



Report on an unannounced inspection visit to police  
custody suites in

# Thames Valley Police

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

**5–16 February 2018**

This inspection was assisted by an inspector from the Care Quality Commission (CQC) in assessing health services under our memorandum of understanding.

### **Glossary of terms**

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# Fact page<sup>1</sup>

## Force

Thames Valley Police

## Chief Constable

Francis Habgood

## Police and Crime Commissioner

Anthony Stansfeld

## Geographical area

Oxfordshire, Berkshire and Buckinghamshire

## Date of last police custody inspection

9–19 September 2013

## Custody cells

Abingdon	30 cells
Aylesbury	24 cells
Banbury	12 cells
High Wycombe	12 cells
Loddon Valley	28 cells
Maidenhead	26 cells
Milton Keynes	24 cells
Newbury	13 cells

## Cell capacity

## Annual custody throughput

1.1.17-31.12.17 31,829 detentions

## Custody staffing

84 custody sergeants

113 civilian detention officers (employed by Noonan)

## Health service provider

Mountain Healthcare Ltd.

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<sup>1</sup> Data supplied by the force.



# Executive summary

- S1 This report describes the findings following an inspection of Thames Valley Police custody facilities. The inspection was conducted jointly by HM Inspectorate of Prisons (HMIP) and HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) in February 2018, as part of their programme of inspections covering every police custody suite in England and Wales.
- S2 The inspection assessed the effectiveness of custody services and outcomes for detained people throughout the different stages of detention. It examined the force's approach to custody provision in relation to safe detention and the respectful treatment of detainees, with a particular focus on vulnerable people and children.
- S3 We last inspected custody facilities in Thames Valley Police in 2013. This inspection found that of the 26 recommendations made during that previous inspection, seven had been achieved, nine had been partially achieved and eight had not been achieved. Two recommendations were no longer relevant.
- S4 To aid improvement we have made three recommendations to the force (and the Police and Crime Commissioner) addressing key areas for concern, and have highlighted an additional 33 areas for improvement. These are set out in Section 6.

## Leadership, accountability and partnerships

- S5 This inspection of custody facilities in Thames Valley was generally positive. The force had demonstrated some progress following our last inspection, especially in health services, and could evidence positive practice. With respect to the significant concerns and areas for improvement we identified, we were confident that the force's strong leadership and clear grip on performance would enable it to act effectively to address these issues.
- S6 Thames Valley Police had a strong and focused governance structure that provided appropriate accountability for custody. There was a clear commitment to providing effective custody services. Custody sergeants were well trained. Shortages of detention officers had, however, sometimes affected detainees.
- S7 The force collated mostly comprehensive data but there were some gaps. It was of serious concern that the force did not comply with several requirements of code C of the Police and Criminal Evidence Act (PACE) codes of practice, covering the detention, treatment and questioning of persons by police officers (see area for concern and recommendation S24). There was some good work to address areas of potentially disproportionate treatment, but this was at times undermined by inaccuracies or incomplete data.
- S8 There was a strong strategic focus, and the force worked well with a range of partner agencies to divert vulnerable people from custody. The force's efforts to ensure that children spent as little time as possible in custody were sometimes diminished by the lack of appropriate alternative accommodation provided by local authorities. However, there had been success in reducing the number of people with acute mental ill health taken into police custody under section 136 the Mental Health Act.<sup>2</sup>

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<sup>2</sup> Section 136 enables a police officer to remove, from a public place, someone who they believe to be suffering from a mental disorder and in need of immediate care and control, and take them to a place of safety – for example, a health or social care facility, or the home of a relative or friend. In exceptional circumstances (for example if the person's behaviour would pose an unmanageably high risk to others), the place of safety may be police custody.

## Pre-custody: first point of contact

- S9 Frontline officers had a good understanding of people's potential vulnerability and took this into account when deciding whether to make an arrest. Although officers felt that they could have had better information to support their decision making, they actively sought to find alternative solutions to avoid taking children and people with mental ill health into custody.

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

- S10 Interactions between custody staff and detainees were respectful, and staff paid good attention to individual and diverse needs. There was a clear strategic commitment at chief officer level to meet the needs of women. However, in practice, the specific needs of women in detention were not always identified and met. Most custody areas lacked privacy, although staff were alert to this and aimed to deal with detainees as sensitively as they could. Some working practices, however, did not always maintain detainee dignity, for example not providing detainees with replacement footwear when their own was removed.
- S11 Initial assessments and management of presenting risks was generally good. Positively, some measures to offset risk were applied in each individual case. Most detainees were looked after and kept safe. However, during the inspection a small number of adverse incidents highlighted that some working practices, including searching, cell watches and responses to cell call bells, were not always conducted sufficiently robustly. Consequently, some serious safety concerns and significant risks to detainees were not managed well enough. (See area for concern and recommendation S23.)
- S12 Detention was properly authorised. Detainees were consistently informed of their rights while in custody, generally in a language and format they could understand. Most cases were progressed diligently, and the detainee's time in custody was mostly used expeditiously to conclude investigations. However, it was not always possible for the police to find appropriate adults, interpreters, duty solicitors or investigators, and so some detainees spent longer in custody than was necessary.
- S13 Inspector reviews of detention were not always good enough. Custody records and our observations indicated that many reviews were not conducted in line with the requirements of PACE or in the best interests of the detainee.
- S14 The force's application and management of bail were generally effective.
- S15 The force gave little importance to facilitating detainees' right to complain about their treatment in custody, and complaints were not always dealt with before they left custody.

## In the custody cell, safeguarding and health

- S16 Custody suites were generally clean and well maintained, with little graffiti. Heating in cells was not always satisfactory and many were too cold. We identified potential ligature points in some cells and communal areas; we gave the force a report highlighting these findings shortly after the inspection.
- S17 Custody staff dealt well with many challenging detainees, and often de-escalated situations effectively to avoid using force. In most cases where force was used, the records were inconsistent and not always in line with recommendations from the National Police Chiefs Council. In cases we reviewed, the use of force was not always proportionate to the threat posed. Governance of the use of force in custody was not sufficiently rigorous. Strip



searches were properly authorised but were not always conducted robustly enough. (See area for concern and recommendation S25.)

- S18 Detainee care did not extend much beyond providing food and drinks. Detainees had limited access to time in the open air, showers and distractions such as reading materials.
- S19 Police officers and custody sergeants understood their responsibility in safeguarding children and vulnerable adults. They showed some good care to children and a focus on minimising their time in detention, although this was not always achieved. Some children and vulnerable adults had long waits before they received support from an appropriate adult to help them through the stages of custody.
- S20 Health services had improved significantly since our previous inspection. Clinical governance arrangements were robust and patient care was generally good. The introduction of mental health liaison and diversion services had improved outcomes for detainees and had offset the gap in support for detainees with substance misuse needs. Some detainees had excessive delays awaiting assessments and transfers under the Mental Health Act. However, most people with acute mental ill health were diverted from custody, and police custody was now only used as a place of safety under section 136 the Mental Health Act in exceptional circumstances.

## Release and transfer from custody

- S21 Custody sergeants were attentive in ensuring that detainees, particularly the most vulnerable, were released safely. However, records of pre-release risk arrangements and person escort records often lacked detail.
- S22 Despite some ongoing work with partner agencies, detainees were still not always presented before the first available court, and some spent longer in police custody than necessary.

## Areas for concern and recommendations

- S23 Area for concern:** There were some serious safety issues and significant risks to detainees that the force did not always manage adequately. For example, searching and strip-searching were not always robust. Processes for conducting cell watches were not always adequate. Arrangements to respond to cell call bells were poor.

**Recommendation:** The force should take immediate action to improve the searching of detainees, ensure close-proximity cell watches are carried out effectively, and that cell call bells are audible and answered promptly at all times.

- S24 Area for concern:** There were several areas where the force did not comply with code C of PACE and which it needed to address as a matter of urgency:
- section 15.7: detainees were not informed of reviews taking place while they were asleep;
  - section 15.14: officers conducting reviews of detainees by telephone did not always record where they were or why the review could not be conducted in person;
  - annex H: staff responsible for rousing intoxicated detainees did not always enter the cell and carry out the rousal in line with approved guidance.

**Recommendation:** The force should ensure that all custody processes comply with the Police and Criminal Evidence Act 1984.

**S25** **Area for concern:** The governance and oversight of the use force in custody were not adequate, data were unreliable and Thames Valley Police did not record all instances where force was used in its custody suites. Not all uses of force were proportionate to the risk or threat posed.

**Recommendation:** All use of force in custody should be properly recorded and in line with recommendations from the National Police Chiefs Council. Incidents should be reviewed and cross-referenced to CCTV records to demonstrate that the force used is proportionate and justified.

# Introduction

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

Our inspections assess how well each police force is fulfilling its responsibilities for the safe detention and respectful treatment of those detained in police custody, and the outcomes achieved for detainees.

Our assessments are made against the criteria set out in the *Expectations for Police Custody*.<sup>3</sup> These independent Expectations are developed by the two inspectorates, widely consulted on across the sector and regularly reviewed to achieve best custodial practice and drive improvement.

The *Expectations* are grouped under five inspection areas:

- Leadership, accountability and partnerships
- Pre-custody: first point of contact
- In the custody suite: booking in, individual needs and legal rights
- In the custody cell: safeguarding and health care
- Release and transfer from custody.

The inspections also assess compliance with the Police and Criminal Evidence Act 1984 (PACE) codes of practice and the College of Policing's *Authorised Professional Practice – Detention and Custody*.<sup>4</sup>

The methodology for carrying out the inspections is based on: a review of a force's strategies, policies and procedures; an analysis of force data; interviews with staff; observations in suites, including discussions with detainees; and an examination of case records. We also conduct a documentary analysis of custody records based on a representative sample of the custody records across all the suites in the force area open in the week before the inspection was announced. For Thames Valley force, we analysed a sample of 150 custody records. The methodology for our inspection is set out in Appendix II.

