Report on an announced inspection of

Her Majesty's Armed Forces Service Custody Facilities

by HM Chief Inspector of Prisons

4–12 September 2017

Glossary of terms

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Section 1. Introduction

HM Inspectorate of Prisons has, by invitation, been inspecting military custodial facilities since 2004, most notably the Military Corrective Training Centre (MCTC). In 2013 this invitation was extended to the inspection of service custody facilities (SCF). These are small short-term secure units that hold mainly servicemen and women who have been detained on suspicion of, or have been sentenced to short terms of detention for, offending against service discipline or the criminal law. SCF were established in their current form in 2009 and replaced army guardhouses and similar such arrangements in the Royal Navy and Royal Air Force. During this inspection, the second of its kind, we visited all 11 SCF currently licensed for use across the UK that had held detainees in the last 12 months. The Royal Navy SCF at HMS Drake (Devonport) was licensed for use but not inspected as it was temporarily suspended due to staffing constraints. They continued to be operated by all three services and this was reflected in some of the operational, procedural and cultural differences we observed between the different SCF.

Details concerning the location and variety of SCF, as well as the differences in operational priorities observed – particularly between the army and the other services – are referred to in the summary of this report. Also referred to in the summary is the remit of HM Inspectorate of Prisons, as well as an indication of the approach we took to this inspection. Our focus has been on the evidenced outcomes for detainees, as measured against our independent criteria, or Expectations, which look in particular at treatment and conditions, individual rights and health care.

Overall this is a very positive report. We were impressed by the attitude of staff in all the SCF and their approach to the care of detainees. The detainees we spoke to all felt safe. Almost without exception we found staff to be professional, caring and respectful. They were alert to risk, although we do make criticism of how risk issues were recorded and, more importantly, assessed and handed over, particularly following escort. We identify this issue in our report as an 'area of concern' and a priority. Greater understanding was needed of the purpose of risk management and the accountability that ensued. This was also a particular problem in relation to self-harm, as the case management records of self-harm incidents we reviewed did not always reflect the good care that was actually offered.

Staff across the services were well trained with generally good procedures in place to manage issues such as child protection, rousing (for a detainee under the influence of alcohol) and use of force. In reality, force had hardly ever been used.

With the exception of Brize Norton and Catterick, we found the environmental conditions in the SCF to be very good with weaknesses largely mitigated by the excellent time out of cell most detainees experienced. For those staying more than a few days, visits arrangements were good and arrangements for those being released indicated good outcomes, although written assessments, where they existed, were superficial. Other concerns we identified included quite limited facilities for detainees with disabilities and searching protocols that were often needlessly excessive and lacked proportionality.

SCF were governed by the recently revised Joint Service Publication or JSP 837 which sets out how the rights of detainees across the three services should be met. Revisions had led to some improvements but the document and its provision were not yet well embedded, and staff had some lack of confidence or understanding of its requirements. Accountability concerning respect for individual rights was further undermined by inconsistent or confused practice. For example, the recording of information was inconsistent, documentation detailing various authorisations, including authority to detain, was often missing and access to legal advice was sometimes too slow. Complaints were rarely made, but complaints procedures had improved since our last inspection.

In truth, the numbers of those held in SCF – particularly in the Navy and the RAF – are comparatively small. SCF staff had quite limited opportunities to put their skills and training into practice. Some limited rationalisation of SCF facilities had taken place. We saw, and welcomed, some cross-service use of SCF, and all Royal Navy SCF had sensible arrangements with the local police to provide custody facilities. However, staffing pressures were evident. Royal Air Force SCF used untrained custodians and, where numbers of detainees were small, trained staff across all three services inevitably became inexperienced and de-skilled. We identify this issue as an area of concern and suggest ongoing consolidation of service provision.

To conclude, overall this is a very good report. Those detained in SCF experienced overwhelmingly good treatment in generally good conditions. Detainees were well cared for and safe. This report looks in greater detail at the experience of each of the three services in turn and inevitably identifies a number of procedural and practice failings. A number of recommendations are made which we hope will assist with the process of continuing improvement.

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

Section 2. Summary, key findings and areas of concern

2.1 Her Majesty's Inspectorate of Prisons is an independent, statutory organisation which reports on the treatment and conditions of those detained in prisons, young offender institutions, secure training centres, immigration detention facilities, police and court custody.

2.2 These statutory inspections 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 is one of several bodies making up the NPM in the UK.

2.3 In 2004, HM Inspectorate of Prisons, by invitation and under an agreed protocol, began regular independent inspections of the Military Corrective Training Centre (MCTC). This is the UK Armed Forces single central custodial facility, holding mainly service personnel who have been sentenced to 14 days' to two years' detention. The MCTC is staffed by service personnel. In 2013, this invitation was extended to include the inspection of service custody facilities (SCF). These are short-term secure facilities for holding mainly service men and women who have been detained on suspicion of, or have been sentenced to short terms of detention for, offending against service discipline or criminal law. There are a number of SCF across the UK. They are operated by all three services and this is reflected in some of the operational, procedural and cultural differences between different SCF.

2.4 This report consists of three sections relating to SCF, one for each service. All three were the second full inspections of SCF. These inspections are not currently fully compliant with OPCAT because they have no statutory basis but they meet these requirements in all other respects.

2.5 The inspections of SCF look beyond the implementation of the Joint Service Publications (JSPs) that relate to custody and the Service Custody and Service of Relevant Sentence Rules 2009 (SCSRSR), the services' statutory instruments. They look at outcomes for detainees, particularly addressing treatment and conditions, individual rights and health care. They are informed by HM Inspectorate of Prison's independent criteria, *Expectations for UK Armed Forces Service Custody Premises* (2014).

2.6 With the exception of the Royal Navy SCF at HMS Drake (Devonport) (which was temporarily suspended due to staffing shortages), we visited all of the SCF licensed for use at the time of the inspection that had held detainees in the previous 12 months. As at the previous inspection, the extent of their use varied enormously.

Service	Location	Number of cells	Throughput 1 September 2016 to 31 August 2017
Royal Navy			
Royal Navy Provost HQ East. (RNPHQ (E)) –	HMS Nelson, Portsmouth	4 single	13
Army			
SCF Northern Ireland	Aldergrove Barracks, County Antrim, Northern Ireland	3 single, 1 x 3-person	5
SCF South	Ward Barracks, Bulford, Salisbury, Wiltshire	6 single, 2 x 3-person dormitory	101
SCF North	Vimy Barracks, Catterick Garrison	1 cell at nearby Marne Barracks Guardroom	11
SCF Scotland	Dreghorn Barracks, Edinburgh	12 single	25
SCF East	Merville Barracks, Colchester, Essex	12 single, 3-person dormitory	101
SCF Midlands & Wales	Beacon Barracks, Stafford, Staffordshire	12 single	18
Royal Air Force			
	RAF Brize Norton, Oxfordshire	3 single	29
	RAF Cosford, Shropshire	2 single	14
	RAF Halton, Aylesbury, Bucks	2 single	7
	RAF Honington, Bury St Edmunds, Suffolk	2 single	8

2.7 Our ability to observe the experiences of, and outcomes for, detainees was limited due to the low numbers of detainees held across all three services at any one time. We tried to offset this by interviewing 17 detainees at the MCTC at the start of the inspection, all of whom had been held in a UK SCF beforehand. We also met and interviewed two other detainees during the inspection – one at SCF South and one at SCF Midlands & Wales.

2.8 The use of SCF differed across all three services. The Royal Navy and Royal Air Force SCF normally held only detainees not under sentence (DNUS) following arrest. Custody was authorised for short periods – rarely more than 12 hours. Initial custody was authorised for 12 hours but could be extended incrementally for up to 48 hours by the commanding officer, and thereafter up to 96 hours by a judge advocate. Detainees were transferred to the MCTC in Colchester to serve a sentence of detention once they had been either sentenced at a court martial or dealt with via a summary hearing (commanding officer award). The

Army SCF held DNUS following arrest but also for short sentences of detention of no more than 14 days. These personnel were known as detainees under sentence (DUS) and could be from any of the three services.

2.9 There were differences in the staffing arrangements in SCF across the services. The arrest and detention of suspects and the subsequent investigation of offences and disciplinary matters in the Royal Navy and the Royal Air Force were the responsibility of the service police. In the Royal Navy and the Royal Air Force, the SCF were within service police buildings, and SCF staff were service police officers who also undertook custodial duties in the SCF. Custodial duties were very infrequent and formed only a small part of their overall police role, and this proved problematic in maintaining skills and knowledge of detention (see below). In the Army, the SCF staff were purely custodians, separate from the Royal Military Police (RMP), with the sole responsibility of care of detainees in their custody. This structure had the benefit of providing regular, dedicated custodial staff.

2.10 As at our last inspection, we found that because of the low numbers of detainees held in some SCF, particularly for the Royal Navy and most of the Royal Air Force SCF, there was inevitable de-skilling of trained custody staff. Some limited rationalisation of SCF facilities had taken place since the previous inspection, mainly because of the closing of old facilities. We saw, and welcomed, some cross-service use of SCF, and some Royal Navy SCF had sensible arrangements with the local police to provide custody facilities. However, staffing pressures were evident and one Royal Air Force SCF used untrained custodians, alongside those trained.

Treatment and conditions

2.11 Transfers to the SCF were normally undertaken by the RMP or service police. The time it took for detainees to reach an SCF varied but was usually short. During escorts undertaken by Army and Royal Navy SCF, staff rarely used handcuffs, and the use of these was based on a risk assessment. All detainees we spoke to reported good treatment from escorting staff.

2.12 There was no formal exchange of risk information between the detainee's home unit and the SCF or MCTC following sentence, despite this being a particularly risky time. Where adopted, the detainee escort record was a welcome introduction but it was not universally used for all transfers. When it was used, there was often a lack of understanding of its purpose, and was often incomplete.

2.13 The lack of access to the MCTC after hours (6pm to 8am) resulted in substantial numbers of detainees being transferred following sentence to SCF East (just a few hundred yards from the MCTC) late at night, undergoing long admittance and assessment processes, only to be transferred to the MCTC a few hours later to follow a repeat process. We considered this to be unnecessary and potentially had a detrimental impact on detainee welfare.

