4S HCPs and LADS. During the inspection, one clinical assessment demonstrated the effectiveness of LADS and substance misuse service partnership working.

6.62 Detainees were provided with information about the substance misuse support available to them in the community, and staff made appropriate onward referrals.

Mental health

6.63 There was a clearly developed force strategy that involved joint working with several partners to provide mental health care services to detainees. Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) provided various services designed to support those in contact with police services.

6.64 The fully integrated LADS team was proving successful. They comprised 10 registered mental health nurses, registered general nurses, and social workers with varied backgrounds in criminal justice, and five support, time and recovery (STR) workers. They provided a service in both Thorpe Wood and Parkside between 8am and 8pm, seven days a week, to support vulnerable detainees and refer or signpost to appropriate services. Ongoing support was available to detainees on release via the STR workers. LADS had impressive relationships with a wide range of community partners and were particularly valued by custody officers for their links with community mental health teams. Between March and June 2017, the service had assessed and supported 37 children and young people, and 332 adults across the Thorpe Wood and Parkside suites.

6.65 Custody staff told us of some long delays to access an approved mental health practitioner (AMHP) for a formal mental health assessment, and this was reflected in AMPS performance data; however, 79% were seen within four hours. The AMHP service was sighted on the issues that caused delays, and were working within the Crisis Care Concordat to help to address them.

6.66 An integrated mental health team (IMHT) that comprised three mental health nurses was employed by CPFT to provide support in the force control room between 10am and 10pm from Monday to Friday, and between 1pm and 9pm at weekends. Rapid access to CPFT electronic patient records enabled these nurses to report any mental health issues appropriately to police in the community, and devise suitable plans of action and care for detainees, particularly those who frequently attended police custody. Between May and July 2017, the service had taken 2,272 referrals from the police. Involvement by the team informed effective risk management and diversion to the most appropriate intervention, including onward referral to community mental health teams in 42% of cases referred. A recent evaluation of the service had identified better-informed decision making by police officers regarding the appropriate use of section 136 of the Mental Health Act.

6.67 Few people were detained in police custody under section 136, with only six in 2016/17, including one child; records indicated none to date in 2017. There was only one dedicated section 136 bed available in the county, located at the Fulbourn Hospital in Cambridge; however, there was agreement through the Crisis Care Concordat that local hospitals could be used in an emergency.

6.68 Custody officers and police officers said that they had received mental health awareness training at some point during their service, and we were told that 70% of officers had completed a modular online training course. Both the LADS team and IMHT told us that they had provided training for officers on common mental health concerns. A one-day mental health training day was planned for delivery during 2018 for all police officers, custody officers and frontline detectives.

Section 7. Release and transfer from custody

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

Pre-release risk assessment

7.1 In our case audits and in the CRA, the recording of pre-release risk assessments (PRRA) was variable. Although PRRAs were always completed by custody sergeants, they did not all contain evidence that risks had been addressed before release. Sergeants used an onscreen 'hard facts' prompt and an aide memoire to assist them with the release process, but the PRRA was not carried out consistently across the force. A new pre-release detainee declaration template had been developed but had not yet been implemented across the force.

7.2 Travel arrangements for detainees post-release were good. In line with force policy, custody sergeants routinely asked detainees how they were planning to travel home after release. Rail travel warrants were issued to detainees regularly, and petty cash was available – and its use could be authorised by an inspector for travel purposes. Vulnerable detainees and children were routinely transported home by police officers.

7.3 LADS was well embedded and custody sergeants made regular referrals to the service. Staff from the scheme saw and assessed many detainees during their stay in custody and also before release. These staff had good access to external support services and could make appointments and referrals – for example, to housing and substance misuse agencies. Most detainees were offered an information leaflet before their release, which provided the contact details of a range of support services available in the community; however, this leaflet was not available in a range of languages or in an easy-read format.

7.4 The person escort records (PERs) we inspected had not all been completed well. There were too many examples where detailed risk information had not been provided. Some warning markers had been identified but the dates of specific incidents not included. In addition, confidential medical records had not always been sealed in envelopes; we saw several examples where loose papers had been attached to the outside or inserted inside the PER, which was unacceptable and disrespectful.