The joint HMIP/HMICFRS national programme of unannounced police custody inspections, which began in 2008, ensures that custody facilities in all 43 forces in England and Wales are inspected, at a minimum, every six years. This inspection is part of the second round of the rolling programme.

**Wendy Williams**  
HM Inspector of Constabulary

**Peter Clarke CVO OBE QPM**  
HM Chief Inspector of Prisons

<sup>3</sup> <http://www.justiceinspectorates.gov.uk/hmiprison/about-our-inspections/inspection-criteria/>

<sup>4</sup> <https://www.app.college.police.uk/app-content/detention-and-custody-2/>



# Section 1. Leadership, accountability and partnerships

## Expected outcomes:

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

## Leadership

- I.1 Thames Valley Police had a clear governance structure for custody. Under the direction of the assistant chief constable (ACC), the superintendent leading the criminal justice department had overall responsibility for the custody function. This was supported by specialist staff trained to deliver custody services, including dedicated central policy officers. The structure was set out in the force policy and provided clear accountability for the safe delivery of custody.
- I.2 Senior officers had sufficient oversight of the custody function and there were effective internal meeting structures to oversee these. A monthly custody performance meeting chaired by the chief inspector informed a quarterly custody strategy meeting chaired by the ACC. Risks were appropriately recorded and escalated to the force risk register.
- I.3 The force had made some progress in achieving recommendations from our previous inspection – seven of the 26 recommendations had been achieved, nine partially achieved and eight not achieved. Two recommendations were no longer relevant. There had been notable improvement in the health services provided in custody.
- I.4 The number of custody sergeants in each suite varied according to its size but was generally sufficient and did not need to rely on cover from officers elsewhere in the force. However, at the time of our inspection there was a shortage of detention officers (DOs). DOs were not directly employed by the police but were outsourced to a private contractor, Noonan, and the force was addressing this issue with the company at senior level. Our observations and case audits showed that the shortage of staff was having an effect on detainees, with cell call bells frequently unanswered, detainee checks not always conducted in line with observation levels set, and on occasion the full or partial closure of suites.
- I.5 Initial training for custody sergeants was good and the force had a dedicated custody trainer. Custody officers were required to complete a three-week nationally accredited course and a period of shadowing experienced peers before undertaking duties. They also received continual professional development with a one-day course within each six-week shift rota.
- I.6 Noonan trained the DOs and it was expected that the training provision would meet national standards for police staff. The force had reviewed this training and found that it failed to meet all national standards, and as a result had brought some aspects in house to be delivered by its own custody trainer. Custody sergeants and DOs, however, did no joint training, which could be beneficial.
- I.7 We found that frontline officers carried out some tasks that we would normally expect of DOs, such as locating detainees in their cells. Frontline officers also performed some other custody roles, including the searching and strip searching of detainees, and close proximity monitoring of high risk detainees. However, it was not clear what training they received for

this. The cases we examined, and several incidents during the inspection, indicated that detainees were able to retrieve concealed items while in the cell, such as drugs and other items that could cause harm, despite having been searched and sometimes while being closely watched. This posed a significant risk to their safety and resulted in some adverse incidents (see paragraph 3.19). We had serious concerns about how effectively detainees were searched and cell watch observations were conducted, and expected the force to address these as a matter of urgency (see area for concern and recommendation S23).

- I.8** The force had adopted the College of Policing *Authorised Professional Practice* (APP) for custody. There were also comprehensive local policies to support staff where relevant. However, not all the processes and practices we observed complied with APP or the force's own policies. In particular, staff often conducted the rousing of intoxicated detainees through cell hatches rather than entering the cell, which did not comply with the Police and Criminal Evidence Act (PACE) code C, annex H (see area for concern and recommendation S24).
- I.9** Despite some weaknesses, the quality of custody records was better than we often see, with some good use of free text and a generally clear narrative of events. There were quality assurance processes, with sergeants expected to conduct a peer review of another sergeant's custody record every month. However, these were not sufficient in quantity and failed to identify the numerous non-compliances with code C of PACE. There was little scrutiny from more senior managers to ensure the reviews were of good quality and robust enough to identify trends and drive improvement.
- I.10** There was a clear strategic focus on the diversion of vulnerable people from custody. Staff actively sought to avoid custody of children and vulnerable adults and their entry into the criminal justice system.

### Areas for improvement

- I.11** **There should be sufficient staffing on all shifts to ensure the safe detention of all detainees.**
- I.12** **Quality assurance processes should be robust and focused on ensuring that all custody records are of an adequate standard.**

### Accountability

- I.13** The force had arrangements to hold contract providers to account with clear escalation processes. The force was actively pursuing these with Noonan for the provision of DOs (see paragraph 1.4) and with Capita for the interpreting services (see paragraph 3.10 and area for improvement 3.14), with a clear focus from senior officers to improve services.
- I.14** The extent and quality of the information to support effective performance management was mixed. The force collated very comprehensive data on immigration detainees and those held under section 136 of the Mental Health Act (see footnote 2), which was positive. However, there were some gaps in data on key areas of custody performance that prevented the force from assessing how well it was doing, and identifying trends and informing learning. In particular, the force was unable to provide data on voluntary attendance<sup>5</sup> to identify if this was used effectively as an alternative to custody (see paragraph 3.25).

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<sup>5</sup> Where suspects involved in minor offences attend a police station by appointment to be interviewed about these, avoiding the need for arrest and subsequent detention.

- I.15** Governance and oversight of the use of force in custody were not adequate. The force did not record all instances where force was used in its custody suites in line with the recommendation of the National Police Chiefs Council. Data provided for our audit of cases were unreliable, and not all instances where force was used were recorded on the custody record (see paragraph 4.11). There was no monitoring process, and no review against CCTV. The force did not therefore have adequate mechanisms to assure itself, the Police and Crime Commissioner and the public that the use of force in detention and custody was always safe and proportionate. (See area for concern and recommendation S25.)
- I.16** There were several areas where the force did not comply with PACE code C on the detention, treatment and questioning of suspects. Where reviews of detention were conducted by telephone, reviewing officers did not always record where they were or why the review could not be conducted face to face (code C section 15.14). Detainees were not informed that a review had taken place while they had been asleep (code C section 15.7), and some reviews of vulnerable detainees and children were completed over the telephone, which was poor practice (code C section 15.3c). (See paragraphs 3.37–3.39 and area for concern and recommendation S24.)
- I.17** The force met the public sector equality duty and its delivery plan included specific objectives for custody. Some custody information was monitored to identify potential disproportionate treatment, and clear plans to address issues identified. This included some work to assess strip searching of children by ethnicity. At a strategic level, the force told us they recognised the specific needs of women detainees and described undertaking some positive work in support of this, such as, in one case, providing a breast-pump for nursing mothers to express milk (see paragraph 3.7). However, although detainees were asked to self-define their ethnicity this was not consistently recorded, which left gaps in the data needed for the robust assessment of fair treatment.
- I.18** The force facilitated access to external scrutiny and was open to challenge. Independent custody visitors reported a positive relationship with the force, and their visits were regular, applied appropriate scrutiny and well recorded. The force responded positively to concerns raised.
- I.19** We were aware that there had been a death in custody at Loddon Valley in April 2017, but at the time of our inspection the Independent Office for Police Conduct had not reported the findings of its investigation and there had not yet been an inquest.

### Area for improvement

- I.20** **The accuracy, collation and monitoring of data on key areas of custody should be sufficient to assess performance, identify trends and drive improvements.**

### Partnerships

- I.21** The force had a strategic focus and good engagement with partners to protect and divert vulnerable people from custody. Clear policies had been agreed to escalate matters where partners were unable to meet their statutory obligations.
- I.22** There were good partnerships to provide support for detainees with mental ill health. There had been a reduction in the number of detainees brought into custody as a place of safety under section 136 of the Mental Health Act, and there were comprehensive data to monitor and support this.

- I.23** The force and the nine local authorities in its geographical area had signed the Home Office concordat on children in custody. There was a clear commitment to achieve the aims of the concordat, but too many children who were charged and had bail refused continued to remain in custody overnight when alternative accommodation should have been provided (see paragraph 4.35 and area for improvement 4.37).
- I.24** Although there were a number of alternatives to custody (see paragraph 3.25), there were limited diversion pathways to prevent vulnerable people from entering the criminal justice system or prevent reoffending. Detainees who had been in the armed forces were told about how to receive support from SSAFA (the armed forces charity), and there were several local support agencies, but the force had developed few wider diversion schemes with partners to achieve its strategic aims.