2.14 We were impressed with the attitude of staff and their approach to the care of detainees. This was echoed in the interviews we undertook at the MCTC and the detainees we met during the inspection. Staff were alert to the needs of all detainees and we were confident that there were sufficient processes to meet most needs, with the exception of detainees with disabilities, for whom provision was mostly poor. There was a commitment to moving women and those under 18 years of age to the MCTC at the earliest opportunity, and the MCTC would accept them out of hours.

2.15 We found excessive routine searching and supervision of detainees at most sites. Rub-down searching was conducted often, even within the confines of the SCF.

2.16 Independent service custody visitors had been introduced, to provide independent observation and monitoring of SCF. Processes were not yet embedded, and in the Royal Air Force padres were tasked with undertaking these visits, which failed to provide adequate independent oversight.

2.17 All detainees had access to welfare services. A wide range of support services were well advertised at Army and Royal Navy, but not Royal Air Force, sites.

2.18 Detainees we spoke to felt safe. Following the recent introduction of a revised JSP 837 (which sets out to standardise the policies, practices and procedures that apply to all categories of detainees held in service custody and detention), staff were confused about the assessment of risk and subsequent application of observation levels for detainees. Detainee risk assessment documentation in all three services did not reflect the new JSP guidance. At most SCF, detainees were automatically treated as high risk on arrival, regardless of their assessment and the risk they actually posed. This potentially increased the risk to detainees as staff failed to distinguish between detainees who were truly high risk and those automatically identified as such.

2.19 We saw some good care of detainees at risk of self-harm but staff were not trained to assess risk and the records we reviewed did not assure us that staff understood how to assess this, or evidence their decision making in relation to risk levels.

2.20 For detainees under the influence of alcohol or drugs, rousing processes were good at Army and Royal Navy SCF. In the Royal Air Force SCF, these procedures were only evident at SCF Cosford.

2.21 Child protection training and referral process were in place and understood at both Army and Royal Navy SCF, but were less developed at Royal Air Force SCF.

2.22 All detainees were returned to the SCF for release, rather than being released by the service police after interview. Pre-release risk assessments were undertaken in the Army and Royal Navy but not in the Royal Air Force. The quality of written assessments was superficial but, in practice, detainees were handed over to their unit with information and good support.

2.23 All SCF staff were trained in the use of force. Records showed that there had been no use of force in any of the SCF; however, in reality we found that there had been at least one use of force in a Royal Navy SCF, which undermined our confidence in the accuracy of the recording processes. There was clear evidence of de-escalation techniques being used effectively.

2.24 With the exception of Brize Norton, SCF were well maintained and clean. Cells were basic, with little or no furniture, little natural light and no drinking water. Most did not have a toilet. This was mitigated to a degree by the large amount of time unlocked and the short stay for most detainees. For those staying for longer periods, conditions were unnecessarily austere. Conditions at SCF North were unsatisfactory.

2.25 Detainee care was very good. All SCF had sufficient good-quality clothing and bedding. Showers and toilets were clean and in good order. Access to showers was good but some lacked privacy.

2.26 The quality of the food provided was good. Meals in the Army SCF were generally taken in mess halls, with detainees being escorted there in uniform. Meals at the Royal Navy and Royal Air Force SCF were delivered to the units.

2.27 Detainees across all SCF were normally unlocked during the day and held in communal areas. Army SCF had a standardised regime, with military training and general education.

2.28 For detainees staying more than a few days, visits provision was good.

Individual rights

2.29 The revised and improved JSP 837 had recently been introduced, and set out how the individual rights of detainees across the three services should be met. However, we were told by custody staff that the JSP had been introduced with little explanation or guidance, and there was some confusing information contained within it that was sometimes contrary to the Service Police Codes of Conduct. At the time of the inspection, it was not yet well enough understood by custody staff or fully embedded, which had resulted in inconsistent practice – notably, concerning the requirement to inform a parent or guardian when a child was detained.[1]

2.30 Royal Navy police officers sometimes had to undertake custody duties for detainees they had arrested, and could often also be involved in the subsequent investigation of their case. This represented a clear conflict of interest.

2.31 There was no consistent recording of information across the services. Information was recorded in a number of places, which made it difficult to establish if individual rights were met consistently.

2.32 Custody staff knew the requirements for authorising detention but we did not always find relevant documentation to reflect that detention had been authorised appropriately. For example, initial authority, delegation of custody powers and extension documentation was sometimes missing or not completed correctly.

2.33 Decisions to hold detainees 'incommunicado' were not always authorised appropriately and there was sometimes no evidence of reviews for continued periods.

2.34 Although custody staff asked DNUS if they wished to make use of the duty solicitor scheme, access to legal advisers was not always facilitated quickly enough and was often provided immediately before interview, which was unacceptable; this was better in Royal Air Force custody facilities.

2.35 Mostly up-to-date versions of the 'Your rights if you are accused of an offence under the Service Justice System' leaflet were available. Copies of the SCSRSR were readily available for issue to detainees, with the exception of most Royal Air Force SCF. Custody staff were prepared to read and explain information to those who needed additional assistance.

2.36 We were told that complaints processes were rarely used. Arrangements for making and dealing with complaints had improved since the previous inspection, except in the Royal Air Force SCF. There were a number of widely publicised avenues through which detainees could make complaints, including the independent service custody visitors and confidential complaints boxes, but some staff still struggled to explain the processes to detainees.

Health services

2.37 The custody staff we met were sensitive to the health needs of detainees, and detainees we spoke to were satisfied with their health care while in custody. Access to health care professionals was good and there were community-equivalent out-of-hours arrangements in

[1] There is a requirement under 2.12C of the Service Police Codes of Practice, Code C to notify the parent/guardian of the detention of a child but 3.71 of Part 2 of the JSP states that they should only be advised if the child gives consent.

place, which was appropriate. Custody staff told us that they would receive instructions from the primary care staff, as necessary, to care for detainees' medical needs.

2.38 Custody staff were able to draw our attention to the JSP containing guidance on accessing support with health emergencies. Some had developed good working relationships with local police and accident and emergency departments, which helped to preserve detainees' dignity when in public.

2.39 Custody staff knew what to do in an emergency and were trained to use first-aid, resuscitation equipment and suicide prevention kits.

2.40 Most facilities had some officers trained in mental health first aid. All staff were aware of indicators of post-traumatic stress disorder.

2.41 There was appropriate guidance on assisting detainees to take their prescribed medications. Secure storage was available. There was no access to over-the-counter remedies such as paracetamol without a prescription, which was unreasonable.

Areas of concern

2.42 Concern: There were small numbers of detainees held in some SCF, particularly the Royal Navy and most of the Royal Air Force SCF. Some limited rationalisation of SCF facilities had taken place. We saw, and welcomed, some cross-service use of SCF, and some Royal Navy SCF had sensible arrangements with the local police to provide custody facilities. However, staffing pressures were evident. Royal Air Force SCF used untrained custodians (alongside trained staff) and, where numbers of detainees were small, trained staff across all three services inevitably became inexperienced and de-skilled.

Recommendation: A review of the current service facilities (SCF) should take place, with a view to further rationalising and consolidating the delivery of the facilities or agreeing with local police custody suites for them to provide custody facilities for the services concerned.

2.43 Concern: There was little initial exchange of information about a detainee's risk on their arrival at an SCF or MCTC following sentencing, despite this being a particularly risky time. Custody staff were not always able to identify, assess, mitigate and address risks in a proportionate way, and the recording of risk information was poor.

Recommendation: Service staff should complete a detainee escort record following sentence, and this should accompany a detainee to the SCF or Military Corrective Training Centre (MCTC). Custody staff should be trained in the identification, assessment and reduction of risk, and how to evidence and record this in risk documentation.

2.44 Concern: Access to the MCTC for new receptions was limited to between 8am and 6pm. This resulted in many detainees being lodged overnight at SCF East (just a few hundred yards from the MCTC). Many detainees arrived there late at night and underwent long admittance and assessment processes, only to be transferred to the MCTC a few hours later to follow a repeat process. This was disruptive and potentially had a negative impact on detainee welfare.

Recommendation: The MCTC should accept detainees out of hours when necessary.

Section 3. Royal Navy

3.1 Due to a lack of custody trained staff, only the service custody facility (SCF) at HMS Nelson in Portsmouth was fully open at the time of the inspection. The SCF at HMS Drake (Devonport) was temporarily suspended (although still licensed for use) due to staff shortages. It was anticipated that the SCF at HMS Drake (Devonport) would reopen in December 2017. There was a memorandum of understanding with the local police force in Plymouth to manage any detained service personnel.

Treatment and conditions

Transfers and escorts

Expected outcomes:
Detainees transferring to and from service custody premises are treated safely, decently and efficiently.

3.2 Detainees normally arrived at SCF Portsmouth following relatively short journeys in dedicated service police secure vehicles. Use of handcuffs was subject to a risk assessment and there were clear instructions that they would always be applied to the front. Most detainees in the previous 12 months had arrived following sentence from court martial to await transfer to the Military Corrective Training Centre (MCTC) in the secure vehicles, and had not usually been handcuffed. These transfers often started between 7.30pm and 9.30pm, which meant that, as detainees would have arrived at the MCTC too late to be admitted, they were lodged at SCF East before onward transfer; however, they arrived there in the early hours of the morning, leaving them with little or no opportunity for sleep. The exception to this (for all services) was the transfer of under-18s and female detainees, for whom the MCTC would allow access (see area of concern 2.44).

3.3 The newly introduced detainee escort record was understood by the SCF staff and had been adopted, although had yet to be used owing to the very low throughput. All arriving detainees were interviewed in the private reception area, with a detainee assessment record (DAR) being used. Staff we spoke to demonstrated a good understanding of the DAR, and the assessments we observed were fully completed.

3.4 For detainees held after sentence, background information was provided by the home unit, including issues such as welfare, financial, service history and where the detainee was to be returned to if not discharged from the service. However, there was little in relation to risk management, and SCF staff therefore had limited information on which to base their own risk assessments (see section on safety and area of concern 2.43).

Respect

Expected outcomes:
Detainees are treated with respect and their diverse needs are recognised and addressed during their time in custody.

3.5 Only 13 detainees had been held at SCF Portsmouth in the previous 12 months. Detainees were held there for short periods and were not usually secured in cells unless held overnight, which was rare. The detainees we spoke to at the MCTC reported respectful and helpful treatment from SCF staff, although they had been given no comfort breaks between Portsmouth and Colchester, a journey of at least three and a half hours.