Areas for improvement

7.5 Pre-release risk assessments should be carried out consistently.

7.6 Confidential detainee medical records should be sealed in envelopes.

Courts

7.7 Detainees were generally collected for court between 6.30am and 8.30am. Custody staff told us that if detainees were ready for court after this cut-off time, they would generally be accepted by the court until 2pm. However, during the inspection two detainees, including a

child, were turned away from the court before 10am because the court cells at Peterborough Magistrates' Court were full. Owing to the tenacity of a custody sergeant at Thorpe Wood, both detainees were accepted later in the day, avoiding the need for an unnecessary overnight stay in police custody.

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

Area of concern and recommendation

8.1 **Area of concern:** The collaboration arrangements with Hertfordshire and Bedfordshire had resulted in a lack of accountability and scrutiny for custody services at senior officer level in Cambridgeshire Constabulary.

Recommendation: The force should take clear accountability for the delivery of custody services to Cambridgeshire detainees, with effective scrutiny and oversight to ensure safe and respectful outcomes for detainees. (2.49)

Areas for improvement

Leadership, accountability and partnerships

8.2 The force should assure itself that its resourcing and staffing levels in custody suites are sufficient to ensure safe detention and the effective and efficient delivery of custody services. (3.10)

8.3 The force should ensure that staff comply with code C of the codes of practice relating to the detention, treatment and questioning of detained persons by the police. (3.18)

8.4 The force should ensure that staff understand their responsibilities under the Equality Act, and that it is meeting its obligations under the public sector equality duty. (3.19)

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

8.5 Booking-in desks should allow effective and private communication between detainees and staff. The discrete facilities at Thorpe Wood should be fully utilised when dealing with sensitive cases and/or involving vulnerable detainees. (5.8)

8.6 All custody staff should receive the same training opportunities specifically relating to better understanding diverse needs, including mental health, vulnerabilities and protected characteristics. (5.9)

8.7 The force's own custody policy minimum requirements for detainees with disabilities, and religious and cultural needs should be met in all custody suites. A full range of religious worship texts and materials should be available and stored appropriately in all custody suites, with relevant guidance on observance and dietary considerations available to staff. (5.10)

8.8 All staff in custody suites should carry anti-ligature knives. (5.19)

8.9 The force should ensure that up-to-date versions of the PACE codes of practice are available for detainees at all the custody suites. (5.28)

8.10 There should be sufficient privacy for detainees to speak to their solicitors. (5.29)

8.11 Investigations should be progressed expeditiously, to ensure that detainees are not kept in custody for longer than necessary. (5.30)

8.12 The force should ensure that when reviews of detention have taken place while a detainee is asleep, the detainee is informed of the review as soon as practicable. This should be recorded on the custody record. (5.34)

8.13 The force should establish a robust system to monitor the progress of investigations for detainees released under investigation, to ensure that there are no unnecessary delays and that cases are expedited. (5.39)

In the custody cell, safeguarding and health care

8.14 All cells and communal areas should be cleaned and maintained adequately. (6.6)

8.15 Fire drills should be recorded and documented accurately. (6.7)

8.16 Cambridgeshire Constabulary should review the personal safety equipment that staff carry in custody. They should ensure that irritant/incapacitant spray and spit hoods are used appropriately and proportionately, and that all uses are recorded accurately. (6.15)

8.17 The force's policy for, and staff's awareness of, arrangements for securing alternative meals for detainees should be clarified. (6.27)

8.18 Appropriately diverse selections (by age, gender, language, type) of reading materials should be available in all suites. (6.28)

8.19 All custody suites should have appropriately sized and located exercise facilities, to provide detainees with access to natural light and outside air, at all times. (6.29)

8.20 Detainees held for longer periods should be offered the opportunity for family visits in all suites. (6.30)

8.21 The force should assess the effectiveness of the appropriate adult service through robust monitoring arrangements, and ensure that custody records consistently capture all relevant information to enable this. (6.40)

8.22 The force should strengthen its joint working with local authority partners, to ensure that children charged and refused bail are moved to appropriate alternative accommodation and not held in custody overnight. (6.41)

8.23 A confidential clinical complaints process should be available to detainees, and this should be advertised and easy to access. (6.50)

8.24 All health care professionals should receive formal clinical supervision. (6.51)

8.25 There should be robust infection control procedures for all the clinical rooms, supported by regular audits of infection control. (6.52, repeated recommendation 6.8)

8.26 All medication that is due while a detainee is at court should be sent with them, with clear instructions for administration. (6.59)