## Section 2. Pre-custody: first point of contact

### Expected outcomes:

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

### Assessment at first point of contact

- 2.1** Frontline officers had a good understanding of vulnerability and the range of factors that affected this, such as disability, age, mental illness or alcohol and drug misuse. They also recognised how circumstances or situation could make a person vulnerable. Officers were clearly confident in assessing vulnerability and taking account of it when making decisions on whether to arrest a person or seek other ways of dealing with an incident.
- 2.2** The force had a definition of vulnerability and had trained officers in how to identify this, covering safeguarding, vulnerability and exploitation. Autism awareness training was being rolled out. Officers had also had training on the Mental Capacity Act 2005 to help them decide whether a person was capable of making their own decisions. Officers generally regarded this training positively in assisting them to carry out their role.
- 2.3** Frontline officers, however, did not always receive good quality information about individuals from the control rooms to assist them when dealing with incidents. The amount and quality of information varied, and there was limited additional information from any intelligence units. We were told that control room operators did their best to meet further requests for information, and officers could access some of this themselves through their laptops and mobile phones, although time pressures usually made this impracticable. Officers said that sometimes it was only following an incident that they found out information that could have influenced their decision about whether to arrest or explore other alternatives.
- 2.4** All children were regarded as vulnerable and frontline officers only took children into custody as a last resort, having actively sought alternatives to arrest. They were aware that custody sergeants would refuse detention without very robust grounds for it. Officers told us that they would use voluntary attendance (see footnote 5) to interview children, provide advice or engage with the youth offending teams to use restorative justice<sup>6</sup> options as ways of avoiding arrest (see paragraph 3.25). In one area, a 'community court' was being piloted in which the victim, offender and an independent member of the community met to discuss the offence, the impact on the victim and how it could best be resolved. Officers tried hard to keep children out of custody and, where possible, avoid their entry into the criminal justice system.
- 2.5** The force's strategic approach to working with mental health partners in dealing with individuals in mental health crisis had made a difference operationally. Frontline officers were detaining fewer people under section 136 of the Mental Health Act (see footnote 2). Only very exceptionally were such detainees taken into custody as a place of safety. The mental health street triage scheme, in which a mental health professional provided advice and assistance and attended incidents, was playing a significant part in achieving this (see paragraph 4.68). Officers said that there were still some long waits at health facilities pending mental health assessments, but outcomes for detainees had improved. Frontline officers also

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<sup>6</sup> Programmes where offenders consider the consequences of their offending for all parties and can offer an apology or reparation.

received advice and assistance to deal with individuals with mental ill health who had committed an offences) but did not need to be detained under section 136. However, the street triage scheme operated mainly during the evening and the early hours of the morning, and when it was not available officers told us it was more difficult to get help from mental health services. This meant they were sometimes unable to find an alternative to arrest, leaving any mental health concerns to be addressed in custody.

- 2.6** Transport for detainees was determined on their behaviour and the risks posed. Vans could be called and unmarked cars were also available, but in practice officers used their patrol cars as this cut waiting times. There was no specific transport for people in wheelchairs, although officers would normally avoid arrest in these circumstances, or else a van would be used.
- 2.7** Individuals detained under section 136 were often taken to health-based places of safety in police vehicles because of long waits for ambulances. This required an inspector's authority. Officers recognised that their cars were not approved or suitable vehicles in these cases, and were inappropriate for such individuals.

### Area for improvement

- 2.8** **The force should continue to work with its health partners to ensure that people subject to section 136 of the Mental Health Act are transported by ambulance to health-based places of safety.**

## Section 3. In the custody suite: booking in, individual needs and legal rights

### Expected outcomes:

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

### Respect

- 3.1 Officers and staff generally engaged with detainees respectfully in custody. Conversations were calm, patient and positive, with good interaction between custody staff and detainees throughout the stages of custody, sometimes in challenging circumstances. Identification of vulnerable detainees and responding to their needs was well understood and embedded in staff work. However, there were areas that affected the dignity of detainees. For example, detainees had to request toilet paper. As part of a risk management strategy, detainee footwear was also routinely removed, which meant they often went barefoot or in their socks, and some had to walk around the custody suite without any footwear, even though alternative supplies were available (see paragraphs 3.18 and 4.19 and area for improvement 3.4).
- 3.2 The custody suites did not provide sufficient privacy for detainees to disclose sensitive and confidential information during the booking-in process. However, staff were aware of this and custody staff sometimes restricted access to custody suites to afford better privacy. Custody sergeants also asked detainees if they wanted to speak to them privately, and we observed this practice used effectively to identify risks for a detainee and offset them through suitable care.
- 3.3 If detainees were required to remove their clothing this was carried out in a private area and their own clothing was stored appropriately. Although cell toilet areas were obscured on all closed-circuit television (CCTV) monitors to ensure detainee privacy, detainees were not always informed so would not know that their dignity was being maintained (see paragraph 3.32).

### Areas for improvement

- 3.4 **Detainee dignity should be maintained at all times. Suitable alternative footwear should be provided to detainees while in custody, and toilet paper should be provided routinely rather than on request (subject to risk assessment).**
- 3.5 **Detainees should be routinely informed that cell toilet areas are obscured on CCTV monitors to ensure their privacy.**

### Meeting individual and diverse needs

- 3.6 Staff who worked in the custody suites were knowledgeable and confident in their ability to identify and address the diverse needs of detainees in their care, including detainees with disabilities or those who were transgender. They also paid good attention to identifying any caring responsibilities that a detainee might have, and to put suitable arrangements in place.

- 3.7** Although at a strategic level the force was committed to offering women detainees a female officer to speak to about their care, this did not always happen in practice. A range of women's sanitary items were available in all the custody suites but women detainees had to request them, potentially from a male officer. We saw one case where a woman detainee complained because she had tried to request sanitary protection but not received it, resulting in her clothes being soiled. This was degrading and did not support the high level commitment to meeting the individual needs of women (see paragraphs S10 and I.17).
- 3.8** Religious or cultural dietary needs were identified and met. There was a wide range of religious books and artefacts for most religions in the custody suites, although they were not always stored in accordance with the faith's requirements.
- 3.9** There were few adaptations to meet the needs of detainees with physical disabilities or mobility problems. There were no cells with high benches and not all suites had adapted shower facilities. Access to the exercise yards was not suitable for those in wheelchairs. Hearing loops were available to help people with hearing difficulties, and most staff knew where they were kept and how to use them.
- 3.10** Custody staff used professional telephone interpreting services to assist detainees who did not speak English. Custody suites had dual handsets, and we saw this facility used effectively while detainees were booked in. However, there were considerable delays in locating the appropriate interpreter and their attendance at custody suites, which often meant that some detainees spent longer than necessary in custody, and some had to be bailed before they could be interviewed (see paragraphs I.13 and 3.26). Staff knew the process for contacting the embassies or consulates of foreign national detainees, and we observed this when they were booked in.
- 3.11** Legal rights and entitlements information was available in a range of languages, and custody sergeants knew how to access this through the custody intranet; we saw this used when foreign detainees were booked in (see paragraph 3.29). Wallcharts in several languages were used to assist detainees identify their respective language. Some suites had printed copies of the easy-read version of this information, but not all custody sergeants were aware of them. The information was also available in Braille, which we do not usually find.

### Areas for improvement

- 3.12 Women detainees should always have the opportunity to speak with a female member of staff to discuss their care needs.**
- 3.13 Religious books and artefacts should be stored appropriately.**
- 3.14 Any delays in obtaining the services of interpreters should be immediately escalated to senior managers to intervene and ensure prompt delivery.**

### Risk assessments

- 3.15** Detainees usually had short waits in vehicles before they were disembarked and booked into custody, but during busy periods we saw long waits in vans and holding cells before they were processed.
- 3.16** All detainees were booked in by custody sergeants who completed a comprehensive risk assessment that focused on their welfare. Sergeants interacted well with detainees, asking in-depth supplementary questions to identify risks and create good understanding of the

detainee's vulnerabilities. We observed several examples of sergeants dealing sensitively with detainees, including identifying potential risks even where not disclosed by them. There were also routine checks of the police national computer (PNC) and previous custody records to provide further information upon which to evaluate risk.

- 3.17** Care plans and observation levels set were generally appropriate and reflected the risks identified in the risk assessment. However, some intoxicated detainees were not placed on observation levels requiring rousals. With some exceptions, checks were carried out at the required times and the frequency set in the care plan. However, not all rousals were in line with annex H of code C of the Police and Criminal Evidence Act (PACE). Detention officers reported, and case audits confirmed, that some rousals took place through the cell door hatch rather than by entering the cell. (See area for concern and recommendation S24 and paragraph 1.8.)
- 3.18** Detainees were often allowed to keep their own clothes, as clothing was only removed on the basis of an individual risk assessment, which was a proportionate response. However, shoes were routinely removed from all detainees, even where they did not have laces, which was disproportionate (see paragraphs 3.1 and 4.19 and area for improvement 3.4).
- 3.19** Although staff had a reasonably good knowledge of the indicators for self-harm, and were attentive to supporting and caring for detainees, some fundamental gaps in practice posed significant risk to the safety of detainees. Cell call bells were routinely left either mute or set to a low volume, with custody staff having to rely on a flashing computer screen to know when a bell had been pressed. We observed times when bells were left unanswered for too long. Anti-ligature knives were no longer issued to custody sergeants, which compromised safety. The searching of detainees was not always carried out effectively. Some detainees were found with dangerous items even after undergoing initial and strip searches, which had resulted in adverse incidents – for example, two detainees were able to ingest drugs while in custody, resulting in hospital admissions. Officers conducting cell watches were sometimes inadequately trained and not always properly briefed, or in possession of cell keys and anti-ligature knives. Some officers were on watch for long periods without sufficient breaks to ensure they remained alert (See area for concern and recommendation S23)
- 3.20** The staff shift handovers we observed were generally good, focusing appropriately and comprehensively on detainee welfare, potential risks and case progression. However, not all custody staff were always present at the handover, which affected the sharing of up-to-date information about detainees. In one suite, the handover was routinely held in a location where it could not be recorded. Custody sergeants frequently did not visit detainees to introduce themselves at the start of their shift, which undermined their knowledge of the individuals in their care. These practices were similar to those we found at our previous inspection.

## Areas for improvement

- 3.21** Observation levels should be commensurate with the risk posed and should always be conducted at the required frequency.
- 3.22** All staff in custody suites should carry anti-ligature knives.
- 3.23** All staff should be present at shift handovers, which should be held in locations where they can be recorded.

