Report on an unannounced inspection visit to police custody suites in

Derbyshire

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

9–19 April 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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Force
Derbyshire

Chief Constable
Peter Goodman

Police and Crime Commissioner
Hardyal Dhindsa

Geographical area
Derbyshire

Date of last police custody inspection
7-11 May 2013

Custody suites	**Cell capacity**
Buxton	13 cells
Chesterfield	20 cells
Derby	43 cells
Glossop contingency suite	
Ripley contingency suite	

Annual custody throughput

Year to 31 March 2018	15,273

Custody staffing

Custody sergeants	27.2 (full-time equivalent)
Civilian detention officers	53.5 (full-time equivalent)

Health service provider
Castlerock Recruitment Group Medical Services

Mental health service provider
Derbyshire Healthcare NHS Foundation Trust

[1] Data supplied by the force.

Executive summary

S1 This report describes the findings following an inspection of Derbyshire 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 April 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 Derbyshire Police in 2013. This inspection found that of the 18 recommendations made during that previous inspection, six had been achieved, one had been partially achieved and nine had not been achieved. Two recommendations were no longer relevant.

S4 To aid improvement we have made seven recommendations to the force (and the Police and Crime Commissioner) addressing key causes of concern, and have highlighted an additional 31 areas for improvement. These are set out in Section 6.

Leadership, accountability and partnerships

S5 Our inspection showed that in many important areas, Derbyshire Constabulary was not delivering custody services to the standards required or expected. There had been little improvement since our inspection in 2013, and we identified several causes of concern that were leading to poor outcomes for detainees.

S6 The force was, however, open to challenge and recognised the weaknesses that needed addressing. We found committed staff and a strong culture of wanting to improve. Early discussions with the force gave us reassurance that it was taking our findings seriously, and we were confident that it will take the necessary steps to deliver the required improvements

S7 There was a clear governance structure for custody with appropriate accountability, although senior officers did not have sufficient oversight of custody functions. There was little effective performance management, and gaps in the data and information needed to support this. The data available were largely inaccurate and unreliable, including data on the use of force in custody, the detention of children, people with mental ill health and immigration detainees.

S8 There had been little investment in the custody estate. We found many potential ligature points across Derbyshire's custody suites. These posed a significant risk to detainees and the force, and required immediate attention.

S9 We found a significant number of instances where the force did not always consistently comply with the Police and Criminal Evidence Act (PACE) code C on the detention, treatment and questioning of suspects, as well as codes D and G and section 37. They included key legislative requirements that the police must follow when booking in detainees, authorising their detention and making them aware of their rights and was having an adverse impact on the outcomes for detainees in some areas. The areas of non-compliance included the following:

- not notifying the appropriate adult (AA) or asking them to attend the custody suite

to support the detainee as soon as practicable (contrary to PACE code C, 3.15);
- taking fingerprints and photographs without an AA present (code D, 2.12);
- interviewing a detainee who was not wearing adequate replacement clothing (code C, 8.5);
- not recording when a detainee was given replacement clothing (code C, 8.9);
- not informing the detainee about the offence for which they had been arrested and why they had been arrested (code C, 3.1(b));
- not bringing the detainee before the custody officer as soon as practicable on arrival in custody (code C, 2.1A);
- not noting comments by the detainee about the arresting officer's account, not recording the grounds for detention in the detainee's presence and not noting any comment on the decision to detain (code C 3.4(a));
- not asking the arresting officer for circumstances and reason for arrest (pre-empting the necessity test) (code G, 4.3);
- not informing the detainee that their detention had been authorised (section 37 (5));
- not creating a custody record when refusing detention for a person brought to the police station (code C, 2.1);
- not giving detainees a written copy of their rights and entitlements documentation (code C, 3.2);
- copies of code C not readily available (code C, 1.2);
- no posters advertising the right to free legal advice displayed in foreign languages (code C, 6.3 and note 6H);
- not reminding detainees that they had been reviewed while they were asleep (code C, 15.7);
- when PACE reviews were conducted over the telephone, failing to record the reason why the inspector could not attend or where they were (code C, 15.14).

(See also paragraphs 3.19, 3.30–3.32, 3.37, 3.39–3.42, 3.45–3.46, 4.30, 4.33.)

S10 The force's custody strategy was aligned to the National Police Chiefs Council (NPCC) national custody strategy, and it had adopted the College of Policing *Authorised Professional Practice* (APP) for custody. However, not all processes and practices complied with APP guidance.

S11 There were generally sufficient custody sergeants in each suite to provide the required level of service. Staff had received training to support them in their role, but this had not focused appropriately on legislative requirements and safe detention principles.

S12 The quality of custody records was generally poor. They often failed to record key information or the justification for important decisions. Quality assurance for checking custody records had not identified non-compliance with legislation and guidance, or that many records were not adequately completed.

S13 The force had a clear strategy to divert vulnerable people away from custody and the criminal justice system, and there were some positive working arrangements with partners to deliver this. However, achieving good outcomes for detainees varied.

S14 There had been progress with partnership arrangements to address people detained under section 136 of the Mental Health Act 1983,[2] which ensured that they were taken appropriately to health-based places of safety. There had been only one instance in the previous 12 months where such a person had been taken into custody. However, there was insufficient partner engagement to improve outcomes for children taken into custody. Too

[2] Enabling a police officer to remove someone from a public place, and take them to a place of safety – for example, a police station.

many children who were charged and had bail refused were detained overnight when the local authority should have provided alternative accommodation.