Release and transfer from custody

8.27 Pre-release risk assessments should be carried out consistently. (7.5)

8.28 Confidential detainee medical records should be sealed in envelopes. (7.6)

Example of good practice

In the custody cell, safeguarding and health care

8.29 The use of force broadly reflected our expectations, with accurate records maintained, individual use of force forms submitted, managerial oversight and analysis, a strong emphasis on de-escalating situations, and good attention to maintaining detainees' dignity when required. (6.16)

Section 9. Appendices

Appendix I: Inspection team

Ian McFadyen	HMI Prisons team leader
Maneer Afsar	HMI Prisons team leader (shadowing)
Fionnuala Gordon	HMI Prisons inspector
Kellie Reeve	HMI Prisons inspector
Norma Collicott	HMICFRS inspection lead
Anthony Davies	HMICFRS inspection officer
Patricia Nixon	HMICFRS inspection officer
Vijay Singh	HMICFRS inspection officer
Liz Walsh	HMI Prisons health services inspector
Helen Ranns	HMI Prisons researcher
Joe Simmonds	HMI Prisons researcher

Appendix II: Progress on recommendations from the last report

The following is a summary of the main findings from the last report and a list of all the recommendations made. The reference numbers at the end of each recommendation refer to the paragraph location in the previous report. If a recommendation has been repeated in the main report, its new paragraph number is also provided.

Strategy

There is a strategic focus on custody that drives the development and application of custody-specific policies and procedures to protect the well-being of detainees.

Main recommendation

The management of custody should provide clear lines of responsibility and accountability, and staffing levels should be sufficient to maintain the safety, care and welfare of detainees. (2.22)
Not achieved

Recommendation

Cambridgeshire police should undertake regular dip sampling of custody records, focusing on the management of risk of harm and the quality of detainee care. (3.14)
Achieved

Treatment and conditions

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

Main recommendation

When risk assessment indicates the need for constant observation at the cell door or rousing, this should be rigorously implemented. (2.23)
Achieved

Recommendations

Staff should receive awareness training on child protection and safeguarding. (4.6)
Achieved

Handover meetings should include all custody staff. (4.11)
Achieved

Cambridgeshire police should collate use of force data from custody and examine it for trends in accordance with the Association of Chief Police Officers policy and National Policing Improvement Agency guidance. (4.17)
Achieved

The use of cells without natural light at Peterborough is inappropriate and should be kept to an absolute minimum. (4.24)
Not achieved

Cambridgeshire police should address the safety issues around ligature points and, where resources do not allow them to be dealt with immediately, the risks should be managed effectively. (4.25)
Achieved

Fire practice evacuations should be held regularly at all suites and documented. (4.26)
Not achieved

Health and safety walk-through arrangements should be thorough and consistently applied at all custody suites. (4.27)
Achieved

Showers should be properly screened so that detainees can have a shower with dignity and in privacy. (4.35)
Partially achieved

All detainees who are in custody for a substantial period should be offered outdoor exercise, and the exercise yard at March should be made safe if the suite is to be re-opened. (4.43)
Partially achieved

Individual rights

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

Recommendations

All detainees should be asked if they have any obligations to dependants while they are in custody. (5.9)
Partially achieved

Senior police officers should engage with UK Border Agency to ensure that the time that immigration detainees spend in police custody is minimised. (5.10)
Achieved

Appropriate adults should be available without undue delay to support juveniles aged 17 and under and vulnerable adults in custody, including out of hours. (5.21)
Achieved

Cambridgeshire police should liaise with court managers to ensure that court cut-off times do not result in unnecessarily long stays in custody. (5.22)
Achieved

Detainees should be routinely informed about how they can make a complaint about their care and treatment, and be able to do this before they leave custody. (5.24)
Partially achieved

Health care

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

Main recommendation

There should be mental health in-reach arrangements to enable detainees with mental health problems to be identified and diverted into mental health services as appropriate, and police custody suites should not be used as places of safety for Mental Health Act Section 136 assessments. (2.24)
Partially achieved

Recommendations

There should be robust infection control procedures for all the clinical rooms, supported by regular audits of infection control. (6.8)
Not achieved (Recommendation repeated, 6.52)

The practice of secondary dispensing by custody officers should cease. (6.9)
Achieved

If it is clinically indicated, methadone should be available to detainees in line with national guidelines. (6.20)
Achieved