## Individual legal rights

- 3.24** We saw custody sergeants booking detainees into custody and asking the arresting officer, in the presence of the detainee, to provide a full explanation of the circumstances of and the reasons for arrest before authorising detention. Sergeants told us that they were confident in refusing detention when the circumstances did not merit it, and we saw detention refused on two occasions.
- 3.25** Alternatives to custody were available through restorative justice, fixed penalty notices and voluntary attendance.<sup>7</sup> Facilities for interviewing voluntary attendees were available outside the custody suites, but the force was unable to provide any data to show if this alternative was used effectively. The force had recognised this shortcoming and had introduced a working group to examine the promotion of voluntary attendance and how such data could be collected (see paragraph 1.14 and area for improvement 1.20).
- 3.26** Other than in exceptional circumstances, we would expect detention to be authorised within a few minutes of the detainee arriving at the custody suite. Force data for the 12 months to the end of January 2018 showed an average waiting time of 13 minutes to be booked in. However, we saw some lengthy delays at one suite when many detainees had been arrested as part of a planned operation. We also saw some delays of between 45 minutes and over two hours in other suites, which was unacceptable, particularly when they involved vulnerable and compliant detainees who could remain in handcuffs throughout this period (see paragraph 4.14 and area for improvement 4.17).
- 3.27** We expect cases to be progressed quickly so that detainees are kept in custody for the minimum time possible. We observed some custody sergeants actively liaising with investigating officers to ensure cases were prioritised, particularly those involving children or vulnerable detainees. We were told, and observed, that investigations were not always progressed promptly. Delays were often due to the non-availability of investigating officers, appropriate adults (AAs) (see paragraph 4.27) or legal representatives. Additional delays occurred where custody sergeants acted as reviewing officers for custody cases. This meant that they made disposal decisions for detainees, such as release under investigation, after reviewing all available evidence. Custody staff highlighted the non-availability of interpreters as a problem. We saw a few cases where there were delays of between four and eight hours to await the attendance of interpreters, which lengthened some detainees' stay in custody (see paragraphs 1.13 and 3.10 and area for improvement 3.14).

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<sup>7</sup> In restorative justice programmes, offenders consider the consequences of their offending for all parties and can offer an apology or reparation. Fixed penalty notices can be issued for some road traffic and disorder offences; if payment is received by the due date, the recipient does not get a criminal conviction. Voluntary attendance is usually used for suspects involved in minor offences who attend a police station by appointment to be interviewed about these, avoiding the need for arrest and subsequent detention.

- 3.28** Custody sergeants reported a good relationship with Home Office Immigration Enforcement officers. We were told that most immigration detainees were moved on within 24 hours of an IS91 warrant of detention<sup>8</sup> being served. Force data showed that 728 immigration detainees had been held in the 12 months to 31 January 2018, which was a 37% decrease from the 1,161 held in the same period in 2015-16. Force data for the year ending January 2018 also showed an average length of detention of 11 hours 53 minutes for immigration detainees following service of an IS91 to transfer to an immigration removal centre (IRC). We saw 14 immigration detainees held overnight at Abingdon after they had illegally entered the country. They were transferred to IRCs reasonably quickly – between three and 10 hours after their IS91s were served.
- 3.29** During booking in, custody sergeants gave detainees a full explanation of their three main rights (to have someone informed of their arrest, to consult a solicitor and access free independent legal advice, and to consult the PACE codes of practice). A written notice setting out detainee rights and entitlements was routinely offered to all detainees, although some chose not to accept this. These notices were available in a range of languages for non-English speaking detainees (see paragraph 3.10). None of the custody sergeants we spoke with were, however, aware that a range of additional written translated documents – such as authorisation of detention, charge details, etc – should have been available for non-English speaking detainees in their own language.<sup>9</sup> We were unable to locate these or any links to them through the force intranet.
- 3.30** All detainees were offered free legal representation and were told that if they declined they could change their mind at any time and accept the offer. All the custody suites had sufficient interview/consultation rooms for detainees to consult their legal representatives in private. Those wishing to telephone their legal representatives could do so in private in their cells or in consultation rooms using portable handsets. Legal representatives were readily given a printout of their client's custody record front sheet. Not all custody sergeants were aware of a 'non-police view' version of the custody record available on the custody computer if a legal adviser requested this. Multilingual posters informing detainees of their right to free legal advice were not available in all the suites; three suites had a single poster in languages from Arabic to Polish but none in Portuguese to Vietnamese.
- 3.31** We saw detainees being told during their booking in that they could read the PACE codes of practice, and custody sergeants routinely explained and offered these. Four custody suites did not have up-to-date copies of PACE code C (on the detention, treatment and questioning of persons by police officers), and one suite had insufficient copies.
- 3.32** Aylesbury and Loddon Valley suites did not display any notices advising detainees that CCTV cameras were installed and recording, which was contrary to PACE code C (section 3.11). Other than at Abingdon, there were no signs in the cells to advise detainees that CCTV cameras were installed, which was also contrary to the force CCTV policy. While most detainees were given this information verbally by officers lodging them in the cells, they were not always told that they could use the toilet facilities in privacy (see paragraph 3.3 and area for improvement 3.5).
- 3.33** As at our previous inspection, we observed that detention officers sometimes stored DNA samples in processing rooms for several hours before putting them in freezers that were outside the custody suite. This practice was contrary to ACPO (now National Police Chiefs Council) guidance that DNA samples should be kept frozen and transported to the laboratory as soon as possible.<sup>10</sup>

<sup>8</sup> Served on an immigration detainee when there is no reasonable alternative course of action, e.g. if there is a likelihood they may abscond; their removal from the UK is imminent, etc.

<sup>9</sup> PACE code C annex M details the documents considered essential for the creation and provision of written translations.

<sup>10</sup> ACPO *DNA Good Practice Manual* (Fifth Edition) 2014.

## Areas for improvement

- 3.34** Thames Valley Police should monitor the time that detainees are kept in custody to ensure there are no unnecessary delays in progressing their cases.
- 3.35** Notices that CCTV cameras are in use should be clear and prominently displayed.
- 3.36** PACE DNA samples should be frozen at the earliest opportunity.

## PACE reviews

- 3.37** PACE reviews were carried out by inspectors or chief inspectors. We observed some good face-to-face reviews in some of the custody suites, which were timely and appropriate, but we also saw many reviews conducted over the telephone; staff said that inspectors had to cover more than one custody suite when engaged in PACE reviews. In our case audits and the custody records we examined, there was not always a record of where the reviewing officer was when conducting a telephone review or why they were not able to attend the suite for a face-to-face review (see area for concern and recommendation S24 and paragraph 1.16). In our custody record analysis, only 20 of the 80 initial reviews required (25%) took place face to face and 17 (21%) were conducted over the telephone.
- 3.38** In our custody record analysis, we also found that 34 initial reviews (42%) took place while the detainee was asleep. In one case, a 15-year old boy received two reviews while he was asleep; we would expect a child to be reviewed face to face to ensure their individual needs were met. In our case audits, we found several cases where detainees had been asleep when their cases were reviewed. but there was no evidence in the logs that the detainee had been informed of this or reminded of their rights and entitlements on waking up. In the suites, we also saw very few detainees being informed that reviews had taken place while they were asleep. Custody sergeants confirmed, and we observed, that the information that reviews had taken place while the detainee was asleep was not always exchanged during staff shift handovers, or flagged as a reminder on the custody computer system (see area for concern and recommendation S24 and paragraph 1.16).
- 3.39** In our case audits, most reviews were recorded on or near the time they were due but some were early. In our custody record analysis, one detainee was reviewed while asleep after only two hours 44 minutes in custody, with no explanation recorded for why this had been brought forward so early from the due time of six hours. While the content of some of the reviews recorded in custody records was very thorough, others were standardised texts that did not make clear whether the detainee had been spoken to face to face or over the telephone. Some had little relevance to the individual detainee under review – for example, two female detainees were referred to as males.

## Access to swift justice

- 3.40** Thames Valley Police's management of bail was generally effective. The force had set up a dedicated bail team in early 2017 to teach all officers involved in police custody about the changes to pre-charge bail brought in by the Policing and Crime Act 2017 from April 2017. The bail team managed all aspects of pre-charge bail for cases since April 2017. Detainees who had been released on pre-charge bail before then were managed by supervisors in the local policing areas. The local supervisors were also responsible for managing cases where detainees were released from custody without bail but remained under investigation.



- 3.41** The force completed investigations during the first period of detention wherever possible, and when detainees were released without charge bail was used sparingly. Most detainees were released without obligation to return to the custody suites, pending the results of investigations, which complied with the College of Policing guidance. All bail applications since the new law came into force were completed in detail, correctly authorised by senior police officers and met the requirements of the College of Policing guidance.
- 3.42** The bail team monitored every bail case, reviewed the need for suspects to remain on bail and decided if conditions continued to be justified. In our audit of bail cases managed by the bail team, investigative action taken while detainees were in custody was documented, further investigative actions were routinely recorded and supervised, and bail was managed effectively. However, in one case strict bail conditions were applied to one child detainee but his three accomplices, all children, were released pending investigation, with their involvement monitored separately by supervisors in the respective local policing area. There was no apparent liaison between the different supervisors to ensure that the cases would be appropriately connected and dealt with consistently. We also found some bail cases that had begun before the new law came into force that were unnecessarily protracted and had left suspects waiting many months to know the results of investigations.
- 3.43** Bail conditions were justified and applied proportionately in all bail cases since April 2017. In two cases we saw pre-dating this, and managed by local supervisors, the conditions imposed were unmanageable.
- 3.44** All bail case investigations were reviewed regularly by detective sergeants, and the supervision of most bail cases was thorough.

## Complaints

- 3.45** There was little emphasis on making detainees aware of their right to complain about their treatment. There were no posters or other relevant material displayed in any of the suites, and there were no Independent Office for Police Conduct (IOPC) information leaflets. The force provided only brief information on making complaints against the police in the rights and entitlements notice given to detainees.
- 3.46** In our observations and case audits, we found some evidence of detainees making staff aware of complaints about their treatment. We did not find subsequent follow-up where complaints were formally logged or dealt with while the detainee was in custody. Some sergeants told us that they would contact an inspector to advise them of complaints. We were also told that some detainee complaints were not facilitated in custody and that they were directed to make their complaints formally after leaving custody. This was contrary to *Authorised Professional Practice* guidance and our *Expectations*.