Pre-custody: first point of contact

S15 Frontline officers had a good understanding of vulnerable people and took vulnerability into account as a determining factor when deciding whether to arrest people or use alternatives to custody. The strategy to divert vulnerable people and children away from custody was generally implemented well at the first point of contact. Children were only taken into custody as a last resort.

S16 Officers sought alternatives for people with mental ill health who had committed an offence, but sometimes arrests were made and access to a mental health assessment or services arranged in custody.

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

S17 Detainees were treated respectfully by staff during routine interactions. However, some practices did not always maintain the dignity of detainees. These included not providing detainees with adequate footwear or suitable replacement clothing.

S18 While custody staff showed an understanding of the individual and diverse needs of detainees, these needs were not always met. There were insufficient adaptations for some detainees with disabilities. Women detainees were rarely offered a named female member of staff to discuss gender-specific issues, and they were not routinely offered sanitary items.

S19 Some detainees waited too long to be booked in, with no prioritisation of their risk. When they did receive a risk assessment, it was applied inconsistently and did not always result in an observation level appropriate for the risks posed. This was of particular concern for detainees who were intoxicated. However, the frequency of visits made to check detainees was generally adhered to.

S20 We were concerned by the frequent use of anti-rip clothing to manage detainee risk. It was often used in isolation, with inadequate rationale and generally accompanied by a low level of observations, which indicated that the risk posed was not significant.

S21 There was a very poor approach to ensuring that detainees' individual and legal rights under PACE were observed, despite our concerns and recommendations about this at our previous inspection (see also paragraph S9). We required the force to take immediate remedial action to address these deficiencies.

S22 Bail was used appropriately and managed effectively. The force had increased the number of investigations completed during the detainee's first period of detention, negating the need for them to be bailed or released under investigation. However, it was not fully aware of the progress of cases where the detainee was released under investigation, and did not update detainees on this.

S23 The arrangements to deal with detainee complaints were not satisfactory. Some information was available for detainees, but staff were not clear or consistent about how complaints were dealt with.

In the custody cell, safeguarding and health

S24 The physical environments in which detainees were held were clean. However, there were potential ligature points in all the suites, including contingency facilities. We gave the force an illustrative report during the inspection and received a positive response.

S25 Most staff were patient with detainees, including the most challenging, and generally only used force as a last resort.

S26 When force was used it was poorly recorded, staff did not always submit individual forms to justify the necessity for it, and handcuffs remained in place for too long on compliant detainees. In the cases we reviewed, not all force was proportionate to the threat or risk posed, and we referred three cases back to the force for review. We were particularly concerned by the number of times force was used to remove detainees' clothing, which was often unnecessary and not properly justified. The governance and oversight of the use of force in custody, including reviews of CCTV evidence, were not adequate to satisfy the force, Police and Crime Commissioner and the public that its use was always proportionate.

S27 The provision of detainee care was not consistent. Most detainees were given sufficient food and drinks but other aspects of care, including access to exercise, showers and reading material, were not actively offered.

S28 Staff generally had a good understanding of safeguarding children and vulnerable adults, although custody officers generally relied on other officers to make safeguarding referrals.

S29 Children and vulnerable adults did not always receive early support from appropriate adults (AAs). This was mainly due to delays in requesting AAs. There were some unacceptably long waits, and some detainees were processed without an AA present. (See paragraph S9.)

S30 The number of children entering custody was reducing and custody sergeants sought to minimise their time in detention. However, some children continued to spend a long time in custody, including overnight, and the rationale for this was not always clear. The care for children in custody was mixed. Most were placed in children's cells and were seen and given support from the Criminal Justice Liaison and Diversion (CJLD) team. However, they were not kept separate from adults in holding rooms or during booking in, and were not always offered easy-read versions of their rights and entitlements. Girls were not always assigned a female officer, which meant the force did not meet its legal obligation under the Children and Young Persons Act 1933.

S31 Many aspects of the health provision for detainees had improved since our previous inspection. The joint work between custody staff, health care professionals, substance misuse workers and mental health workers was impressive. The conditions in the medical rooms varied but all paid good attention to infection control compliance. Preparedness for medical emergencies was good. The introduction of opiate substitution therapy had enabled more efficient care, but the lack of nicotine replacement therapy was a gap. Health care was delivered in accordance with national guidelines, and detainees were generally satisfied with it.

S32 The liaison and diversion teams provided good mental health services, and police custody was rarely used as a place of safety under section 136 of the Mental Health Act 1983 (see paragraph S14). However, some detainees who required a mental health assessment in custody had excessive waits for the assessment and subsequent transfer to mental health inpatient facilities. The force did not monitor this and so had no understanding of the scale of the problem.

Release and transfer from custody

S33 Custody staff were not always sufficiently focused on ensuring that all detainees were released safely. Some did not think that the safe release of detainees was their responsibility. Although we were told, and sometimes saw, that children and vulnerable detainees were conveyed home if required, this was not always made evident on custody records.

S34 There were reasonable arrangements to ensure that detainees remanded to court were produced in front of the first available court.

Causes of concern and recommendations

S35 **Cause of concern:** There were a substantial number of potential ligature points in all the force custody suites. This posed a risk to detainees and the force, and required immediate remedial action.

Recommendation: The force should take immediate action to identify and deal with potential ligature points in all its custody suites.