3.6 SCF staff undertook only rub-down searches of detainees but these were too frequent and unrelated to any risk posed, often taking place when detainees moved within the SCF.

3.7 Staff were aware of the potential needs of detainees. Although there were no specific arrangements for women, we were satisfied that on the rare occurrence of a female detainee being held, provision would be made quickly from the home unit, including arranging for female staff to be present if none were available at the SCF.

3.8 Cell doors were wide enough to accommodate a wheelchair and ramp access was provided, but beyond this there were no adapted facilities to cater for detainees with disabilities. However, to date, no such detainees had been held at the SCF.

3.9 There were clear guidelines in standing orders for the care of other protected groups such as transgender and young detainees. All staff had undergone child protection training and there were good links with local children's services.

3.10 The independent service custody visiting (ISCV) scheme provided by the Soldiers, Sailors, Airmen and Families Association (SSAFA) was in operation, and contact was made whenever a detainee was received into custody.

Recommendations

3.11 Rub-down searches should only be undertaken when supported by an identified risk.

3.12 Detainees with disabilities that affect their mobility should not be held in an SCF unless provision can be made to meet their needs.

Safety

Expected outcomes:
Detainees feel and are safe throughout the duration of their detention. Detainees presenting any risks to themselves or others are assessed and managed by custody staff.

3.13 All staff at the SCF were trained in safety issues and there was a good awareness of the need for frequent training to maintain custody skills, and this was reflected in the staff training plan.

3.14 Training included safer custody, and anti-ligature knives were available for issue whenever a detainee was held. Anti-tear clothing was also available for issue, although it had not been

used. There had been one incident of attempted self-harm in the previous year, and this had been managed well.

3.15 New detainees were assessed for their risk of suicide and self-harm or risk to others routinely on arrival. However, staff were not aware of the instructions in the new Joint Service Publication (JSP) about risk and observation levels to be applied. Staff were still routinely treating all new arrivals as high risk, irrespective of the risk they actually posed, even though this was no longer advised in JSP 837. This potentially increased the risk to detainees as staff failed to distinguish between detainees who were truly high risk and those automatically identified as such.

3.16 Night lights were left on permanently whenever a cell was occupied, which was likely to affect disrupt detainees' rest. Emergency response equipment was easily accessible and contingency plans were easily available.

3.17 Observation of detainees was enhanced by unit-wide closed-circuit television, including in each cell. Monitoring screens were placed discreetly in the main office, out of public view.

3.18 Fifteen-minute rousing checks had been introduced for intoxicated detainees.

Recommendation

3.19 Staff should understand the risk categories and observation levels identified in the revised Joint Service Publication (JSP) 837. Detainees records should be updated to reflect the terminology used in the JSP, so that staff can accurately record and follow the observation levels set.

Safeguarding

Expected outcomes:
Young detainees (under 18) are properly protected in a safe environment. All staff safeguard and promote their welfare. Detainees will only be subject to force that is proportionate, lawful and used as a last resort. Detainees are transferred or released safely and decently.

3.20 No under-18s had been detained at the SCF since the previous inspection. Child protection training and a referral process were in place and understood. Local standing orders outlined responsibilities for the care of detainees under the age of 18.

3.21 All staff were trained in the use of force, and there was a programme of refresher training. There had been one recorded use since the previous inspection. Records held at the SCF provided a good account of the incident and also showed a focus on de-escalation.

Release

3.22 Following interviews held elsewhere, usually by Royal Navy police, detainees were always returned to SCF custody before release, which enabled pre-release assessments to be completed. All detainees underwent a basic pre-release risk assessment, and this was shared with the receiving unit. These risk assessments were too basic, consisting of a tick sheet which did not pay sufficient attention to individualised risk. In practice, a range of informal arrangements were in place and detainees were well supported by their home unit on release. Information on a wide range of welfare and support services was available and all

detainees were given a useful contacts booklet on leaving the SCF, including information and contact details for a wide range of support services.

Recommendation

3.23 Pre-release risk assessments should record all ongoing risk factors and identify how they will be addressed.

Physical conditions

Expected outcomes:
Detainees are held in a safe, clean and decent environment, which is in a good state of repair and fit for purpose.

3.24 The unit was relatively new and in good order. The three cells in use were basic, and all had a low bed plinth; a fourth had a small fixed table and chair but this cell had not yet been licensed. Cell call bells were installed in all cells and were tested daily. The stark conditions were mitigated by the infrequent and short-term use of the cells. Communal dining facilities were available if needed, and the bathroom areas both for male and female detainees were clean and provided sufficient privacy. The exercise yard was of a good size but we were told that detainees usually only asked to use it for short smoking breaks.

Detainee care

Expected outcomes:
Detainees are able to be clean and comfortable while in service custody facilities. Detainees are offered sufficient food and drink. Detainees have regular access to facilities and activities that preserve and promote their mental and physical well-being.

3.25 Each cell had a corresponding locker (located outside the cell) containing bedding, basic toiletries, overalls and slippers for issue if a detainee was to be held overnight. Each cell contained a tear-proof mattress and pillow. Detainees were expected to wear uniform; if they arrived in civilian clothing, the home unit would send over sufficient items of uniform and equipment up to and including the kit listed for the MCTC.

3.26 Food was provided to detainees in 'hot boxes' owing to the long distance to the main galley. There was no provision for out-of-hours food but, again, this was rarely needed and, in reality, most overnight stays had been as a result of intoxication.

3.27 Hot drinks and drinking water were freely available on request.

3.28 All detainees were offered a free telephone call at the earliest opportunity, and this was recorded in the unit log, including the outcome of the call, and there was an appropriate system for lodging complaints.

3.29 The relatively short times in custody negated the necessity for an activity regime. Books and newspapers were available.

Individual rights

Rights relating to detention

Expected outcomes:
Detention is appropriate, authorised and lasts no longer than is necessary.

3.30 SCF Portsmouth held detainees not under sentence (DNUS) without charge for up to 48 hours.[2] They also held detainees under sentence (DUS) for short periods pending transfer to the MCTC. Initial authority to detain from the time of arrest was given by a commanding officer (CO) or an officer delegated with custody powers by the CO. Detention was granted in the first instance for a 12-hour period, after which reviews of detention were required by the CO at least every 12 hours, up to 48 hours. In the cases we reviewed, all the DNUS had had their detention authorised for 12 hours but some had been released after five to seven hours following the completion of interviews and further investigative enquiries, which was proportionate. Several detainees had been held for over 12 hours, mainly because of their intoxication levels, which required their detention periods to be reviewed and extended accordingly.

3.31 Custody staff were clear on the need to have correct authorisation for detention from a CO, but in our review of cases we found a number of administrative anomalies. It was not always clear who had authorised detention as the relevant forms were often not signed and, even when signed, the signatures were indistinguishable and there was nothing in the records to identify these individuals. In two cases, the authorisations had been signed too long after the detainee had been released from custody. We also found no paperwork in the records which confirmed if an authorising officer had been delegated with custody powers by the CO, where applicable, and staff told us that they did not routinely request this. Accompanying paperwork which was held in the records for serving on detainees was not always fully completed, so we were not satisfied that detainees were always informed of their rights (for example, how long they could be kept in custody).

3.32 Royal Navy police officers sometimes had to undertake custody duties for detainees they had arrested, and could often also be involved in the subsequent investigation of their case. This represented a conflict of interest which could compromise both the care of the detainee and the integrity of the investigation.

3.33 Up-to-date copies of the 'Your rights if you are accused of an offence under the Service Justice System' leaflet were available for issue to detainees on arrival at the SCF. A copy of Part 3 of the Service Custody and Service of Relevant Sentence Rules 2009 (SCSRSR) was also available for issue to detainees, as was a copy of the Service Police Codes of Conduct. None of these were available in an easy-read format to support detainees who might have had a problem in understanding the detailed information reproduced within, such as those with dyslexia; however, staff said that they would read through and explain the content of any documents to a detainee if this was needed.

3.34 Staff told us, and we saw from the cases that we reviewed, that some efforts had been made to standardise the contents of the detainee custody record. Despite this, we found that information was recorded in multiple places, both on paper and electronically, which made it difficult to establish if detainees' individual rights were met consistently.

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[2] Detention could be further extended up to 96 hours by a judge advocate, or in very exceptional circumstances by a commanding officer if it is not practical to arrange a hearing with a judge advocate.

3.35 There were no posters displayed advising detainees of their right to free legal advice but all detainees were told about this during the SCF admission process. In two cases we reviewed, the detainees had asked to avail themselves of the right to free legal advice, but we were unable to confirm if these requests had been facilitated or not. A duty solicitor scheme was available, although staff told us that if a detainee wished to use this service, they would refer this request back to the investigating officer to action. Staff said that legal consultations were usually arranged to take place immediately before interview. This resulted in detainees experiencing delays in receiving legal advice. In our review of cases, we found one case where a detainee's detention had had to be extended, albeit by just one hour, owing to a delay in the attendance of the legal adviser for the interview.

3.36 Detainees had the right to have someone informed of their whereabouts on arrival at the SCF. Staff told us that they would make contact with a named person and that they would also allow the detainee to speak to their nominated person if they wished to do so. We saw evidence of this right being facilitated in some of the cases we reviewed. Detainees were sometimes held 'incommunicado', which meant that the right to have someone informed could be suspended for a specified period. However, this had to be authorised at a senior level, and a copy of the authorisation, showing the justification for this and the length of time that it should remain in place, provided to custody staff. Staff were unaware that this should be documented. In one of the cases we reviewed, we found that the detainee had been held incommunicado for just under five hours but we could find no evidence of why this had been introduced or any details of who had authorised this.

3.37 If staff had any concerns about a detainee's level of intoxication and their fitness to remain in custody or be interviewed, they sought medical advice. Detainees who were intoxicated were, quite rightly, not interviewed but given a period of uninterrupted rest.

Recommendations

3.38 Signed authorisation of detention and, where applicable, confirmation of the delegation of custody powers should be received without significant delay and copies should be held within the detainee's custody record.

3.39 Custody staff should have no involvement in the arrest or investigation of offences allegedly committed by detainees under their care.

3.40 Information relating to the detainee should be kept in one contemporaneous custody record.

3.41 Custody staff should ensure that documentation authorising a detainee to be held 'incommunicado' is authorised at an appropriate senior level and details the timescales during which it should remain in place.