## Area for improvement

- 3.47** **There should be effective arrangements to take and record complaints by detainees and, where possible, these should be dealt with before the detainee leaves custody.**



## Section 4. In the custody cell, safeguarding and health care

### Expected outcomes:

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

### Physical environment is safe

- 4.1 Conditions and cleanliness in the eight designated suites were generally good. Most were very clean but some had grime and stained walls. However, there was very little graffiti. There was a rolling programme of redecoration during our inspection, and because of this there were some areas we could not inspect.
- 4.2 As at our previous inspection, some cells in Abingdon, Banbury, High Wycombe, Loddon Valley and Maidenhead were far too cold. We saw detainees being moved to warmer cells.
- 4.3 We identified potential ligature points in cells in five suites, and also in exercise yards and other communal facilities. We provided the force with a report to enable it to take appropriate action to manage and mitigate the risks.
- 4.4 Each suite had its own cleaning arrangements, which were mostly adequate. The schedules in two suites meant there was not always sufficient time for all the cells to be cleaned routinely, leaving the cleaning responsibility to detention officers (DOs), who were also responsible for cleaning and tidying the cells out of hours. Where required, a specialist cleaning company provided a prompt and effective service.
- 4.5 There were daily and weekly cell checks. Quarterly inspections were also carried out and necessary remedial work identified. This was monitored at quarterly custody strategy meetings. Defects were often rectified locally by facilities staff, resulting in quick repairs.
- 4.6 Staff knowledge of fire evacuation procedures was mixed, and there were incomplete records showing fire evacuation practices. There had been recent table-top evacuation exercises, but attendance was limited and no names were recorded in the suite evacuation folders. Most suites had sufficient handcuffs to evacuate detainees safely in an emergency, and there were grab bags with additional equipment, such as tabards.
- 4.7 All custody staff held current first aid qualifications. Custody sergeants were trained to use a comprehensive range of emergency equipment, including oxygen and airways, and could access them. First aid and emergency equipment was standardised across the suites and checked and recorded weekly, but despite this we found some missing, expired and non-standard equipment in several suites. Spare oxygen cylinders were not stored correctly in most suites.

## Areas for improvement

- 4.8** The cells in all custody suites should be kept at a suitable temperature and be well ventilated.
- 4.9** The force should identify any potential ligature points and eliminate or mitigate any risks they present.
- 4.10** Custody staff should have easy access to standardised appropriately-checked emergency and first aid equipment in all suites. Spare oxygen cylinders should be stored correctly.

## Safety: use of force

- 4.11** Governance of the use of force in custody was not effective. The data provided by the force were unreliable. Only five of seven cases of use of force that we reviewed had a submitted use of force in custody form. We were shown a further seven cases where force was used at the point of arrest. This indicated that the force was either unable to collate use of force in custody separately and/or that there was inaccurate recording (see paragraph 1.15 and area for improvement 1.20).
- 4.12** Although most staff were up to date with their operational safety training, many did not submit individual use of force forms after they had used force against a detainee. Detention log entries were mostly insufficient to justify the use of force, with very little detail on the rationale and techniques used. The use of force forms we reviewed did not contain sufficient information to assess proportionality. Not all custody sergeants always wore personal protective equipment. CCTV blind spots in some suites presented a risk.
- 4.13** Staff were generally patient and reassuring when dealing with challenging and vulnerable detainees. In our audits and CCTV reviews, we found cases where the use of force did not appear proportionate, and we referred three cases to the force, in particular those showing extended prone restraint of detainees and poor technique that could lead to injuries. There was no structured approach to reviewing CCTV following a use of force incident, and footage was only accessed following a public complaint or for evidential purposes. The CCTV viewing/downloading facilities in some suites were unsuitable and had poor security. Information was not protected through a proper audit system.
- 4.14** There was no consistent force approach to applying and removing handcuffs. Officers were unclear who was responsible for authorising removal when the detainee arrived at the suite. Handcuffs were not always removed quickly enough from compliant detainees (see paragraph 3.26). In one case we reviewed on CCTV, a boy with ADHD was handcuffed for over 30 minutes during a close proximity cell watch. We saw no attempts to de-escalate the situation before the handcuffs were applied.
- 4.15** Force data showed that 7% of detainees who arrived in custody were strip searched, which was slightly lower than we usually see. Strip searching or removal of clothing was mostly justified and properly recorded on custody records, and took place with sufficient privacy; we noted good attention to maintaining the dignity of detainees during the process. Most suites had separate search rooms, but the searches were not recorded if the CCTV was switched off, although some officers thought that it was switched on. Strip searching was not always robust (see area for concern and recommendation S23). In one case that we referred back to the force, a detainee disposed of some drugs and was then strip searched with no more drugs located. He was transferred to another suite, not searched and later found to have drugs in his possession in his cell.

## Areas for improvement

- 4.16 Every member of staff involved in using force against a detainee should submit an individual Thames Valley Police use of force form.**
- 4.17 Handcuffs should be removed from compliant detainees at the earliest opportunity.**

## Detainee care

- 4.18** The approach to detainee care was mixed. There was very good attention to providing food and drinks, at regular intervals and on request. Our custody record analysis showed that 74% of detainees were offered a meal, as were all those in custody more than 24 hours. However, other aspects of detainee care were more limited and had not improved since our previous inspection. In our custody record analysis, only 9% of all detainees were offered a shower, and only half of those held over 24 hours. Although exercise yards with fresh air and natural light were available at most custody suites, access to them was rare, and facilitated for only 3% of detainees. There was limited reading material available, with little for children or in foreign languages, and it was not routinely offered. In some cases, detainees spent many hours in custody without their care needs suitably met.
- 4.19** There were adequate supplies of comfortable replacement clothing for detainees but underwear was poor quality. Detainees' footwear was routinely removed and replacements were not always given, even though there were sufficient stocks available. This left some detainees barefoot or in their socks in cold cells, with an effect on their health and well-being (see paragraph 3.1 and area for improvement 3.4).

## Areas for improvement

- 4.20 All detainees should be offered showers and regular exercise, particularly those in custody for lengthy periods and kept overnight.**
- 4.21 A range of reading material should be available and offered to detainees, and include provision for children and non-English speakers.**

## Safeguarding

- 4.22** All the officers we spoke with showed a good understanding of safeguarding for children and vulnerable adults and how to recognise concerns. The force had provided relevant training, for example on child sexual exploitation, and safeguarding referral arrangements to the force's specialist teams and partner agencies were well embedded. Custody sergeants were clear that it was their responsibility to ensure that appropriate referrals had been made by arresting or investigating officers and safeguarding concerns properly identified. To aid this, questions were included in the release process to make sure custody sergeants addressed safeguarding issues, although the answers to these were not always recorded on the custody record.
- 4.23** The approach to safeguarding was well supported by the health care practitioners (HCPs). In addition to referrals through their own health systems, HCPs also made referrals directly to the force's specialist protection team and wider partner agencies (see paragraph 4.43). The HCPs and custody staff worked well together, and we observed some good discussions about how best to meet the needs of vulnerable and child detainees.

- 4.24** Vulnerable adults and children did not always receive early support from appropriate adults (AAs) to help them understand their rights and entitlements and the various stages of the custody process. There had been little improvement in this since our previous inspection. Family members or friends were sought to act as AAs in the first instance, but where this was not possible requests were made to the relevant local authority social care services, which provided their own staff or volunteers. Some AAs arrived promptly but sometimes there were long delays, from families as well as social care services.
- 4.25** Custody sergeants reported that the daytime and early evening service for children provided through the youth offending teams (YOTs) generally worked well. However, there was little provision overnight with AAs only attending in very specific circumstances (for example, when a strip search was needed). Obtaining AAs for vulnerable adults was difficult as there was no statutory requirement on social care services to provide them. Provision varied across the force area, and was rare at night.
- 4.26** AAs were not always requested promptly and often only attended for the interview, which could be a considerable time after the detainee had entered custody. Arresting officers tried to arrange an AA while at the incident or on the way to custody, which sometimes resulted in early attendance. But some detainees spent longer than needed in custody because of delays in obtaining an AA – for example, one child waited over 15 hours (see paragraph 3.27). In another case, a child was not charged until after the 24-hour PACE clock had expired because an AA could not be obtained to attend for charging. We referred this case to the force for review.
- 4.27** The force monitored the time between the request to social care services for an AA and their arrival, and its recordkeeping was generally better than we usually see. However, the monitoring did not cover waits for family members acting as AAs, or the time between a detainee arriving in custody and the request made for an AA. The force could not, therefore, assess overall waiting times for AAs. However, it was actively working with its partners to improve AA provision for vulnerable adults, as it recognised that the current service did not meet their needs.
- 4.28** The force also monitored whether AAs were present for strip searches of children, which was positive. However, in one case we looked at a strip search took place without an AA present, without sufficient justification, which was a breach of the Police and Criminal Evidence Act (PACE) code of practice.<sup>11</sup>
- 4.29** There was comprehensive written guidance for AAs who were not familiar with the role, although this was not always given out. We were told that custody sergeants explained the role verbally as the guidance was lengthy.
- 4.30** Children were shown some good care to meet their needs in custody and there was a strong focus on keeping children safe. In accordance with force policy, an inspector was notified as soon as possible of any child entering custody. They then reviewed the circumstances and needs of the child to ensure that detention was appropriate. There was a child-friendly leaflet for detained children, although some suites had run out of these or relied on less attractive printed sheets. The force was also due to introduce a short video, developed with local students, to show to children coming into custody. This was intended to help them understand the custody process, allay worries and reassure them that they were in a safe place to raise any concerns.
- 4.31** All children were seen promptly by HCPs who checked their records, spoke with the child, and assessed their needs and any risks. This offered reassurance to the child as well as providing additional information to the custody sergeants to inform the risk assessment.