S36 **Cause of concern:** There were too many areas (15) where the force did not comply with legislation or guidance, notably code C of the Police and Criminal Evidence Act (PACE). This required immediate remedial action, with arrangements to demonstrate compliance.

Recommendation: **The force must take immediate action to ensure that all custody procedures comply with legislation and guidance, and that officers consistently implement these. Quality assurance should be applied to test compliance with the legislative requirements.**

S37 **Cause of concern:** Children and vulnerable adults did not always receive early support from appropriate adults (AAs). The force failed to ensure, or monitor, that requests were made without undue delay, and that an AA was present at all key stages of the custody process.

Recommendation: Children and vulnerable adults should receive early, and ongoing, support from appropriate adults throughout their time in custody.

S38 **Cause of concern:** The quality of custody records was poor, key decisions and justification for actions were often not recorded, and quality assurance arrangements were weak.

Recommendation: Custody records should be comprehensive with key decisions and the justification for actions clearly and properly recorded. Quality assurance processes should be robust to ensure that this is achieved and that outcomes for detainees are good.

S39 **Cause of concern:** The collation and monitoring of data on key areas of custody were inadequate, and often unreliable. This did not support effective performance management.

Recommendation: The force should have sufficient and accurate data to allow effective scrutiny across all areas of custody. There should be a clear performance management framework to review the data and performance information, and the force should use this to assess outcomes for detainees, hold statutory partners to account and improve services.

S40 **Cause of concern:** The governance and oversight of the use force in custody were not adequate, data were unreliable and not all instances where force was used in custody suites were recorded. Some use of force was disproportionate to the risk or threat posed.

Recommendation: All use of force in the custody suites should be recorded in line with the recommendations of the National Police Chiefs Council, and fully justified on the custody record. Governance and oversight of the use of force should ensure that all use of force is proportionate to the risk posed, and include comprehensive review of CCTV records.

S41 **Cause of concern:** Children charged and refused bail were not moved to alternative accommodation arranged through the local authority. The force did not monitor this with partner agencies to identify and agree on the improvements needed.

Recommendation: The force should work with the appropriate partners to monitor data on children detained overnight and use this to improve outcomes for them. Requests for alternative accommodation and the reasons for children remaining in custody overnight should be clearly recorded on custody records.

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 & Fire and 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*.[3] These standards are underpinned by international human rights standards and 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*.[4]

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 Derbyshire force we analysed a sample of 116 records. The methodology for our inspection is set out in full at Appendix II.

The joint HMIP/HMICFRS national rolling 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.

Wendy Williams
HM Inspector of Constabulary

Peter Clarke CVO OBE QPM
HM Chief Inspector of Prisons

[3] http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/inspection-criteria/
[4] 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

1.1 Derbyshire Constabulary had a clear governance structure for custody. Under the direction of the assistant chief constable (ACC), the superintendent who led the criminal justice department had overall responsibility for the custody function, and specialist staff were trained to deliver custody services. This structure provided clear accountability for the safe delivery of custody. However, despite this, senior officers did not have sufficient oversight of the custody function. Although custody matters were discussed at regular meetings, there was no performance framework for effective monitoring and oversight of important aspects of custody, and to ensure its safe and respectful delivery.

1.2 The force had made limited progress in achieving our previous recommendations. This inspection found significant concerns, including many that required immediate action. The force was open to scrutiny and staff showed a clear commitment to wanting to improve. We were confident that the force will implement the necessary measures to deliver the required improvements.

1.3 There had been little investment in the custody estate, and we found many potential ligature points in all the custody suites. These had not been identified, despite daily checks by custody staff. Their existence posed a significant risk to detainees and the force, and required immediate remedial action (see recommendation S35).

1.4 The force had a custody strategy that aligned to the National Police Chiefs Council (NPCC) national custody strategy. The force did not have a specific custody policy but followed the College of Policing *Authorised Professional Practice* (APP) for custody. However, not all the processes and practices we observed complied with APP, the Police and Criminal Evidence Act 1984 (PACE) or its codes of practice. There were too many areas where the force did not comply with PACE code C on the detention, treatment and questioning of suspects. (See paragraph S9 and recommendation S36.)

1.5 Many areas of non-compliance stemmed from a force requirement for arresting officers to complete a form before detainees were brought before the custody officer. This had led to detainees not being booked in as soon as practicable on arrival at a police station (contrary to PACE code C 2.1), arresting officers not always being asked the reasons for arrest (contrary to PACE code G 4.3), and detainees not always being informed of the offence they had been arrested for (contrary to PACE code C 3.1(b)). Further examples (see also paragraph S9) included non-compliance with the requirements for the provision of appropriate adults (AAs), authorisation of detention, provision of a written copy of rights and entitlements, and the conduct of PACE reviews of detention. This was a significant concern and required immediate remedial action. (See recommendation S36.)

1.6 The number of custody sergeants in each suite varied according to its size but was generally sufficient. There was some reliance on cover from officers elsewhere in the force but this

was infrequent. Officers who provided cover had received training but told us they were not kept up to date and did not feel confident to perform custody duties.

1.7 There had been a commitment to improving custody training, and the force had created a comprehensive training plan. Custody officers and civilian detention officers (CDOs) were trained together, which was positive, and staff were appropriately accredited and received continuing professional development. However, the training did not always focus on legislative requirements and safe detention principles, and did not support custody officers adequately in following legislative requirements and good practice.