Rights relating to treatment

Expected outcomes:
Detainees know how to make a complaint and are able to do so.

3.42 Staff had a basic awareness of the complaints process, and advised detainees of this during the SCF admission process, and details were also contained within the SCSRSR. A small notice was displayed in the main cell corridor, advising detainees that they should speak to a member of SCF staff if they had a complaint. Complaints forms were not readily available to detainees but a stock was held in the reception area for issue if requested. A locked post

box for posting confidential complaints was available, and the keys were held by the duty CO.

3.43 In addition to speaking to staff or submitting a formal complaint, detainees were told that they could complain to the duty officer or the ISCV visitors during their visits. Staff had some awareness of the role of the Service Complaints Ombudsman but there was little written documentation on this subject available for issue to detainees. Staff told us that they were unaware of any complaints ever having been raised by detainees while being held in the SCF.

Health services

Expected outcomes:
The health needs of detainees are addressed during their time in custody.

3.44 Detainees we spoke to expressed satisfaction with their health care at the SCF. We were impressed by the sensitivity of custody staff to the health needs of detainees.

3.45 Custody staff had JSP 837 to hand, and could point out sections related to their practices in getting access to health care, medicines administration, intimate searching and emergency care. SCF Portsmouth had developed local unit standing orders and protocols based on the JSP. HMS Nelson had also developed good working relationships with local police and accident and emergency departments, which helped to preserve detainees' dignity by reducing exposure to the public while being accompanied or in restraints (following initial arrest) in the local hospital.

3.46 The initial SCF detainee assessment contained a minimal number of questions related to physical and mental health needs, which was appropriate for this population.

3.47 There appeared to be no unnecessary restrictions on access to health care. If necessary, arrangements were made for the detainee to see a health care professional (HCP), or a detainee could ask to see an HCP, which would be facilitated. They could ask to see a an HCP of their own gender, although such requests were rare.

3.48 Custody staff knew to ask for detainee permission to share their personal information with HCPs, and garrison primary care arrangements for gaining consent were to NHS standards.

3.49 In general, the available health services were suitable for addressing the needs of detainees and included various permutations of garrison primary care, on-call military doctors, access to out-of-hours on-call general practitioners, NHS drop-in and emergency facilities. On-site primary care facilities did not routinely offer a visiting service to the SCF, which left custody staff frustrated.

3.50 The custody records we saw contained references to detainees visiting health centres, and satisfied us that appropriate instructions would be given to custody staff about the continuing care of a detainee, although it was left to custody staff to summarise instructions in the custody record.

3.51 JSP 837 contained instruction on the provision of emergency health care and equipment. Custody staff knew what to do in an emergency and were trained to use first-aid and resuscitation equipment. The equipment available included automated external defibrillators and suicide prevention kits, was subject to regular, documented checking and was in good order.

3.52 The JSP also contained clear instruction on assisting detainees to take their prescribed medications. Medicines were stored in lockable cabinets and detainees were able to receive the medications they had been prescribed before being taken into custody, after suitable verification. Medicines were handled safely. There was no access to over-the-counter remedies such as paracetamol, except via an HCP, which was unreasonable.

3.53 Most SCF Portsmouth staff had been trained in mental health first aid. Staff were aware of potential indicators of post-traumatic stress disorder and when to refer detainees for assistance with this. Detainees with mental health or substance misuse issues were first seen by the naval base primary care staff, or in more urgent cases via the on-call doctor or local NHS services. Additionally, naval primary care staff or doctors were able to refer detainees to departments of community mental health for further assessment. These arrangements were appropriate.

3.54 We saw no detainees subject to mechanical restraint or planned physical restraint during the inspection. Custody staff said that planned physical restraint was rare but there was guidance on positional asphyxia and other restraint-related safety issues in the JSP. Custody staff told us that they would involve HCPs in such situations.

Section 4. Army

Treatment and conditions

Transfers and escorts

Expected outcomes:
Detainees transferring to and from service custody premises are treated safely, decently and efficiently.

4.1 Journey times to service custody facilities (SCF) varied. Detainees usually arrived at the SCF escorted by the Royal Military Police (RMP), generally in standard vehicles and without handcuffs. Army SCF staff undertook some escorts, usually around the military base, and use of handcuffs was rare, and always based on a risk assessment.

4.2 Detainees told us, and records supported, that adequate comfort and refreshment stops were provided, and that treatment by escort staff was good.

4.3 There was no formal exchange of risk-based information between the detainee's home unit and the SCF or Military Corrective Training Centre (MCTC) following the sentencing or remand of a detainee, despite this being a particularly risky time. Unit staff provided a written report which provided some relevant information and background on the detainee but this did not cover all potential risk, safety and security issues (see area of concern 2.43).

4.4 The detainee escort record had been introduced recently but it was not universally used for all transfers. Not all staff responsible for completing this understood its purpose, and some said that they would retain the detainee escort record rather than hand it over to the receiving staff. Even when this record was used, it was poorly completed and often failed to record all relevant risk information. For example, one detainee had had a history of recent self-harm but this had not been included in his detainee escort record on transfer to the MCTC (see area of concern 2.43).

4.5 The lack of access to the MCTC after hours (that is, before 8am or after 6pm) resulted in many detainees arriving late at night or in the early hours of the morning at SCF East (just a few hundred yards from the MCTC). This was seen as the 'out-of-hours' MCTC, and detainees underwent long admittance and assessment processes there, only to be transferred to the MCTC a few hours later, where these procedures were repeated. This practice was unsatisfactory and had a detrimental effect on detainee welfare. For example, one high-risk detainee with a history of self-harm had arrived at SCF East following court martial at 2.10am and had been transferred to the MCTC at 8.10am on the same day. Forty out of the 50 SCF East receptions in the previous six months had been sent there purely to await admission to MCTC the following day, including at least seven from the Royal Navy, which did not hold detainees overnight after sentence (see area of concern 2.44).

Respect

Expected outcomes:
Detainees are treated with respect and their diverse needs are recognised and addressed during their time in custody.

4.6 Detainees we spoke to said that staff were helpful, friendly and supportive, and we were impressed by the concern and care shown by staff towards detainees.

4.7 All staff were aware of the need to treat women, those under 18 and those with specific needs differently and we were satisfied that there were adequate arrangements to meet most needs, with the exception of those of detainees with disabilities. Staff could not remember when a woman or under-18 had been detained but all staff were clear that they needed a female member of staff present if they held a woman in custody, and all had arrangements for using female RMP. Staff were well informed about how to care for transgender detainees. Arrangements to care for those with physical disabilities were limited to the provision of an adapted toilet and of a shower seat in some of the SCF. All SCF had access to a padre, had identified the most common religions and had the relevant information and artefacts on site.

4.8 SCF staff undertook only rub-down searches of detainees but these were too frequent (sometimes taking place when a detainee moved between cells in the SCF) and not informed by an identified risk.

4.9 The independent service custody visiting (ISCV) scheme had been introduced, and provided a level of regular independent observation and comment on the SCF. Visitors from the scheme attended the SCF at least monthly and were always informed (although did not always visit) when a detainee was received. Issues raised in visit reports were actioned and were mostly about physical conditions, such as heating. This was not the case for SCF Northern Ireland, where it continued to prove difficult to recruit these visitors.

4.10 All detainees had access to welfare services. Each SCF had noticeboards displaying support organisations such as Citizens Advice and Alcoholics Anonymous, and a range of leaflets signposting detainees to support. Staff said that they would refer a detainee to the welfare department if required.

Recommendations

4.11 Detainees with disabilities that affect their mobility should not be held in an SCF unless provision can be made to meet their needs.

4.12 Rub-down searches should only be undertaken when supported by an identified risk.

Safety

Expected outcomes:
Detainees feel and are safe throughout the duration of their detention. Detainees presenting any risks to themselves or others are assessed and managed by custody staff.

4.13 All detainees we spoke to felt safe. All staff were custody trained and had undergone a range of relevant training (and refresher training), including suicide and self-harm prevention and use of force training. All staff carried anti-ligature knives and cells were free from ligature points.

4.14 All detainees were assessed for their risk of harm (to themselves or others) on arrival at the SCF. Staff saw all detainees in private and completed a comprehensive assessment document called the detainee assessment record (DAR). For detainees arriving out of hours, a less in-depth out-of-hours DAR was completed. The recently revised Joint Service Publication (JSP) 837 had introduced new risk categories and detainee observation levels. These were not well understood by SCF staff, many of whom were still using the old terminology, and the DARs had not been updated to reflect current guidance, which was confusing for staff. Some of the guidance in the JSP, particularly concerning observation levels, was unclear and staff found it difficult to identify appropriate observation levels, particularly if the cells did not have closed-circuit television installed. In some instances, observation levels were not set at all.

4.15 Despite guidance to the contrary in JSP 837, staff at SCF South were still under the impression that all detainees should be identified as high risk during their first 24 hours in custody. This had the potential to create complacency among staff and potentially increased the risk to detainees as staff failed to distinguish between detainees who were truly high risk and those automatically identified as such. Staff mistakenly thought that a detainee not under sentence (DNUS) should only have an out-of-hours DAR completed.

4.16 We heard and saw evidence of good care for detainees who were at risk of suicide and self-harm but often this was not reflected in the assessment and care documents. Staff were skilled in settling detainees in and ascertaining their state of mind, but they were not trained in the assessment of risk, and we often saw decisions on risk being made which were not supported by recorded evidence (see area of concern 2.43).

4.17 New, clear guidance had been issued on, and staff were clear about, the care and 'rousing' of detainees under the influence of drugs or alcohol. SCF Midlands & Wales, and SCF South had alcohol recovery rooms, the doors to which were kept open, enabling excellent staff observations.

4.18 Although detainees were generally held in single-occupancy cells, all SCF, except for SCF North, also had multiple-occupancy cells but staff could not recall having used them.

Recommendation

4.19 Staff should understand the risk categories and observation levels identified in the revised Joint Service Publication (JSP) 837. Detainee assessment records should be updated to reflect the terminology used in the JSP, so that staff can accurately record and follow the observation levels set.

Safeguarding

Expected outcomes:
Young detainees (under 18) are properly protected in a safe environment. All staff safeguard and promote their welfare. Detainees will only be subject to force that is proportionate, lawful and used as a last resort. Detainees are transferred or released safely and decently.