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<sup>11</sup> Code C annex A B11(c) says this must only happen where there is risk of serious harm to self or others.

HCPs continued to be involved with the child as necessary, and worked closely with the custody staff, contributing to the safe release of children.

- 4.32** There were no specific cells for children, although alternatives were sometimes used when the AA was present, such as waiting in a consultation room or in a cell with the door open. Custody sergeants assured us that all girls were assigned a female officer (as required under the Children and Young Persons Act 1933), but we did not always observe this, and it was not clear from custody records that this happened.
- 4.33** Custody sergeants only accepted children into custody when there was robust justification for this. Where children were detained they sought to minimise the length of detention and, in particular, avoid keeping them overnight. However, this was not always achieved. Some cases were progressed quickly, including overnight, while other children remained in custody overnight for their case to be dealt with the following morning.
- 4.34** There was close monitoring of children entering custody with each case reviewed to assess whether they had been dealt with appropriately and as quickly as possible. The criminal justice department chief inspector received a weekly report of the findings, along with any cases where a child was charged and refused bail. Monthly joint meetings with partner agencies considered a range of data, including the number of detentions, first-time offenders, average time in custody, the number of remands, and requests for secure and non-secure accommodation and if they were met. However, the force did not monitor how many children were detained overnight before charge to assess its effectiveness in avoiding this. Our observations and the cases we looked at indicated that many children were detained overnight before their case was dealt with.
- 4.35** There was some good joint working with partners and a clear commitment to move children charged and refused bail to alternative accommodation, arranged through children's social services. There were jointly agreed procedures following the principles of the Home Office concordant on children in custody, which included raising the matter higher when alternative accommodation was not provided, and the completion of juvenile detention certificates for the court. There was also some activity on setting up secure accommodation as there was none locally. There were regular joint meetings at a senior level between the force and local authorities to oversee the arrangements (see paragraph 1.23). Despite this commitment and joint working, few children were moved to alternative accommodation. Force data showed that in the 12 months to 31 January 2018, 72 children had been charged with bail refused, with 66 requests for appropriate accommodation. No children were moved to secure accommodation, and only seven were moved to other accommodation

### Areas for improvement

- 4.36 The force should have effective arrangements to secure appropriate adults promptly for vulnerable adults and children on a 24-hour basis.**
- 4.37 The force should continue to work with local authority partners to avoid the overnight detention of children in custody by transferring them to suitable alternative accommodation.**

### Governance of health care

- 4.38** Mountain Healthcare Limited had provided primary health services since 2015. Health provision had significantly improved since our previous inspection and was mostly good. Joint working between Mountain and the force was effective and supported by regular meetings.

The service contract contained clear performance measures, including staffing levels and response times, which Mountain consistently achieved. The clinical governance systems were robust and had been enhanced by the recent appointment of a quality improvement nurse for the eight suites. Lessons learned from health incidents and audits helped improve services and were shared with clinical staff.

- 4.39** Highly trained and competent nurses and paramedics (health care professionals, HCPs), provided all care, including enhanced interventions often completed by doctors, such as intimate searches. An HCP was embedded in the four busiest suites at all times, and two HCPs covered the other four suites; increased cover was planned for when staff levels improved. An on-call doctor provided support.
- 4.40** All staffing gaps were covered through bank staff, overtime or reallocating staff. Mountain had a robust escalation policy to ensure detainees were seen promptly at times of high demand, which included basing a doctor in a suite if necessary.
- 4.41** Detainees who required a HCP were aimed to be seen within 90 minutes in suites with an embedded HCP and 120 minutes in the others. Most detainees were seen within these times, and in embedded suites were seen very quickly. In our custody record analysis, detainees requiring an HCP waited an average of 43 minutes, which was much quicker than we usually see.
- 4.42** Mountain's effective leadership supported a positive culture. Inductions were satisfactory; new HCPs discussed each of their first 50 consultations with a doctor to ensure consistent decision making. All clinical staff had excellent access to mandatory training and wider development opportunities, including regular training days on emergency scenarios, clinical refreshers and competence updates. All clinical staff had regular individual supervision, peer meetings, performance reviews and easy access to an appropriate range of custody-specific policies.
- 4.43** All the clinical staff we spoke to demonstrated a good understanding of safeguarding issues and how to make referrals to the local authority (see paragraph 4.23). The Mountain safeguarding lead facilitated a weekly safeguarding conference call, which clinical staff could join to discuss any concerns.
- 4.44** The Mountain complaints policy was not clearly advertised to detainees, and HCPs we spoke to were unsure of the process. The force and Mountain said they had not received any complaints about health provision.
- 4.45** The clinical environment was mostly satisfactory, but the facilities at High Wycombe and Newbury were too small. There were no privacy curtains in any suite. Required infection prevention and control standards were not consistently met; for example, many waste bins did not comply, sharps bins were not dated and signed, and there were no regular audits. A clear cleaning schedule meant rooms were generally clean, but high surfaces in some suites were dusty. All clinical rooms contained appropriate clinical equipment and stock, but we found some expired items in a few suites. HCPs wiped down surfaces before forensic testing.
- 4.46** Health staff used the custody suite emergency equipment. Emergency drugs were stored in locked cupboards, which could create some delays in an emergency.

### Area for improvement

- 4.47** **Clinical rooms should consistently meet the required infection prevention and control standards, supported by regular audits.**



## Good practice

- 4.48** *Robust clinical governance arrangements, including comprehensive training and regular supervision for clinical staff, supported positive outcomes for detainees.*

## Patient care

- 4.49** Custody staff referred detainees appropriately to health professionals based on identified need or a detainee's request. Additionally, children, people arrested entering the country illegally and those detained on serious sexual offences were automatically referred.
- 4.50** We observed excellent partnership working between custody and health staff. Custody staff said the care provided was good but there were some delays in suites where HCPs were not based, due to the distance they had to travel. We observed HCPs provide good and compassionate care, but doors to clinical rooms were not always closed when the risk was low.
- 4.51** Women detainees could have access to a female HCP or chaperone, but this was not clearly promoted. Staff said that they used professional interpreting for detainees with limited English. A small selection of health promotion literature was available in all clinical rooms.
- 4.52** All health professionals completed paper records, which were generally stored appropriately, although they were not always adequately secured when HCPs left the clinical room. The clinical records we examined were mostly good. Clinical staff summarised their consultation on to custody records, which supported continuity of care without breaching medical confidentiality. There were regular audits of some clinical records for all clinicians, and lessons learned were shared appropriately.
- 4.53** Medicines management had improved and was generally good. Securely stored drug cupboard keys were only accessible to health staff. Some drug cupboards were too small. Standardised stock medicines were stored tidily in all suites, and there were regular reconciliation and date checking. At Milton Keynes, some medicines were stored inappropriately in a staff food refrigerator, but this was addressed when we raised it with managers. Medicines that were discarded were not monitored, which meant discrepancies could not be identified.
- 4.54** Police retrieved medication from detainees' homes where necessary, and health staff assessed the detainee and the medicine before administration. There were appropriate systems to obtain critical medicines if the detainee did not have their own supplies. Medicines were authorised and administered on the Niche police records management system, and staff described safe administration practices. Detainees' medication was generally stored securely with their property, but at High Wycombe and Banbury we were told individual doses might be stored with their custody paperwork, which created risks of misplacement.
- 4.55** In suites where HCPs were not embedded, the custody sergeants held a few medicines that could be administered following authorisation by an HCP. Storage of these medicines was appropriate, but systems to ensure they were in date and monitor who the stock was administered to were not sufficiently robust.
- 4.56** HCPs could administer symptomatic relief for drug and alcohol withdrawal. Medication to treat opiate and/or alcohol withdrawal that was due while a detainee was at court was not routinely sent with them to court, although HCPs said that where they had concerns they would request that a detainee be handled quickly through the court process.

- 4.57** Only pregnant women could continue their methadone prescription in custody, which was too restrictive. HCPs said they would liaise with community services to explain why the person was not attending to prevent the prescription being stopped.
- 4.58** Nicotine replacement patches were theoretically available in all suites, and Niche prompted the necessary risk questions to support safe administration, which was positive. However, the patches provided were too low a dose for heavy smokers, and during the inspection only Aylesbury, Banbury and Maidenhead had stocks. Custody staff said that detainee take-up was low, although their availability was not promoted.

### Areas for improvement

- 4.59** **Detainees who are on a community prescription of opiate substitution treatment should be able to continue it in custody, if clinically appropriate.**
- 4.60** **Medication for alcohol withdrawal that is due while the detainee is at court should be sent with them.**

### Substance misuse

- 4.61** Support for detainees with substance misuse issues had deteriorated since our previous inspection. There were no longer any visiting drug and alcohol practitioners. Instead, HCPs or mental health liaison and diversion workers could offer some harm reduction advice and potentially book appointments for detainees with local services. If a need was identified, the liaison and diversion workers could support people to engage with services after release. However, these referrals were less likely to be made in suites where these services were not embedded. Only 53 referrals had been made to community drug and alcohol services in the six months to January 2018, which was low, and ranged from one in Milton Keynes and Aylesbury to 17 in Maidenhead. It was positive that the community service was contacted after release to check if the person had attended.
- 4.62** There were no needle exchange schemes or overdose prevention interventions in any suites.