1.8 The quality of custody records was generally poor, and they lacked a comprehensive and clear narrative of events. There was an over-reliance on drop-down scripts, important information was sometimes missing, and not all events, actions or decisions were recorded. Although there were quality assurance processes, with inspectors sampling custody records, these were not sufficiently robust or appropriately focused, and had failed to identify extensive non-compliance with code C of PACE. There was little further scrutiny from more senior managers to ensure that quality assurance was robust enough to identify trends and drive improvement. (See recommendation S38.)

1.9 There was a clear strategic focus on the diversion of vulnerable people from custody, with a strategic framework supported by action plans, and arrangements that offered alternatives to arrest. All the staff we met fully understood this strategy, and actively sought to avoid custody for children and vulnerable adults and their entry into the criminal justice system.

Areas for improvement

1.10 There should be a clear performance framework with regular governance meetings to ensure that senior management has clear oversight of all aspects of custody provision, and that outcomes for detainees are good.

1.11 The training of custody staff should be sufficiently focused on the legislative requirements of custody to equip officers to fulfil the role.

Accountability

1.12 The extent and quality of the information to support effective performance management were insufficient. Much of the data provided to the inspection team were unreliable, including figures on children held in custody overnight and the time that immigration detainees spent in custody. There were also some gaps in data on key areas of custody that prevented the force from assessing its performance, identifying trends and informing learning. For example, the force was unable to provide data on the provision of AAs, as too often the time of requests for them and their time of arrival in suites were not recorded on custody records. (See recommendation S39.)

1.13 Governance and oversight of the use of force in custody were not adequate. The force did not record all instances when 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. There was no monitoring and no consistent review of incidents against CCTV records. The force had no adequate mechanisms to assure itself, the Police and Crime Commissioner and the public that the use of force in custody was always safe and proportionate. (See recommendation S40.)

1.14 The force demonstrated a clear understanding of the public sector equality duty, although its delivery plan did not include any specific objectives for custody. It was positive that the force had completed an internal review following publication of the 2017 Lammy Review[5] to identify any potential disproportionality in its treatment of detainees from black and minority ethnic backgrounds. This had identified several areas for the force to address.

1.15 The force facilitated access to external scrutiny and was open to challenge. Independent custody visitors (ICVs) reported a positive relationship with the force, and their visits were regular and applied appropriate scrutiny. However, the force did not always respond to the concerns raised, some of which were the same or similar to those we also identified and should have been subject to remedial action earlier. A recent pilot scheme inviting ICVs to sample custody records for the treatment of children and vulnerable adults indicated the force's commitment to improving its service.

1.16 There had been three deaths in custody since the last inspection. The Independent Office for Police Conduct (IOPC) had completed investigations in two cases without any recommendations to the force. The remaining death was still under investigation by the IOPC.

Partnerships

1.17 Derbyshire Constabulary had a very clear strategic focus on protecting and diverting vulnerable people from custody, and all its staff understood this priority. Frontline officers were focused on avoiding the arrest of children, and many referral routes were available. However, senior officers had insufficient engagement with statutory partners to deliver improved outcomes for children whose arrest and detention were necessary. Too many children who were charged and had been refused bail were detained in custody overnight when the local authority should have provided alternative accommodation. Despite jointly agreed procedures, this position was not improving. (See recommendation S41.)

1.18 There were good partnership arrangements aimed at reducing the use of police custody as a place of safety under section 136, Mental Health Act 1983,[6] with only one instance in the previous 12 months. Wider partnership support for detainees arrested for an offence and potentially requiring a Mental Health Act assessment, either before or while in custody, were less clear. There was a lack of data to enable the force and its partners to understand and assess outcomes for detainees who came into contact with the police in this way.

1.19 A range of external agencies worked with the force to provide support for detainees, and staff could refer those with complex needs to several support networks. These included the Addaction charity, which provided specialist alcohol or substance misuse services for adults and young people. The force had also introduced an alcohol diversionary scheme in which offenders could attend a three-hour course to address their issues.

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5 An independent review into the treatment of, and outcomes for Black, Asian and Minority Ethnic individuals in the criminal justice system, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/643001/lammy-review-final-report.pdf

6 Enabling a police officer to remove someone from a public place, and take them to a place of safety – for example, a police station.

Area for improvement

1.20 The force should work with its partner agencies to understand and address the reasons for delays for detainees with mental ill health, and minimise the time that they wait for mental health assessments and onward transfer to a mental health bed.

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 individuals' vulnerability, including factors such as their age, drug and/or alcohol misuse and mental health, as well the vulnerability that arose because of an individual's circumstances. All children were regarded as vulnerable. There was a force definition of vulnerability but officers used their own knowledge and experience to assess this. They were confident in making decisions and took account of a person's vulnerability as a determining factor in deciding the action to take when dealing with an incident, or whether to arrest an individual.

2.2 Frontline officers had been trained in vulnerability to support their role, for example on mental health issues. However, not all staff had taken the range of training on offer. They felt there was an over reliance on e-learning, which they did not regard as effective. Frontline officers could obtain advice and support from the specialist vulnerability teams in the force, and some officers were trained as autism champions. Officers found these a useful source of help when dealing with vulnerable people.

2.3 Frontline officers generally felt they received sufficient information from the call centre to help them deal with incidents, although this could depend on how busy the call centre was and officers did not always know the information available from other agencies – such as whether a child protection plan was in place. Officers contacted the call centre to obtain further information if needed, and could also access some through their mobile hand-held devices. They felt they had enough information to make decisions on whether to arrest a suspect or explore alternatives, with flexibility to change their approach if further information emerged during an arrest.