4.20 Only SCF North had experience of holding an under-18 detainee. It was clear that there was a desire to keep under-18s out of SCF custody and we were confident that transfers to the MCTC would be expedited (including out of hours), unless the detainee was required for interview. All SCF had clear instructions in place about the actions to be taken in the event of a child safeguarding issue being raised. All staff received regular child protection training.

4.21 Force had not been used in any of the SCF. All staff had been trained in the use of force, undertook annual refresher training and spoke knowledgeably to us about de-escalation and the use of force as a last resort.

4.22 Handcuffs had not been used in any of the SCF, and staff understood the need for approval if they were required.

Release

4.23 All detainees were released from an SCF, rather than directly from a police interview, which enabled pre-release risk assessments to be completed. However, these were often of poor quality and superficial. Staff in the SCF said that they encouraged contact from the detainee's unit during their sentence, and that detainees were handed over to their unit with information and practical support. However, we came across cases where critical issues related to a detainee's offending had not been addressed. One such example involved a detainee who was released following a sentence for being drunk and disorderly. He had a history of drink-related offending behaviour but neither his pre-release assessment nor the discharge letter sent to his unit post-release identified alcohol as a concern to be addressed.

4.24 Most detainees facing onward transfer to the MCTC were able to view the MCTC information DVD before transfer but it was out of date.

Recommendation

4.25 Pre-release risk assessments should record all ongoing risk factors and identify how they will be addressed.

Physical conditions

Expected outcomes:
Detainees are held in a safe, clean and decent environment, which is in a good state of repair and fit for purpose.

4.26 All cells and communal areas were light, clean, well decorated and in good order, although the cells were sparsely furnished. Three cells in each SCF were equipped with a table and chair but most had a low concrete bed plinth, with no toilet (with the exception of SCF Midlands & Wales) or running drinking water. Windows were above head height and opaque. Detainees were not permitted to have any personal possessions in their cell and had no control over their lighting – a night light was kept on all night to aid observation. These unwelcoming conditions were mitigated, to some degree, by the fact that many detainees stayed for only a short time and spent much of their day out of their cells, but for those who experienced long stays or were struggling to cope, these conditions were unnecessarily austere.

4.27 All cells had a cell call bell and detainees told us that they generally used this to be let out to use the toilet or ask for drinking water, and that staff responded promptly.

4.28 Conditions at SCF North were unsatisfactory. The cells there were out of use due to a lack of heating in all but the (unlicensed) multiple-occupancy cell. Similarly, there was no heating in offices or in communal areas. This meant that if a detainee was to be kept overnight, a single licensed cell at the back of the Marne Barracks guardroom, about 15 minutes away, would have to be used. The cell was clean and in good order but there were no other facilities for detainees there, which meant that detainees had to be transported back to the SCF for showers, telephone calls, visits and exercise. We were told that even this single cell was sometimes out of use and that there were often problems accessing transport to take detainees from the SCF to Marne Barracks on the few occasions that it had been needed. If there was a need to locate more than one detainee overnight, SCF Scotland or SCF Midlands & Wales would be used, which involved approximately an eight-hour round trip. There were no office facilities at Marne Barracks for the SCF staff, who resided in an adjacent cell whenever any detainees were held there.

Recommendations

4.29 Detainees residing in the SCF for more than 48 hours should, subject to a risk assessment, be allowed to have furniture and personal possessions in their cell and should be able to control their lighting.

4.30 Cellular accommodation and communal facilities at SCF North should be made fit for use.

Detainee care

Expected outcomes:
Detainees are able to be clean and comfortable while in service custody facilities. Detainees are offered sufficient food and drink. Detainees have regular access to facilities and activities that preserve and promote their mental and physical well-being.

4.31 All SCF provided detainees with good-quality clean bedding and also had anti-ligature bedding and clothes available.

4.32 Detainees usually arrived with their own clothing, uniform and toiletries; if not, their home unit was asked to provide these. As a last resort, or if a detainee's clothing had been seized, some emergency clothing, and overalls, were stored. Toiletries and limited feminine hygiene products were also available. During the working day, detainees wore uniform but could wear overalls or PE kit during association and 'down time'. Laundry facilities were available.

4.33 Showers were offered on arrival and then at least daily. During lock-up, in all SCF, except SCF Midlands & Wales (which had in-cell toilets), detainees had to rely on staff unlocking them to use the toilet. We were confident that this happened swiftly (see also paragraph 4.27) but not all toilets offered sufficient privacy.

4.34 Detainees generally went to the mess/cookhouse for their meals. They either walked or were transported there in a vehicle, and wore their uniform. Staff said that if a detainee was anxious about attending the cookhouse, they would collect a meal for them to eat in the SCF. Detainees said that the quality and quantity of the food provided were good.

4.35 Detainees were usually unlocked from 6am to 8pm. A full published regime was displayed and included a range of activities and training sessions, including PE, military knowledge and general education. Although not all aspects of the training were available, detainees were kept relatively active. Exercise yards were bleak but, in reality, were used only for smoking breaks. Detainees were offered sufficient PE sessions at most SCF.

4.36 With the exception of SCF North, all detainees had daily association and 'down time' in the evenings, when they could watch television and read books. Staff often sat and mixed with detainees during these sessions.

4.37 All SCF had functional but sparse facilities for visits – both for legal advisers and families. Visits from families were rare, mostly because detainees did not want their family to visit, but we saw evidence of an effective and supportive visit where staff had worked hard to help to ease the concerns of an anxious detainee and his family.

Individual rights

Rights relating to detention

Expected outcomes:
Detention is appropriate, authorised and lasts no longer than is necessary.

4.38 SCF held DNUS for up to 96 hours. Detainees were generally brought into custody by arresting officers from the RMP. Initial authority to detain was given from the time of arrest by a commanding officer (CO) or an officer with delegated custody powers. Reviews of detention were required by the CO or delegated officer at least every 12 hours, up to 48 hours.[3] We saw some periods of detention authorised for less than 12 hours when the CO had considered that the process could be dealt with more swiftly; this was appropriate and gave us confidence that there was a focus on minimising the detention period. If a detainee was charged and was to be held in custody after charge, this could be authorised by a judge advocate up to a further eight days. Detainees under sentence (DUS) could be held in the SCF for up to 14 days. Any period of detention longer than this were served at the MCTC.

[3] Detention could be further extended up to 96 hours by a judge advocate, or in very exceptional circumstances by a commanding officer if it is not practical to arrange a hearing with a judge advocate.

4.39 Despite efforts to standardise the content of the detainee custody record, it continued to be difficult to get an overall picture of the extent to which detainees' rights were respected during their stay in custody. It was often unclear if some aspects of facilitating individual legal rights, such as access to a legal adviser, were carried out by the RMP before custody. Although custody staff were aware of the requirements to authorise detention, we found a number of administrative anomalies. Information about detainees, including initial authority, delegation of custody powers and review/extension documentation, was not always located together and was sometimes missing or not completed thoroughly.

4.40 There were no notable delays in opening custody facilities out of hours, and we were confident from the documentation we reviewed that stays in detention were kept to a minimum.

4.41 With the exception of SCF Northern Ireland, up-to-date versions of the 'Your rights if you are accused of an offence under the Service Justice System' leaflet were readily available. Detainees we spoke to at SCF South and SCF Midlands & Wales confirmed that they had received a copy of the booklet detailing their rights on arrival at the SCF. Copies of Part 3 of the Service Custody and Service of Relevant Sentence Rules 2009 (SCSRSR) were also readily available, issued to detainees as required and displayed prominently. Custody staff told us that they would assist detainees who did not understand their rights by explaining the booklet and/or SCSRSR to them.

4.42 Not all custody staff understood the required authorisation for DNUS to be held 'incommunicado', whereby their communication with others was restricted for a specified period.[4] We found a number of examples where custody staff had accepted requests from the RMP to hold detainees incommunicado without the correct level of authority and without receipt of the appropriate documentation to authorise the decision. Infrequently, periods of incommunicado were extended but we found no review documentation to authorise the ongoing requirement.

4.43 Few SCF proactively publicised the detainees' right to access free and independent legal advice on arrival, as required by Service Police Codes of Practice Code C. Some custody staff were not aware of the Defence Solicitors Call Centre (which offered a duty on-call scheme to provide free and independent legal advice to detainees). Some detainees accessed swift legal advice either by private telephone or face-to-face consultation in the SCF. However, SCF records suggested that some detainees had experienced delays in accessing legal advice. It was unclear from these records whether detainees had accessed legal advice before arrival in custody, as arranged by the RMP. Some requests for legal advice after location in the SCF were passed on to the RMP, and consultation was generally arranged to take place directly before interview; this resulted in some long delays in the facilitation of legal advice, which was unacceptable.

4.44 Detainees' right to inform someone of their whereabouts on arrival in an SCF was mostly facilitated, and was free of charge to the detainee. However, in our review of custody records, we came across a couple of examples where detainees had asked to defer their telephone call to advise someone of their whereabouts, and it had not subsequently been recorded that the call had been facilitated. Some staff were unclear about whether to inform an under-18's parent or guardian about their detention. The instructions in JSP 837 were unclear.

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[4] The Service Police Codes of Practice Code C 1.10 states that detainees held 'incommunicado' should be authorised at an appropriate senior level. 2.42 of Part 2 of the JSP states that DNUS could be held 'incommunicado' as long as the justification and length of time this was required for was recorded and a copy of the authorisation retained in the custody record.

4.45 Custody staff demonstrated a good focus on ensuring that DNUS received a period(s) of uninterrupted rest, and this was well recorded in individual custody records. However, custody staff had too much discretion when assessing fitness to interview, particularly concerning detainees who displayed signs of intoxication. These detainees were not routinely assessed by a health care professional (HCP) to assess their fitness (see paragraph 4.64 and recommendation 4.66).

Recommendations

4.46 Signed authorisation of detention and, where applicable, confirmation of delegation of custody powers should be received without significant delay, and copies should be held within the detainee's custody record.

4.47 Information relating to the detainee should be kept in one contemporaneous custody record.

4.48 Custody staff should ensure that documentation authorising a detainee to be held 'incommunicado' is authorised at an appropriately senior level and specifies the timescale over which it should remain in place.

4.49 Detainees should have access to a legal adviser facilitated at the earliest opportunity. The reason for any delays should be documented in the detainee custody record.

4.50 Detainees should have the opportunity to inform someone of their whereabouts at the earliest opportunity, and reasons for this not happening should be documented.