### Area for improvement

- 4.63** **Detainees with drug and alcohol issues should have easy access to harm minimisation interventions and active support to engage with relevant services after their release.**

### Mental health

- 4.64** Custody staff we spoke to had a reasonable understanding of mental health issues. However, there was no regular face-to-face mental health awareness training, and most detention officers and some custody sergeants we spoke to felt they needed more training.
- 4.65** Mental health provision had significantly improved with the implementation of mental health liaison and diversion services in all suites. Central and North West London NHS Foundation Trust provided one practitioner in Milton Keynes on weekdays from 9am to 5pm, but there was no back up for staff absences. Berkshire NHS Foundation Trust provided liaison and diversion practitioners in four suites between 7am and 8pm daily, with satellite support to Aylesbury, Newbury and Banbury suites. Liaison and diversion practitioners offered support

to adult and child detainees with vulnerabilities, including signposting them to appropriate services and referring them for specialist youth services or time-limited post-release support from a support worker. Custody staff were very positive about how the service supported effective risk management.

- 4.66** The force collected and analysed data on all Mental Health Act assessments in custody, which was good practice. The data showed that in the six months to December 2017, 61 of the 122 detainees who received a Mental Health Act assessment in custody were transferred to mental health facilities. The average wait across the force between the time that an assessment was requested until the person was transferred to a mental health facility was 12 hours, ranging from three to 40 hours. Delays were due to external factors, including the availability of specialist staff, beds and ambulances. The force was working closely with partners to improve outcomes for detainees. The case records showed that escalation processes were used appropriately when delays occurred.
- 4.67** The local Mental Health Act section 136 policies reflected the recent changes in the Policing and Crime Act, which called for police custody to be used as a place of safety only in exceptional circumstances.
- 4.68** Regular meetings supported effective partnership work between the force and community mental health providers. Each of the three mental health providers in the force area operated a mental health street triage scheme, which were effective in supporting people in mental health crisis to access appropriate services (see paragraph 2.5).

### Area for improvement

- 4.69** **Custody staff should receive regular face-to-face mental health awareness training.**

### Good practice

- 4.70** *The force collected data on all Mental Health Act assessments completed in custody, and shared this information with relevant stakeholders to improve outcomes for detainees.*



## Section 5. Release and transfer from custody

### Expected outcomes:

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

### Pre-release risk assessment

- 5.1** In the records we reviewed and in our case audits, the completion of pre-release risk assessments (PRRA) was inconsistent, often failing to record how risks had been addressed. In our observations, the PRRA template was frequently completed after the detainee had been released. However, in practice, we saw many good quality pre-release processes. Custody sergeants routinely took the time to explain release arrangements with detainees, checking how they were feeling and what support would be available to them on returning home.
- 5.2** Although the PRRA did not prompt sergeants to ask detainees or record how they would be travelling home, staff routinely made arrangements to ensure vulnerable detainees were collected or taken home by police transport. Travel warrants, petty cash and some free bus tickets were also available.
- 5.3** Sergeants were particularly aware of the specific offences and circumstances that made detainees more at risk on release. There was an enhanced process for individuals arrested under suspicion or charged with committing sexual offences. This included conducting the release process from a confidential area, ensuring the detainee had been seen by the mental health liaison and diversion service before release, and providing links or referrals to support organisations, such as the Lucy Faithfull Foundation and Circles UK.
- 5.4** A leaflet setting out contact details for a range of support and advice groups was available for detainees on release but was not always given to them. We observed some sergeants highlighting key organisations for individual detainees and encouraging them to seek that support.
- 5.5** The person escort records (PERs) we examined were of varying quality. Not all information was dated, and staff were confused about how the record should be completed. In particular, the suicide/self-harm warning alert, designed to identify current risk, was completed with historical information, negating the purpose of the alert. We were told that there had been little training for staff on how to complete the PER.

### Areas for improvement

- 5.6 Arrangements made for detainees' release should be fully recorded, including how they travel home.**
- 5.7 Person escort records should be completed correctly.**

## Courts

- 5.8** Custody staff told us that local remand courts did not normally accept detainees for court appearance after 1pm to 2.30pm on weekdays, and sometimes even earlier than that. During our inspection, we saw Slough Magistrates' Court refuse to accept a detainee at midday, and Reading Magistrates' Court refused to accept a detainee at 1pm (although it had accepted a child who arrived into police custody at 12.16pm). These refusal times were too early and resulted in some detainees remaining in police custody for longer than necessary.
- 5.9** At High Wycombe, we saw detainees who were handcuffed and walked from the police custody suite up a side road to board the escort vehicle outside the main police station entrance, and so were in view of passing motorists and pedestrians. Similarly, at Banbury we were told that it was practice for escort staff and police officers to walk detainees through the police station foyer in handcuffs to attend the adjacent magistrates' court, which again lacked privacy. We had raised concerns about these practices at our previous inspection.

## Areas for improvement

- 5.10 Senior police managers should engage with HM Courts and Tribunal Service and the prisoner escort contractor to ensure that detainees are not held in police custody for longer than necessary.** (Repeated recommendation 5.33)
- 5.11 Where detainees are transferred, this should always be done safely and in a secure timely manner which does not involve movement through any public area.** (Repeated recommendation 5.34)

# Section 6. Summary of areas for concern, recommendations and areas for improvement

## Areas for concern and recommendations

**6.1 Area for concern:** There were some serious safety issues and significant risks to detainees that the force did not always manage adequately. For example, searching and strip-searching were not always robust. Processes for conducting cell watches were not always adequate. Arrangements to respond to cell call bells were poor.

**Recommendation:** The force should take immediate action to improve the searching of detainees, ensure close-proximity cell watches are carried out effectively, and that cell call bells are audible and answered promptly at all times. (S23)

**6.2 Area for concern:** There were several areas where the force did not comply with code C of PACE and which it needed to address as a matter of urgency:

- section 15.7: detainees were not informed of reviews taking place while they were asleep;
- section 15.14: officers conducting reviews of detainees by telephone did not always record where they were or why the review could not be conducted in person;
- annex H: staff responsible for rousing intoxicated detainees did not always enter the cell and carry out the rousal in line with approved guidance.

**Recommendation:** The force should ensure that all custody processes comply with the Police and Criminal Evidence Act 1984. (S24)

**6.3 Area for concern:** The governance and oversight of the use of force in custody were not adequate, data were unreliable and Thames Valley Police did not record all instances where force was used in its custody suites. Not all uses of force were proportionate to the risk or threat posed.

**Recommendation:** All use of force in custody should be properly recorded and in line with recommendations from the National Police Chiefs Council. Incidents should be reviewed and cross-referenced to CCTV records to demonstrate that the force used is proportionate and justified. (S25)

## Areas for improvement

### Leadership, accountability and partnerships

**6.4** There should be sufficient staffing on all shifts to ensure the safe detention of all detainees. (I.11)

**6.5** Quality assurance processes should be robust and focused on ensuring that all custody records are of an adequate standard. (I.12)

- 6.6** The accuracy, collation and monitoring of data on key areas of custody should be sufficient to assess performance, identify trends and drive improvements. (1.20)

### **Pre-custody: first point of contact**

- 6.7** The force should continue to work with its health partners to ensure that people subject to section 136 of the Mental Health Act are transported by ambulance to health-based places of safety. (2.8)

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

- 6.8** Detainee dignity should be maintained at all times. Suitable alternative footwear should be provided to detainees while in custody, and toilet paper should be provided routinely rather than on request (subject to risk assessment). (3.4)
- 6.9** Detainees should be routinely informed that cell toilet areas are obscured on CCTV monitors to ensure their privacy. (3.5)
- 6.10** Women detainees should always have the opportunity to speak with a female member of staff to discuss their care needs. (3.12)
- 6.11** Religious books and artefacts should be stored appropriately. (3.13)
- 6.12** Any delays in obtaining the services of interpreters should be immediately escalated to senior managers to intervene and ensure prompt delivery. (3.14)
- 6.13** Observation levels should be commensurate with the risk posed and should always be conducted at the required frequency. (3.21)
- 6.14** All staff in custody suites should carry anti-ligature knives. (3.22)
- 6.15** All staff should be present at shift handovers, which should be held in locations where they can be recorded. (3.23)
- 6.16** Thames Valley Police should monitor the time that detainees are kept in custody to ensure there are no unnecessary delays in progressing their cases. (3.34)
- 6.17** Notices that CCTV cameras are in use should be clear and prominently displayed. (3.35)
- 6.18** PACE DNA samples should be frozen at the earliest opportunity. (3.36)
- 6.19** There should be effective arrangements to take and record complaints by detainees and, where possible, these should be dealt with before the detainee leaves custody. (3.47)

### **In the custody cell, safeguarding and health care**

- 6.20** The cells in all custody suites should be kept at a suitable temperature and be well ventilated. (4.8)
- 6.21** The force should identify any potential ligature points and eliminate or mitigate any risks they present. (4.9)



- 6.22** Custody staff should have easy access to standardised appropriately-checked emergency and first aid equipment in all suites. Spare oxygen cylinders should be stored correctly. (4.10)
- 6.23** Every member of staff involved in using force against a detainee should submit an individual Thames Valley Police use of force form. (4.16)
- 6.24** Handcuffs should be removed from compliant detainees at the earliest opportunity. (4.17)
- 6.25** All detainees should be offered showers and regular exercise, particularly those in custody for lengthy periods and kept overnight. (4.20)
- 6.26** A range of reading material should be available and offered to detainees, and include provision for children and non-English speakers. (4.21)
- 6.27** The force should have effective arrangements to secure appropriate adults promptly for vulnerable adults and children on a 24-hour basis. (4.36)
- 6.28** The force should continue to work with local authority partners to avoid the overnight detention of children in custody by transferring them to suitable alternative accommodation. (4.37)
- 6.29** Clinical rooms should consistently meet the required infection prevention and control standards, supported by regular audits. (4.47)
- 6.30** Detainees who are on a community prescription of opiate substitution treatment should be able to continue it in custody, if clinically appropriate. (4.59)
- 6.31** Medication for alcohol withdrawal that is due while the detainee is at court should be sent with them. (4.60)
- 6.32** Detainees with drug and alcohol issues should have easy access to harm minimisation interventions and active support to engage with relevant services after their release. (4.63)
- 6.33** Custody staff should receive regular face-to-face mental health awareness training. (4.69)