2.4 The force had restorative justice[7] options as an alternative to arrest. 'Community remedy' was used for low-level crimes or incidents to agree on appropriate action. The Office of the Police and Crime Commissioner (OPCC) also ran the 'Remedi' scheme, which offered mediation and other options for more complex cases. Guidance was available for officers to help decide the action to take.

2.5 In line with the force's strategic objectives, frontline officers were focused on avoiding arrest for children and keeping them out of custody. The percentage of children dealt with by voluntary attendance[8] interviews had increased significantly and was used as much as possible. Officers referred all children suspected of being involved in an offence to the youth offending service to consider restorative justice options or other interventions. They also involved the safer neighbourhood teams, where appropriate, to engage with children to prevent further criminal or antisocial activities.

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

8 Voluntary attendance is usually used for lesser offences, and involves suspects attending by appointment at a police station to be interviewed about these, avoiding the need for arrest and subsequent detention.

2.6 Frontline officers avoided using custody as a place of safety for people in mental health crisis detained under section 136 of the Mental Health Act 1983.[9] They took such detainees to health-based places of safety or, if there was a physical injury or issue, to the hospital. However, officers reported long waits for ambulances, as well as for assessments or mental health beds (see area for improvement 1.20). Officers sometimes used their own cars to transport detainees, contrary to force policy, to avoid people in mental health crisis waiting in police cars or at the scene of the incident. Officers also remarked that some waiting areas at health facilities were not conducive to the wellbeing of the detainee.

2.7 Mental health professionals based in the call centre operated a triage service and provided advice and assistance for officers to deal with people with mental ill health. This offered additional information to inform officers' decisions and facilitated access to mental health units or other services. However, officers had mixed views about how effectively they were supported. The triage service was only available between 4pm and midnight. Outside these hours, officers depended on wider mental health services or local GPs for advice and support. Where an individual had committed an offence, officers could not always access support for information about the option of a health-based alternative to custody, or professional advice about whether a person had mental capacity. They often had to make these decisions themselves. Officers tried their best to divert people with mental ill health away from custody, but where a substantive offence had been committed, they felt there was little choice but to take the individual into custody and then arrange necessary mental health assessments there.

2.8 Detainees were transported to custody in police cars or a caged van, depending on their risk, and were sometimes taken to hospital inappropriately in police vehicles (see paragraph 2.6).

Area for improvement

2.9 The force should continue to work with partners to ensure that frontline officers have effective support at the first point of contact in helping them divert people with mental ill health away from custody. Detainees held under section 136 of the Mental Health Act should be transported by ambulance, and officer waiting times with such detainees should be minimised.

[9] Enabling a police officer to remove someone from a public place, and take them to a place of safety – for example, a police station.

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 generally calm, patient and positive, with good interaction between custody staff and detainees throughout custody, sometimes in challenging circumstances.

3.2 The identification of vulnerable detainees was mostly good and their needs were well understood by custody staff. However, some practices affected the dignity of detainees. For example, detainees' footwear was routinely removed and they were often left barefoot or in their socks while in the custody suite, even though replacement footwear was available.

3.3 The custody suites did not provide sufficient privacy for detainees to disclose sensitive and confidential information during their booking in. Although there were screens between the booking-in areas, at Derby the area was noisy when more than one detainee was being booked in and did not enable confidential conversations. Custody sergeants did not ask detainees if they preferred to disclose any confidential or sensitive information privately.

3.4 If a detainee was required to remove their clothing this was carried out in a private area and their own clothing was stored appropriately. Cell toilet areas were obscured on all closed-circuit television (CCTV) monitors, ensuring privacy for detainees. However, detainees were not always informed that they could use the toilet without being observed.

Areas for improvement

3.5 Replacement footwear should be provided to detainees to ensure their dignity, respect, health and wellbeing while in custody.

3.6 Custody sergeants should enable detainees to disclose any confidential or sensitive information to them privately during their booking in.

3.7 Detainees should be routinely informed that CCTV monitors provide pixilation of the in-cell toilets.

Meeting diverse and individual needs

3.8 Custody suite staff were knowledgeable and confident in their ability to identify and address most of the diverse needs of detainees in their care. This included detainees with disabilities and those who were transgender. However, the distinct needs of female detainees were not always understood, identified or met. Women detainees were not routinely offered a named female member of staff to discuss gender-specific issues or particular care needs while in

custody. Sanitary items were not routinely offered to women detainees, even though there were sufficient stocks at all the custody suites.

3.9 There were few adaptations to meet the needs of detainees with physical disabilities or mobility needs. Wheelchairs were available, although these had not been regularly serviced. There were no adapted showers or other aids, such as thicker mattresses. There were hearing loops to help people with hearing difficulties, and most staff knew where they were kept and how to use them. Some staff had been trained in British Sign Language (BSL) and could be used in the early stages of booking in, which was positive.

3.10 There was a wide range of religious books and artefacts for most religions in the custody suites, although they were not always stored respectfully. Religious or cultural dietary requirements were also identified and met.

3.11 Custody staff used professional telephone interpreting services to assist detainees who did not speak English. Custody suites had dual handsets for interpreting and we saw this facility used effectively while detainees were booked in. However, there were sometimes delays in locating an interpreter in the required language and their attendance at custody suites, which meant some detainees spent longer in custody than necessary. Staff knew the process for contacting the embassies or consulates of foreign national detainees.