4.51 SCF staff should understand whether and when to notify a child's parent or guardian of their detention in custody.

Rights relating to treatment

Expected outcomes:
Detainees know how to make a complaint and are able to do so.

4.52 We were consistently told that few detainees made complaints while in custody. Since the previous inspection, attention had been paid to ensuring that detainees were made aware of avenues for complaint, including during admission to the SCF, in the rights booklet and/or in the SCSRSR, and on noticeboards within each SCF. Detainees could make a complaint in a variety of informal and formal ways, including through SCF staff, duty officers, ISCV visitors, confidentially through a locked box (which was not accessible by SCF staff) and through the Service Complaints Ombudsman.

4.53 However, there were inconsistencies in the application of complaints procedures. Some SCF staff broadly knew of the avenues for making a complaint but they were not fully conversant with the processes. Although forms were readily available in association/training areas, there was no standardised complaints form.

Health services

Expected outcomes:
The health needs of detainees are addressed during their time in custody.

4.54 Detainees we spoke to expressed satisfaction with their health care at the SCF. We were impressed by the sensitivity of custody staff to the health needs of detainees.

4.55 Custody staff had JSP 837 to hand and could point out sections related to their practices in getting access to health care, medicines administration, intimate searching and emergency care. Most SCF had developed local unit standing orders and protocols based on the JSP.

4.56 The initial SCF detainee assessment contained a minimal number of questions related to physical and mental health needs, which was appropriate for this population.

4.57 There appeared to be no unnecessary restrictions on access to health care. If necessary, arrangements were made for the detainee to see an HCP, or a detainee could ask to see an HCP, which would be facilitated. They could ask to see an HCP of their own gender, although such requests were rare.

4.58 Custody staff knew to ask for detainee permission to share their personal information with HCPs, and garrison primary care arrangements for gaining consent were to NHS standards.

4.59 In general, the available health services were suitable for addressing the needs of detainees and included various permutations of garrison primary care, on-call military doctors, access to out-of-hours on-call general practitioners, NHS drop-in and emergency facilities. On-site primary care facilities did not routinely offer a visiting service to the SCF, which left custody staff dissatisfied.

4.60 The custody records we saw contained references to detainees visiting health centres, and HCPs assured us that they would give appropriate instructions to custody staff about the continuing care of a detainee, although it was left to custody staff to summarise instructions in the custody record.

4.61 The JSP contained instruction on the provision of emergency health care and equipment. Custody staff knew what to do in an emergency and were trained to use first-aid and resuscitation equipment. The equipment available included automated external defibrillators and suicide prevention kits, was subject to regular, documented checking and was in good order.

4.62 The JSP also contained clear instruction on assisting detainees to take their prescribed medications. Detainees were able to receive the medications they had been prescribed before being taken into custody, after suitable verification. We observed good management of medicines at SCF Scotland, although there was no access to over-the-counter remedies, such as paracetamol, except via an HCP, which was unreasonable.

4.63 Several SCF, such as SCF East and SCF South, had arranged mental health first-aid training locally, although not all staff had received training. However, all custody staff were aware of potential indicators of post-traumatic stress disorder and when to refer detainees for assistance with this. Detainees with mental health or substance misuse issues were first seen by garrison primary care staff, or in more urgent cases via the on-call doctor or local NHS services. Additionally, garrison primary care or military on-call doctors were able to refer detainees to departments of community mental health for further assessment. These arrangements were appropriate.

4.64 Most SCF had a cell with a lower bed plinth, to minimise the risk of a fall by an intoxicated detainee who was 'sleeping it off'. Custody staff were vigilant to detainees with addictions, although we noted that one detainee who had had recurrent detentions related to alcohol intoxication had not been referred for assessment and treatment, which was a missed opportunity.

4.65 We saw no detainee subject to mechanical restraint or planned physical restraint during the inspection. Custody staff said that planned physical restraint was rare but there was guidance on positional asphyxia and other restraint-related safety issues in the JSP. Custody staff told us that they would involve HCPs in such situations.

Recommendation

4.66 Service personnel recurrently detained when intoxicated should be assessed for alcohol-related issues by an appropriate health care professional.

Section 5. Royal Air Force

Treatment and conditions

Transfers and escorts

Expected outcomes:
Detainees transferring to and from service custody premises are treated safely, decently and efficiently.

5.1 Detainees were escorted to the service custody facilities (SCF) by service police. Most escorted journeys were short and took place on camp. Escort vehicles had been updated since the previous inspection and were now all modern and fit for purpose. Detainees were routinely (and without any assessment of risk) front handcuffed while in vehicles, even in dedicated custody vehicles. There was no longer any behind-the-back handcuffing.

5.2 Detainee escort records were not yet in use in the Royal Air Force. We saw records of detainees who had been taken to the local civilian police for interview, and also of some who had been transferred to another SCF. In both instances, it was not clear how risk information had been communicated to the receiving agency.

Recommendations

5.3 Detainees should only be handcuffed when justified by a risk assessment.

5.4 A detainee escort record should be completed for every transfer of a detainee from one location to another. It should ensure that all risks, vulnerabilities and individual care needs associated with the detainee have been identified and communicated to those who are responsible for them.

Respect

Expected outcomes:
Detainees are treated with respect and their diverse needs are recognised and addressed during their time in custody.

5.5 Staff we spoke to talked thoughtfully and respectfully about detainees who had been in their care. Most detainees spent only a few hours in the SCF and were never locked in a cell, which was proportionate and respectful.

5.6 All detainees were given a rub-down search on arrival. There had been no strip-searching at any Royal Air Force SCF. There was a good proportion of custody-trained female staff at most SCF to conduct the searching of women.

5.7 Bathroom visits were subject to varying degrees of supervision. Supervision was excessive at Halton, where staff said that they would routinely stand inside the room while detainees showered because without supervision, they would need to search them again. This was disproportionate to the risk levels that most detainees posed, and contrasted with the otherwise respectful treatment.

5.8 All detainees were offered an interview in private on arrival. Staff were alert to the needs of detainees and there was good evidence in the records of a caring approach. There was little in place for female detainees, but women were rarely detained and we were confident that staff would meet their needs in a caring manner. Staff at all SCF recognised the possibility of detaining a transgender individual and said that they would respect and accommodate their chosen gender. However, the needs of detainees with disabilities had still not been met. None of the cells or bathrooms had not been adapted for detainees with disabilities, although in the records we found no examples of any detainees with mobility problems.

5.9 Christian chaplains, known as padres, offered good support to detainees and staff.

5.10 The independent service custody visiting (ISCV) scheme was gradually being implemented and had just started at Brize Norton and Cosford. However, padres were tasked with undertaking these visits, which did not constitute independent scrutiny.

Recommendations

5.11 Supervision of bathroom visits should be commensurate to a detainee's risk.

5.12 Rub-down searches should only be undertaken when supported by an identified risk.

5.13 Detainees with disabilities that affect their mobility should not be held in an SCF unless provision can be made to meet their needs.

5.14 The independent service custody visiting scheme should be delivered by an independent body.

Safety

Expected outcomes:
Detainees feel and are safe throughout the duration of their detention. Detainees presenting any risks to themselves or others are assessed and managed by custody staff.

5.15 We saw some examples of good, individualised care for those at risk of self-harm, particularly at Cosford, in the case of a detainee charged with serious offences who had refused food. However, there were not always enough trained custody staff to run Royal Air Force SCF safely. At Brize Norton, we were concerned to find that detention had sometimes been overseen by a sole trained custodian. On other occasions, a member of custody-trained staff ran the SCF alongside a member of the Royal Air Force (not necessarily from the service police) who did not have custody training. These practices were potentially risky. Custody training had also lapsed for a couple of staff at Honington but there were still sufficient custody-trained staff available. We had concerns that the infrequent use of Royal Air Force SCF meant that staff were unable to embed learning and could easily become de-skilled (see area of concern 2.42).

5.16 There was no specific suicide and self-harm training but some staff at Halton had completed a promising mental health first-aid course. There was an anti-ligature knife available in every SCF, although sometimes this was in a cupboard and not immediately available. Cells were free from ligature points. There was no anti-tear clothing available for detainees.

5.17 All detainees had a private risk assessment on arrival. However, SCF staff were not yet using the new detainee assessment record (DAR) introduced in revised Joint Service Publication

(JSP) 837, and instead continued to use an outdated risk assessment form based on a checklist. The lack of suicide and self-harm training for staff was reflected in the quality of most of the risk assessments we saw. Occasionally, staff demonstrated proper and thoughtful consideration of a detainee's circumstances but most assessments were simply tick lists and did not show any rationale or clear understanding of risk factors (see area of concern 2.43).

5.18 As at the time of the previous inspection, all detainees were automatically treated as high risk on arrival and for the first 24 hours, which effectively meant throughout their short stays. This potentially increased the risk to detainees as staff did not distinguish between detainees who were truly high risk and those identified as such. Staff were unaware of the new risk levels identified in the new JSP 837.

5.19 Automatic high-risk assessments meant that all detainees were observed at 15-minute intervals. This was disruptive to the sleep of low-risk detainees, and defeated the purpose of a risk assessment. The automatic removal of shoes and belts while in-cell at some SCF was also excessive. Detainees never shared cells.

5.20 Despite the large number of intoxicated detainees held, rousing procedures were generally not clearly understood by custody staff, and we found little evidence of their use, except at Cosford. Some Royal Air Force staff told us that they would let a detainee 'sleep it off'.

5.21 Staff were familiar with basic emergency response procedures but protocols for a death, hostage scenario or escape were underdeveloped.

Recommendations

5.22 Staff without appropriate custody training should not work in an SCF.

5.23 All SCF staff should complete suicide and self-harm training and the mental health first-aid course.

5.24 Staff should understand the risk categories and observation levels (including those for intoxicated detainees) identified in the revised Joint Service Publication (JSP) 837. Detainee records should be updated to reflect the terminology used in the JSP, so that staff can accurately record and follow the observation levels set.

Safeguarding

Expected outcomes:
Young detainees (under 18) are properly protected in a safe environment. All staff safeguard and promote their welfare. Detainees will only be subject to force that is proportionate, lawful and used as a last resort. Detainees are transferred or released safely and decently.