### **Release and transfer from custody**

- 6.34** Arrangements made for detainees' release should be fully recorded, including how they travel home. (5.6)
- 6.35** Person escort records should be completed correctly. (5.7)
- 6.36** Senior police managers should engage with HM Courts and Tribunal Service and the prisoner escort contractor to ensure that detainees are not held in police custody for longer than necessary. (5.10, repeated recommendation 5.33)
- 6.37** Where detainees are transferred, this should always be done safely and in a secure timely manner which does not involve movement through any public area. (5.11, repeated recommendation 5.34)

## Examples of good practice

- 6.38** Robust clinical governance arrangements, including comprehensive training and regular supervision for clinical staff, supported positive outcomes for detainees. (4.48)
  
- 6.39** The force collected data on all Mental Health Act assessments completed in custody, and shared this information with relevant stakeholders to improve outcomes for detainees. (4.70)

## Section 7. Appendices

### Appendix I: Progress on recommendations from the last report

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

#### Strategy

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

#### Main recommendations

The force should use meetings with partner organisations to drive forward improvements in detainee care, particularly in their attendance at court. (2.29)

**Partially achieved**

The force should expedite NHS commissioning of both physical and mental health services for detainees as a matter of urgency. (2.30)

**No longer relevant**

The force should work with all relevant organisations to ensure there is sufficient capacity for detainees to receive prompt assessment under section 136 of the Mental Health Act 1983. (2.31)

**Achieved**

#### Recommendations

Detention officers should be deployed effectively in a consistent way. (3.8)

**No longer relevant**

The force should encourage staff to refer to managers any issues that affect detainees adversely, and ensure that such issues can be raised with partners through attendance at local criminal justice meetings. (3.15)

**Achieved**

There should be a quality assurance process for sampling custody records, which is corporate, recorded, has an audit trail of feedback and dissemination to staff, and which informs refresher training. The process should also include cross-referencing to person escort records and CCTV. There should be a similar provision for shift handovers. (3.21)

**Not achieved**

## Treatment and conditions

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

### Recommendations

Booking-in desks should allow effective and private communication between detainees and staff. (4.10)

**Not achieved**

Staff in custody suites should have a clearer focus on the needs of all detainees, particularly children, women and those with disabilities. (4.11)

**Partially achieved**

Custody sergeants and detention officers should receive their handovers together, in an area cleared of other staff and detainees. (4.32)

**Partially achieved**

Custody sergeants and custody staff should ensure that non-custodial staff do not visit detainees in cells unsupervised. (4.33)

**Not achieved**

The quality of pre-release risk assessments should be improved. (4.34)

**Partially achieved**

The force should address the design issues that have raised potential ligature points. (4.46)

**Partially achieved**

The heating and ventilation of cells in the Abingdon, Loddon Valley and Newbury suites should be improved. (4.47)

**Not achieved**

All detainees held overnight, or who require one, should be offered a shower, which they should be able to take in private. (4.57)

**Partially achieved**

All detainees who require food should be offered meals that are of good quality and sufficient calorific content. (4.58)

**Achieved**

Detainees should be offered outside exercise if they are held for long periods or overnight. (4.59)

**Not achieved**

## Individual rights

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

### Recommendations

Appropriate adults should be available out of hours for young people and vulnerable adults. (5.16)

**Not achieved**

Thames Valley Police should engage with the local authorities to ensure the provision of safe beds for young people who have been charged but cannot be bailed. (5.17)

**Partially achieved**

Senior police managers should engage with HM Courts and Tribunal Service and the prisoner escort contractor to ensure that detainees are not held in police custody for longer than necessary. (5.33)

**Partially achieved** (repeated as area for improvement 5.10)

Where detainees are transferred, this should always be done safely and in a secure timely manner which does not involve movement through any public area. (5.34)

**Not achieved** (repeated as area for improvement 5.11)

## Health care

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

### Recommendations

There should be robust governance arrangements to monitor health service provision, including attendance times, training, supervision and accountability of individual practitioners in their clinical practice. (6.6)

**Achieved**

There should be regular infection control audits. (6.7)

**Not achieved**

Clinical records should meet professional requirements and be subject to regular audit. (6.17)

**Partially achieved**

There should be robust audit and reporting processes to account for the ordering, storage, prescribing and administration of medications, including the recording of all medications liable to abuse. (6.18)

**Achieved**

The police health partnership board should ensure that there are mental health diversion and liaison services in all police custody suites. (6.28)

**Achieved**

The force should work with all relevant organisations to ensure robust monitoring of the use of police custody and section 136 suites. (6.29)

**Achieved**



## Appendix II: Methodology

Police custody inspections focus on the experience of, and outcomes for, detainees from their first point of contact with the police and through their time in custody to their release. Our inspections are unannounced and we visit the force over a two-week period. Our methodology includes the following elements, which inform our assessments against the criteria set out in our *Expectations for Police Custody*.<sup>12</sup>

### Document review

Forces are asked to provide a number of key documents for us to review. These include: the custody policy and/or any supporting policies, such as the use of force; health provision policies; joint protocols with local authorities; staff training information, including officer safety training; minutes of any strategic and operational meetings for custody; partnership meeting minutes; equality action plans; complaints relating to custody in the six months before the inspection; and performance management information.

Key documents, including performance data, are also requested from commissioners and providers of health services in the custody suites and providers of in-reach health services in custody suites, such as crisis mental health and substance misuse services.

### Data review

Forces are asked to complete a data collection template, based on police custody data for the previous 36 months. The template requests a range of information, including: custody population and throughput; demographic information; the number of voluntary attendees; the average time in detention; children; and detainees with mental ill health. This information is analysed and used to provide contextual information and help assess how well the force performs against some key areas of activity.

### Custody record analysis

A documentary analysis of custody records is carried out on a representative sample of the custody records opened in the week preceding the inspection across all the suites in the force area. Records analysed are chosen at random, and a robust statistical formula provided by a government department statistician is used to calculate the sample size required to ensure that our records analysis reflects the throughput of the force's custody suites during that week.<sup>13</sup> The analysis focuses on the legal rights and treatment and conditions of the detainee. Where comparisons between groups or with other forces are included in the report, these differences are statistically significant.<sup>14</sup>

### Case audits

We carry out in-depth audits of approximately 40 case records to assess how well the force manages vulnerable detainees and specific elements of the custody process. These include looking at records for children, vulnerable people, individuals with mental ill health, and where force has been used on a detainee. The audits examine a range of issues to assess how well detainees are treated and cared for in custody. For example, the quality of the risk assessments, whether observation levels are met, the quality and timeliness of Police and Criminal Evidence Act (PACE) reviews, if children and vulnerable adults receive timely support from appropriate adults, and whether detainees are released safely. Where force is used against a detainee, we assess whether it is properly recorded and if it is proportionate and justified.

<sup>12</sup> <http://www.justiceinspectorates.gov.uk/hmiprison/about-our-inspections/inspection-criteria/>

<sup>13</sup> 95% confidence interval with a sampling error of 7%.

<sup>14</sup> A statistically significant difference between the two samples is one that is unlikely to have arisen by chance alone, and can therefore be assumed to represent a real difference between the two populations. In order to appropriately adjust p-values in light of multiple testing, p<0.01 was considered statistically significant for all comparisons undertaken. This means there is only a 1% likelihood that the difference is due to chance.

### **Observations in custody suites**

Inspectors spend a significant amount of their time during the inspection in custody suites assessing their physical conditions, and observing operational practices and how detainees are dealt with and treated. We speak directly to operational custody officers and staff, and to detainees to hear their experience first hand. We also speak with other non-custody police officers, solicitors, health professionals and other visitors to custody to obtain their views on how custody services operate. We look at custody records and other relevant documents held in the custody suite to assess the way in which detainees are dealt with, and whether policies and procedures are followed.

### **Interviews with key staff**

During the inspection, we carry out interviews with key officers from the force. These include: chief officers responsible for custody; custody inspectors; and officers with lead responsibility for areas such as mental health or equality and diversity. We speak to key people involved in the commissioning and delivery of health, substance misuse and mental health services in the suites and in relevant community services, such as local Mental Health Act section 136 suites. We also speak with the co-ordinator for the Independent Custody Visitor scheme for the force.

### **Focus groups**

During the inspection we hold focus groups with frontline response officers, and response sergeants. The information gathered informs our assessment of how well the force diverts vulnerable people and children from custody at the first point of contact.

### **Feedback to force**

The inspection team provides an initial outline assessment to the force at the end of the inspection, in order to give it the opportunity to understand and address any issues at the earliest opportunity. Following this, a detailed report is published within four months giving our detailed findings and recommendations for improvement. The force is expected to develop an action plan in response to our findings, and we make a further visit approximately one year after our inspection to assess progress against our recommendations.



## Appendix III: Inspection team

Kellie Reeve	HMIP team leader
Fran Russell	HMIP inspector
Fiona Shearlaw	HMIP inspector
Norma Collicott	HMICFRS inspection lead
Viv Cutbill	HMICFRS inspection officer
Adrian Gough	HMICFRS inspection officer
Patricia Nixon	HMICFRS inspection officer
Vijay Singh	HMICFRS inspection officer
Majella Pearce	HMIP health service inspector
Kathleen Byrne	Care Quality Commission inspector
Laura Green	HMIP researcher
Joe Simmonds	HMIP researcher