3.12 There was up-to-date legal rights and entitlements information for detainees in a range of languages, as well as in Braille and easy-read format in some custody suites. At Derby and Chesterfield, this information was also available in BSL on DVD. Despite this, we saw several non-English speaking detainees not offered rights and entitlements information in their preferred language (see paragraph 3.37).

Areas for improvement

3.13 The force should ensure that the distinct needs of women are consistently identified and met. Women detainees should have the opportunity to speak with a female member of staff to discuss their care needs, and be offered sanitary items routinely.

3.14 There should be arrangements for disabled detainees to shower, and thicker mattresses should be available in all custody suites.

3.15 Religious books and artefacts should be stored respectfully in accordance with the requirements of the specific faith.

3.16 Any delays in obtaining professional interpreters should be escalated immediately to senior managers to intervene and ensure these services are promptly delivered.

Risk assessments

3.17 Under a force directive, arresting officers were not required to inform custody sergeants routinely when they were transporting a prisoner to custody, and so custody sergeants had no specific information about such detainees before their arrival. There was no system for custody sergeants to liaise with arresting officers to prioritise waiting detainees most at risk or vulnerable, such as children. During busy periods, we observed some long delays for detainees waiting on vehicles and in holding rooms, many of whom were wearing handcuffs (see paragraph 4.11).

3.18 Most detainees were treated well during their booking in by custody staff who were calm and patient in assessing detainee risk. However, we observed both custody sergeants and civilian detention officers (CDOs) booking detainees into custody, and CDOs were not always under the supervision of a custody sergeant, which was inappropriate. The questions included in the standardised risk assessment were too limited and so staff had to ask different supplementary questions to obtain the required information to assess detainee risk effectively. This led to inconsistencies in how staff gathered risk information from detainees. CDOs routinely and promptly cross-referenced warning markers from the police national computer and historical information on the custody record system to inform risk assessments further.

3.19 Clothing with cords and footwear were routinely removed from all detainees, without an individual risk assessment, before they were placed in a cell; this was a disproportionate response to managing risk. Anti-rip clothing was also used too often to manage risk. The rationale for its use often could not be fully explained by staff, and detainees in such clothing were often placed on minimal observations, suggesting that their risks were not significant and so the use of anti-rip clothing had not been necessary. In some cases, anti-rip clothing was justified for detainees because they did not answer the risk assessment questions, and we saw some detainees told that they would have their clothing removed if they did not cooperate with the risk assessment. The routine use of anti-rip clothing to manage non-compliant detainees or those with a history of self-harm without an individual risk assessment was not effective in minimising risk. Recording the use of anti-rip clothing without a justification in custody records was contrary to Police and Criminal Evidence Act (PACE) code C 8.9 (see recommendation S36).

3.20 Although all custody staff had been issued with anti-ligature knife, as at the previous inspection, not all routinely carried them in the custody suites, which posed a significant risk to the most vulnerable detainees

3.21 Cell call bells were in good working order and staff responded to them promptly. However, we observed that when detainees pressed them continuously or indiscriminately, some staff muted the call bells without a time limit or sufficient oversight by custody sergeants. This could pose a significant risk to detainees who required assistance.

3.22 The frequency of observations of detainees was mostly adhered to, with staff checking them regularly and systematically. However, in our case audits, the recording of initial observation levels set by custody sergeants for some intoxicated detainees did not take a full account of the risks posed, and was too often set at too low a level that was not commensurate with the risks identified. We also found cases where set observation levels were not adhered to; some of these were repeatedly late, even though they were level two (intermittent) observation requiring rousals of intoxicated detainees. In the custody records we reviewed, three intoxicated detainees - two involved in a minor road traffic accident - were not placed on rousal checks throughout the night, despite their levels of intoxication. Staff recording of some rousing was not clear, and in too many custody records and during the inspection we saw staff carrying out rousing checks of intoxicated detainees through the cell door hatch, which posed a significant risk.

3.23 The quality of staff shift handovers was reasonable and they usually included all relevant staff. They focused properly on detainee welfare and case progression, and took place with sufficient privacy. However, at the start of a new shift, sergeants did not routinely visit all detainees in their care, which we would expect to see; this task was sometimes carried out by CDOs. Although handovers were recorded on CCTV, custody sergeants did not receive any feedback from managers about their quality.

Areas for improvement

3.24 All detainees should be booked in without delay when they arrive at the custody suite.

3.25 Custody sergeants should supervise civilian detention officers who book in detainees.

3.26 The risk assessment template should include an appropriate range of questions to assess detainee risk effectively.

3.27 Clothing with cords and footwear should not be routinely removed from detainees without an individual risk assessment, and anti-rip clothing should only be issued after an individual risk assessment.

3.28 Observations levels should be set at an appropriate level commensurate with the risks posed, and the frequency of required observations should always be adhered to.

3.29 Staff should carry anti-ligature knives at all times. (Repeated recommendation 4.20)

Individual legal rights

3.30 When arresting officers arrived at the custody suites they completed a custody information form for each detainee, and custody sergeants and CDOs used this information to open and complete custody records. In too many cases this was done without the detainee present, which was poor practice and non-compliant with the PACE codes of practice. We saw that completion of the form delayed the booking-in process, with detainees not brought before the custody officer as soon as practicable on arrival. (See paragraph S9 and recommendation S36.)