5.25 We saw some good examples in detainee records of appropriate care for under-18s in custody. Staff relied heavily on the Royal Air Force's on-camp welfare services for guidance. These resources were especially good at Halton, where many young recruits were based. Staff understood that the presence of an appropriate adult was required for interviews, and a padre, welfare officer or senior personnel from the detainee's unit typically acted in this role. None of the SCF had clear localised guidance for steps to take when detaining under-18s. Similarly, there were no links to local children's services departments if staff had concerns about the welfare of under-18s. Staff had not received any child protection training.

5.26 Staff completed 12 hours of personal safety training (PST) each year, and this was up to date. Apart from PST, there was no specific training in the appropriate and safe use of force on detainees. We were told that there had been no recent uses of force inside a Royal Air Force SCF, and found no evidence of any. However, staff were sometimes confused about what constituted use of force, and recording was therefore inconsistent. For example, paperwork was occasionally completed when handcuffs had been used to escort detainees, which was unnecessary.

5.27 There was no local oversight or monitoring of the use of force at any of the SCF. Use of force paperwork we saw gave no opportunity to record the rationale for its use, which was unhelpful.

Recommendations

5.28 Custodial staff should be fully trained in the needs of detainees under 18 years of age and other detainees at risk, and how to make referrals to appropriate services.

5.29 Custodial staff should be trained in the safe use of force.

Release

5.30 We were satisfied that staff gave good verbal handovers to the detainee's unit or welfare services when they were released. Detainees on release were also given a good self-referral leaflet, which provided a helpful range of contacts.

5.31 However, there was no structured pre-release risk assessment which properly considered the detainee's state of mind and addressed any concerns. There had been a large increase in the number of arrests for serious sexual offences, and we were concerned that detainees facing the potential loss of their jobs, accommodation and families might not have received sufficient support.

Recommendation

5.32 Comprehensive pre-release risk assessments should be completed routinely before release, identifying all ongoing risk factors and how they will be addressed.

Physical conditions

Expected outcomes:
Detainees are held in a safe, clean and decent environment, which is in a good state of repair and fit for purpose.

5.33 Cells were basic, with little natural light from the windows, which were above head height and opaque. They were well painted and free of graffiti, but bleak and unnecessarily austere. All cells had a low plinth, but there was no furniture, no drinking water and no integral toilet or shower. The cells at Brize Norton were noticeably cold. Conditions were mitigated to a degree by limited use – many detainees never entered a cell – and the short stays for most detainees.

5.34 Evacuation procedures were simple, and known to staff. Cell call bells were all in working order, but at Brize Norton the cell call panel to alert staff was located outside the SCF, in the guardroom. This meant that SCF staff detaining an individual were not immediately alerted to cell calls, which was unsafe. Brize Norton had also introduced in-cell closed-circuit television, which had the potential to improve safety, but the viewing facilities were located outside the SCF, so they could not be used by staff during detention.

Recommendation

5.35 At Brize Norton, the cell call panel should be relocated inside the SCF.

Detainee care

Expected outcomes:
Detainees are able to be clean and comfortable while in service custody facilities. Detainees are offered sufficient food and drink. Detainees have regular access to facilities and activities that preserve and promote their mental and physical well-being.

5.36 Detainee care was very good. As most had short stays and were often not locked in cells, bedding was usually given only on request. All cells had their own tear-proof mattress and pillow. There was a supply of blankets and basic toiletries, which sometimes included feminine hygiene products. Toilet roll was freely available at all SCF. Detainees could wear their own clothes but unisex overalls in larger sizes were available if they needed to change or had to hand in their clothing as evidence.

5.37 Showers, toilets and urinals inside the SCF buildings were generally in good condition, although the bathroom at Honington was shabby and the shower curtain was dirty. Most detainees were admitted too briefly but could request a shower if they stayed for longer periods. However, it was not always possible to shower privately. The bathroom at Honington had no door and there was excessive supervision at Halton (see paragraph 5.7). Toilet visits for those held in-cell were requested using the cell call bell, which was a problem at Brize Norton as the staff would not be alerted (see paragraph 5.34 and recommendation 5.35). There were regular checks, mostly daily, on the basic fabric of the buildings, which now included running the water.

5.38 Staff fetched food from the mess or a nearby supermarket on an ad-hoc basis, which was a sensible arrangement. Detainees ate out of cell, usually on a chair at the front desk. Water or a hot drink was provided on arrival and then when requested. Honington had no drinking water, and so detainees were provided with bottled water.

5.39 Exercise yards were in poor condition and were typically used only for detainees' smoking breaks. The yard at Honington was still no more than a cage facing the road. Owing to the very short stays, there was no published regime and there were no reading or writing materials, activities or visits facilitated. Detainees were all offered a free telephone call on arrival but most refused.

Individual rights

Rights relating to detention

Expected outcomes:
Detention is appropriate, authorised and lasts no longer than is necessary.

5.40 The Royal Air Force SCF only held detainees before charge. All but one of the cases we reviewed had been held for under 12 hours in order for the Royal Air Force police or the Special Investigation Branch to undertake further investigations, such as searching property and/or interviewing the detainee about the alleged offence. In some cases, authorisation was given for just a few hours, based on the time needed to complete the further investigative tasks, which was appropriate. For example, at Honington authorisation was often given for about four hours, to enable the service police to conduct a search of the detainee's home and seize specific property.

5.41 Staff were aware of the process for gaining authorisation to detain a person for longer than 12 hours, and the need to apply to a judge advocate for authorisation beyond 48 hours. We found appropriate authorisation from a judge advocate included in the detainee custody record for one man who had been held for 54 hours at Cosford.

5.42 A couple of the SCF made use of section 69 of the Armed Forces Act 2006 to remove a person from a situation that could lead to an offence being committed, to avoid the need to take them into detention.

5.43 There was clear separation of arresting officer and custody officer duties, and this worked well almost all of the time. The records showed only one minor delay in admitting a new detainee, and this was caused by having to wait for a custody-trained member of staff to be available on-site.

5.44 Copies of the signed authorisation form for detention were often missing from the SCF detainee custody files. At Halton, not all staff ensured that a copy of the authorisation was added to the detainee detention file. At Cosford, staff said that it was often difficult to obtain copies of the authorisation form from the investigating officers when the accused had been brought there from another Royal Air Force base. In addition, in one case, the authorisation form had not been signed by the commanding officer until after the detention period had ended, which was not good practice.

5.45 Detainees were offered the opportunity to make a telephone call in private to inform someone that they were being detained after arrest; if the first attempt at calling was unsuccessful, staff allowed them to try again several times. There was confusion about informing the parents or carers of the detention of under-18s. At Honington, we were told that this would always be done but at the other SCF parents or carers were only contacted with the detainee's permission. The JSP did not give clear guidance on this.

5.46 Some detainees were held 'incommunicado' but it was unclear if this was authorised appropriately; entries in the detainee custody records suggested that this was done by the arresting officer but there was no evidence of authorisation at a higher level. Detainees were not held incommunicado for too long and there was evidence of them being allowed to call a person of their choice at the earliest opportunity.

5.47 Detainees were given information about their right to have free legal advice, and each SCF had posters on display to promote this. Detainees declining this on arrival could change their

mind at any point during their detention. Access to solicitors was not problematic and we saw evidence of face-to-face or telephone contact being undertaken promptly. Interviews were held in private.

5.48 All sites were able to provide the detainee with a copy of the Service Police Codes of Practice if requested, and copies of the most up-to-date version of the 'Your rights if you are accused of an offence under the Service Justice System' leaflet were available, and given to each detainee. Copies of the Service Custody and Service of Relevant Sentence Rules 2009 (SCSRSR) rules were not routinely available.

5.49 Written information was not available in easy-read formats to support detainees, such as those with dyslexia, who might struggle to understand the detailed information. However, staff said that they would explain the information to a detainee if this was needed.

5.50 SCF records were held in different places, making it difficult to see if all rights had been met consistently. However, most recording in the detainee custody record was comprehensive and evidenced the completion of mandatory tasks, such as accessing a legal adviser.

5.51 SCF staff understood that a person under the influence of alcohol or drugs should not be interviewed until they were fit to take part; if the person was significantly impaired, they would not be detained and would be directed to hospital instead. Intimate searching had not taken place in the last few years but staff were clear that this could only be carried out by a medical officer.

Recommendations

5.52 Written authorisation for detention should always be undertaken without significant delay, and a copy of this should always be placed in the detainee's custody record.

5.53 Custody staff should ensure that documentation authorising a detainee to be held 'incommunicado' is authorised at an appropriately senior level and specifies the timescale over which it should remain in place.

5.54 SCF staff should understand whether and when to notify a child's parent or guardian of their detention in custody.

5.55 Information relating to the detainee should be kept in one contemporaneous custody record.

Rights relating to treatment

Expected outcomes:
Detainees know how to make a complaint and are able to do so.

5.56 The complaints process had not developed much since the previous inspection. Not all SCF displayed notices about how to make a complaint. There were a number of routes for making a complaint but forms were not readily available to detainees while in the SCF. Staff were not aware of timescales for reply but said that detainees could request the help of an assisting officer if they wanted help to make a complaint.

5.57 Posters advertising the Service Complaints Ombudsman were displayed in some SCF but the ISCV scheme was not well developed (see also paragraph 5.10) and we were not confident that detainees were always seen by the duty officer, to ask if they had any complaints.

Recommendation

5.58 Detailed written and verbal information about how to make a complaint should be given and all detainees should be seen in private by the duty officer, to check if they have any complaints.

Health services

Expected outcomes:
The health needs of detainees are addressed during their time in custody.

5.59 Detainees we spoke to expressed satisfaction with their health care at the SCF. We were impressed by the sensitivity of custody staff to the health needs of detainees.

5.60 Custody staff had JSP 837 to hand, and regular staff could point out sections related to their practices in getting access to health care, medicines administration, intimate searching and emergency care. At Halton, local unit standing orders and protocols based on the JSP had been developed. At Honington, custody staff had good access to protocols for medical emergencies such as an asthma attack or sudden collapse, which was impressive.

5.61 The initial SCF detainee assessment contained a minimal number of questions related to physical and mental health needs, which was appropriate for this population.

5.62 There appeared to be no unnecessary restrictions on access to health care. If necessary, arrangements were made for the detainee to see a health care professional (HCP), or a detainee could ask to see an HCP, which would be facilitated. They could ask to see an HCP of their own gender, although such requests were rare.