3.31 Arresting officers were not always asked, in the presence of the detainee, to explain fully the circumstances of and the necessity criteria for arrest. In most cases, custody sergeants and CDOs recorded what they believed to be the necessity criteria without requesting this from arresting officers, as this information was not provided on the custody information form. In too many cases, custody sergeants recorded the grounds for detention and authorised this while creating the custody record without the detainee present. We observed that some detentions were authorised between 18 and 25 minutes before the detainee was presented at the booking-in desk, which also questioned the validity of the custody records. Some detainees were advised of the circumstances and necessity for their arrest by arresting officers, but any detainee comments in response to this were not noted. Although custody sergeants told detainees the reasons why they were authorising their detention, we saw a CDO booking in detainees without a custody sergeant telling them that their detention had been authorised. All these practices, which were contrary to PACE codes of practice (see paragraph S9), had changed very little since our previous inspection, even though we were given a reassurance then that the use and purpose of the custody information form was under review. (See recommendation S36.)

3.32 Sergeants told us that they were confident in refusing detention when the circumstances did not merit it, and provided details of such cases. We saw detention refused appropriately on two occasions during our inspection. However, in one case the sergeant failed to open a custody record for the detainee who was held in a vehicle outside the custody suite (contrary to PACE code C). This detainee was diverted to hospital as a non-emergency and

the record could have been opened and closed when practicable to record his presence at the police station.

3.33 Alternatives to custody were available through restorative justice, fixed penalty notices and voluntary attendance.[10] Voluntary attendance facilities in most custody suites meant the individual had to pass through the main booking-in area, which was contrary to the aim of diverting individuals from custody. We saw that interviewing officers did not always check if it was appropriate to bring voluntary attendees into the custody suite environment and did not always ensure that they signed the visitors' register, and sergeants were often unaware that voluntary attendees were in the suites, which was a safety risk for these individuals. Frontline officers told us there were facilities for interviewing voluntary attendees at several police stations, as well as at the custody suites, and these were well used. Force data showed increasing use of voluntary attendance as an alternative to arrest. In the year to 31 March 2018, 6,884 voluntary attendees were interviewed compared with 3,587 in the previous year, which was a 92% increase.

3.34 We would usually expect detention to be appropriately authorised in no more than a few minutes after a detainee arrives at the custody suite. Force data showed that the average waiting time to be booked in in the year to 31 March 2018 was 35 minutes for adults and 37 minutes for children, significantly higher than we have seen elsewhere. We were, however, not confident that data provided were accurate or reliable. Frontline officers in our focus groups said they regularly experienced long waits in holding rooms and in vehicles to have their detainees booked into custody. At Derby we saw delays of up to 99 minutes, with several detainees held in vehicles outside the suite due to congestion in the holding room (see paragraph 3.17). Such delays were unacceptable, particularly when they involved vulnerable and compliant detainees, who usually remained in handcuffs throughout this wait (see paragraph 4.11 and area for improvement 4.13).

3.35 Custody sergeants were aware of the need to minimise time in detention and to progress cases quickly. However, we observed, particularly at Derby, that as the custody sergeants were fully involved in the booking-in process they did not liaise routinely with investigating officers to ensure cases were prioritised, particularly those involving vulnerable detainees. We were told, and observed, that investigations were not always progressed promptly, with delays due to the non-availability of interpreters, legal representatives and sometimes investigating officers. We saw a few cases where there were waits of between four and nine hours for interpreters to attend, which lengthened detainees' time in custody, delaying investigations.

3.36 Custody sergeants reported a good relationship with 'Operation Advenus' staff, a small dedicated team of police officers who worked closely with Home Office Immigration Enforcement officers in dealing with immigration matters. We were told that most immigration detainees were moved on within 24 hours of being served with an 'IS91' authority to detain notification, but there were sometimes longer delays. Force data showed that 99 immigration detainees had been held in the year to 31 March 2018 (a 98% increase from the 50 held in the previous year). However, the force was unable to provide any reliable data on the average length of detention for immigration detainees following service of an IS91 and subsequent transfer to an immigration removal centre (IRC).

3.37 During booking in, custody sergeants advised detainees of their three main rights - to have someone informed of their arrest, to consult a solicitor and access free independent legal

[10] Restorative justice provides the opportunity for individuals to consider the consequences of their offending for all parties and to offer an apology or reparation. Fixed penalty notices can be issued for many road traffic offences 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 lesser offences, and involves suspects attending by appointment at a police station to be interviewed about these, avoiding the need for arrest and subsequent detention.

advice, and to consult the PACE codes of practice. Although a written notice set out a detainee's full rights and entitlements, not all custody sergeants routinely offered this to them. These notices were available in a range of foreign languages, but not all non-English speaking detainees were offered these (contrary to PACE code C). One detainee who could not read or write was not issued with any notice and not offered an opportunity to have a staff member explain the full rights and entitlements documentation to him. (See recommendation S36.)

3.38 We saw detainees told that they could inform someone of their arrest, which staff facilitated. They sometimes also allowed the detainee to speak to their nominated representative while still at the booking-in desk.

3.39 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. There were sufficient interview or consultation rooms in all the custody suites to allow private consultations between detainees and their legal representatives. Detainees could also speak to legal representatives by telephone in private in their cells using portable handsets or in a consultation room using a landline. Legal representatives were readily given a printout of their client's custody record front sheet on arrival at the custody suites. Not all custody sergeants were aware that a redacted version of the custody record was available for a legal adviser to view on the custody computer system on request. Multilingual posters informing detainees of their right to free legal advice were not available at Derby and Chesterfield, and only partially displayed at Buxton (Arabic to Polish only), which was contrary to PACE code C. (See recommendation S36.)