5.63 Custody staff knew to ask for detainee permission to share their personal information with HCPs, and primary care arrangements for gaining consent were to NHS standards.

5.64 In general, the available health services were suitable to address the needs of detainees and included various permutations of Royal Air Force primary care, on-call military doctors, access to out-of-hours on-call general practitioners, NHS drop-in and emergency facilities. On-site primary care facilities did not routinely offer a visiting service to the SCF, which left custody staff dissatisfied. At Cosford, the primary care service was limited and the military doctor on call was not always accessible, so the SCF defaulted to the community on-call service, which was a reasonable approach to take.

5.65 The custody records we saw contained references to detainees visiting health centres, and HCPs assured us that they would give appropriate instructions to custody staff about the continuing care of a detainee, although it was left to custody staff to summarise instructions in the custody record.

5.66 The JSP contained instruction on the provision of emergency health care and equipment. Custody staff knew what to do in an emergency and were trained to use first-aid and resuscitation equipment. The equipment available included automated external defibrillators and suicide prevention kits, was subject to regular, documented checking and was in good order.

5.67 The JSP contained clear instruction on assisting detainees to take their prescribed medications. Medicines were stored in lockable cabinets, except at Honington, where staff said that they would use the 'DNA fridge', which was not acceptable. Detainees were able to receive the medications they had been prescribed before being taken into custody, after suitable verification. Medicines were handled safely. There was no access to over-the-counter remedies, such as paracetamol, except via an HCP, which was unreasonable.

5.68 Most SCF had arranged mental health first-aid training locally. At Brize Norton, staff had not received training but this was being sourced at the time of the inspection. However, all custody staff were aware of potential indicators of post-traumatic stress disorder and when to refer detainees for assistance with this. Detainees with mental health or substance misuse issues were first seen by Royal Air Force primary care staff, or in more urgent cases via the on-call doctor or local NHS services. Additionally, military primary care staff or doctors were able to refer detainees to departments of community mental health for further assessment. These arrangements were appropriate.

5.69 Most SCF had a cell with a lower bed plinth, to minimise the risk of a fall by an intoxicated detainee who was 'sleeping it off', and custody staff were vigilant to detainees with addictions.

5.70 We saw no detainees subject to mechanical restraint or planned physical restraint during the inspection. Custody staff said that planned physical restraint was rare but there was guidance on positional asphyxia and other restraint-related safety issues in the JSP. Custody staff told us that they would involve HCPs in such situations, and we were given an example of this at Honington.

Recommendation

5.71 At Honington, medicines should be stored in a locked cabinet at room temperature, unless accompanying manufacturer's medicine leaflets indicate otherwise.

Section 6. Summary of areas of concern and recommendations

The reference numbers at the end of each recommendation refer to the paragraph location in the report.

Areas of concern and recommendations

To the MoD

6.1 **Area of concern:** There were small numbers of detainees held in some SCF, particularly the Royal Navy and most of the Royal Air Force SCF. Some limited rationalisation of SCF facilities had taken place. We saw, and welcomed, some cross-service use of SCF, and some Royal Navy SCF had sensible arrangements with the local police to provide custody facilities. However, staffing pressures were evident. Royal Air Force SCF used untrained custodians (alongside trained staff) and, where numbers of detainees were small, trained staff across all three services inevitably became inexperienced and de-skilled.

Recommendation: A review of the current service facilities (SCF) should take place, with a view to further rationalising and consolidating the delivery of the facilities or agreeing with local police custody suites for them to provide custody facilities for the services concerned. (2.42)

6.2 **Area of concern:** There was little initial exchange of information about a detainee's risk on their arrival at an SCF or MCTC following sentencing, despite this being a particularly risky time. Custody staff were not always able to identify, assess, mitigate and address risks in a proportionate way, and the recording of risk information was poor.

Recommendation: Service staff should complete a detainee escort record following sentence, and this should accompany a detainee to the SCF or Military Corrective Training Centre (MCTC). Custody staff should be trained in the identification, assessment and reduction of risk, and how to evidence and record this in risk documentation. (2.43)

6.3 **Area of concern:** Access to the MCTC for new receptions was limited to between 8am and 6pm. This resulted in many detainees being lodged overnight at SCF East (just a few hundred yards from the MCTC). Many detainees arrived there late at night and underwent long admittance and assessment processes, only to be transferred to the MCTC a few hours later to follow a repeat process. This was disruptive and potentially had a negative impact on detainee welfare.

Recommendation: The MCTC should accept detainees out of hours when necessary. (2.44)

Recommendations – Royal Navy

Respect

6.4 Rub-down searches should only be undertaken when supported by an identified risk. (3.11)

6.5 Detainees with disabilities that affect their mobility should not be held in an SCF unless provision can be made to meet their needs. (3.12)

Safety

6.6 Staff should understand the risk categories and observation levels identified in the revised Joint Service Publication (JSP) 837. Detainees records should be updated to reflect the terminology used in the JSP, so that staff can accurately record and follow the observation levels set. (3.19)

Safeguarding

6.7 Pre-release risk assessments should record all ongoing risk factors and identify how they will be addressed. (3.23)

Rights relating to detention

6.8 Signed authorisation of detention and, where applicable, confirmation of the delegation of custody powers should be received without significant delay and copies should be held within the detainee's custody record. (3.38)

6.9 Custody staff should have no involvement in the arrest or investigation of offences allegedly committed by detainees under their care. (3.39)

6.10 Information relating to the detainee should be kept in one contemporaneous custody record. (3.40)

6.11 Custody staff should ensure that documentation authorising a detainee to be held 'incommunicado' is authorised at an appropriate senior level and details the timescales during which it should remain in place. (3.41)

Recommendations – Army

Respect

6.12 Detainees with disabilities that affect their mobility should not be held in an SCF unless provision can be made to meet their needs. (4.11)

6.13 Rub-down searches should only be undertaken when supported by an identified risk. (4.12)

Safety

6.14 Staff should understand the risk categories and observation levels identified in the revised Joint Service Publication (JSP) 837. Detainee assessment records should be updated to reflect the terminology used in the JSP, so that staff can accurately record and follow the observation levels set. (4.19)

Safeguarding

6.15 Pre-release risk assessments should record all ongoing risk factors and identify how they will be addressed. (4.25)

Physical conditions

6.16 Detainees residing in the SCF for more than 48 hours should, subject to a risk assessment, be allowed to have furniture and personal possessions in their cell and should be able to control their lighting. (4.29)

6.17 Cellular accommodation and communal facilities at SCF North should be made fit for use. (4.30)

Rights relating to detention

6.18 Signed authorisation of detention and, where applicable, confirmation of delegation of custody powers should be received without significant delay, and copies should be held within the detainee's custody record. (4.46)

6.19 Information relating to the detainee should be kept in one contemporaneous custody record. (4.47)

6.20 Custody staff should ensure that documentation authorising a detainee to be held 'incommunicado' is authorised at an appropriately senior level and specifies the timescale over which it should remain in place. (4.48)

6.21 Detainees should have access to a legal adviser facilitated at the earliest opportunity. The reason for any delays should be documented in the detainee custody record. (4.49)

6.22 Detainees should have the opportunity to inform someone of their whereabouts at the earliest opportunity, and reasons for this not happening should be documented. (4.50)

6.23 SCF staff should understand whether and when to notify a child's parent or guardian of their detention in custody. (4.51)

Health services

6.24 Service personnel recurrently detained when intoxicated should be assessed for alcohol-related issues by an appropriate health care professional. (4.66)

Recommendations – Royal Air Force

Transfers and escorts

6.25 Detainees should only be handcuffed when justified by a risk assessment. (5.3)

6.26 A detainee escort record should be completed for every transfer of a detainee from one location to another. It should ensure that all risks, vulnerabilities and individual care needs associated with the detainee have been identified and communicated to those who are responsible for them. (5.4)

Respect

6.27 Supervision of bathroom visits should be commensurate to a detainee's risk. (5.11)

6.28 Rub-down searches should only be undertaken when supported by an identified risk. (5.12)

6.29 Detainees with disabilities that affect their mobility should not be held in an SCF unless provision can be made to meet their needs. (5.13)

6.30 The independent service custody visiting scheme should be delivered by an independent body. (5.14)

Safety

6.31 Staff without appropriate custody training should not work in an SCF. (5.22)

6.32 All SCF staff should complete suicide and self-harm training and the mental health first-aid course. (5.23)

6.33 Staff should understand the risk categories and observation levels (including those for intoxicated detainees) identified in the revised Joint Service Publication (JSP) 837. Detainee records should be updated to reflect the terminology used in the JSP, so that staff can accurately record and follow the observation levels set. (5.24)

Safeguarding

6.34 Custodial staff should be fully trained in the needs of detainees under 18 years of age and other detainees at risk, and how to make referrals to appropriate services. (5.28)

6.35 Custodial staff should be trained in the safe use of force. (5.29)

6.36 Comprehensive pre-release risk assessments should be completed routinely before release, identifying all ongoing risk factors and how they will be addressed. (5.32)

Physical conditions

6.37 At Brize Norton, the cell call panel should be relocated inside the SCF. (5.35)

Rights relating to detention

6.38 Written authorisation for detention should always be undertaken without significant delay, and a copy of this should always be placed in the detainee's custody record. (5.52)

6.39 Custody staff should ensure that documentation authorising a detainee to be held 'incommunicado' is authorised at an appropriately senior level and specifies the timescale over which it should remain in place. (5.53)

6.40 SCF staff should understand whether and when to notify a child's parent or guardian of their detention in custody. (5.54)

6.41 Information relating to the detainee should be kept in one contemporaneous custody record. (5.55)

Rights relating to treatment

6.42 Detailed written and verbal information about how to make a complaint should be given and all detainees should be seen in private by the duty officer, to check if they have any complaints. (5.58)

Health services

6.43 At Honington, medicines should be stored in a locked cabinet at room temperature, unless accompanying manufacturer's medicine leaflets indicate otherwise. (5.71)

Section 7. Appendices

Appendix I: Inspection team

Martin Lomas	Deputy Chief Inspector
Alison Perry	HMI Prisons team leader
Paul Rowlands	HMI Prisons inspector
Fiona Shearlaw	HMI Prisons inspector
Jonathan Tickner	HMI Prisons inspector
Sandra Fieldhouse	HMI Prisons inspector
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Paul Tarbuck	HMI Prisons health services inspector