3.40 Detainees were told during their booking in that they could read the PACE codes of practice, but these were not always fully explained or actively offered to detainees. The current version of PACE code C (on the detention, treatment and questioning of persons by police officers) was not available at Buxton, there was only one loose-leaf copy at Derby in a poor condition, and there were a few copies at Chesterfield; this provision was insufficient for the size of the custody suites. We saw two detainees who accepted the offer to read a copy of code C, but these were not issued to them and they were given a copy of the rights and entitlements document instead, itself contrary to code C. (See recommendation S36.)

3.41 Very few custody sergeants were aware that a range of written translated documents – such as authorisation of detention and charge details – should have been available for non-English speaking detainees in their own languages, as per code C, annex M. (See recommendation S36.)

3.42 Detainees were not interviewed if they were under the influence of alcohol or drugs, which was positive. However, we observed some detainees being interviewed and cautioned while wearing anti-rip clothing and no footwear, which was contrary to code C. (See recommendation S36 and also paragraph 3.19 and area for improvement 3.27.)

3.43 The management of custody suite refrigerators and freezers was inadequate. We found a substantial number of old DNA samples and exhibits in those at Derby and Chesterfield, which required immediate attention. However, we were shown evidence that the custody inspectors had started to address these backlogs.

PACE reviews

3.44 PACE reviews of detention were undertaken by dedicated custody inspectors and operational reactive inspectors across the force area. Some reviews that we observed were well conducted and prompt, while others only met the basic legal requirements (reminding

detainees of their rights), with just brief details on the status of their investigation. Inspectors did not always cover other aspects of detention, such as the detainee's care and welfare needs.

3.45 In our custody record analysis, of the 74 detainees who required an initial review, custody records showed that 32 reviews were conducted face-to-face and only three were conducted over the telephone, which was positive in the context that the operational reactive inspectors must balance this role alongside their other duties. Our custody record analysis also disclosed that 34 of the initial reviews were carried out while the detainee was asleep. Of the remaining five reviews, three were conducted while the detainee was in interview and two records were unclear as to how the review had taken place. In our case audits we found several cases where detainees had been asleep during their PACE reviews with no evidence in the logs that the detainee had been informed of this on waking or reminded of their rights and entitlements (contrary to PACE code C) (see recommendation S36).

3.46 The recording of PACE reviews in our case audits and additional custody records we examined was inconsistent. While some entries were very thorough, others lacked detail and were inadequate. Some were recorded as conducted in person, even though the detainee was recorded as asleep at the time. Several reviews took place early or late and it was unclear why this was so, as no rationale was routinely recorded (contrary to PACE code C). We also found that some reviews by telephone failed to record where the inspectors were or why they could not attend in person for the review (also contrary to PACE code C). (See recommendation S36.)

Access to swift justice

3.47 Bail was effectively managed and supported by a detailed policy that provided guidance for staff. When detainees were released without charge, bail was used appropriately in accordance with the applicable bail periods, which were strictly adhered to and proportionate to the complexity of investigations. Appropriate investigative plans were in place. When bail conditions were applied, they had a focus on safeguarding victims and preventing reoffending.

3.48 The arrangements for detainees 'released under investigation' were not so good. In many cases the force was unclear about the progress or the status of the investigation. Too many such cases did not attach investigative plans, including realistic timescales. Of the 20 cases we examined, in only two the suspect was updated on progress. Most were unaware of the status of the investigation and if they were to face court proceedings.

3.49 Since April 2017, there had been an increase in detainees whose investigations were completed during their first period of detention - 41% compared with 32% in the previous year. More detainees now knew the outcome of their case and did not need to be bailed or released under investigation, which helped ensure detainee access to swift justice.

Area for improvement

3.50 The force should monitor the status of investigations for detainees released under investigation, and keep them informed about this.

Complaints

3.51 No information on the complaints process was displayed in the custody suites, although this was contained in the rights and entitlements notice offered to most detainees (see paragraph 3.37). Most custody staff told us they would direct detainees who wished to make a complaint to attend the police station front desk on release, or give them contact numbers or details of the IOPC. A few staff said they would make the custody or reactive inspector aware of a detainee wishing to make a complaint. However, some inspectors told us they would only note a complaint once the individual had been fully dealt with, while others said they would deal with complaints at any point during a detainee's detention.

3.52 We saw two detainees express concern that they had been assaulted by staff - one during their detention for a search under the Misuse of Drugs Act and the other during their time in custody. However, neither detainee was asked if they wished to make a formal complaint and management were not made aware of their concerns. These cases did not assure us that a detainee would be able to make a complaint while they were still in police custody

Area for improvement

3.53 The force should ensure that detainees are able to make a complaint while they are in 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 Physical conditions and cleanliness in the three operational suites were generally good, although the Ripley contingency suite required repairs and cleaning before use. Most cells had natural light and a suitable temperature. Cell call bells were in working order.

4.2 We identified many potential ligature points in cells in every suite. Most were as a result of gaps in mastic, holes in walls, and gaps between cell doors and hatches. There were also potential ligature points in exercise yards and other communal facilities. During the inspection, we gave the force a comprehensive illustrative report to enable it to take appropriate action to manage and offset the risks. (See recommendation S35.)

4.3 Civilian detention officers (CDOs) made and recorded daily checks of cells and facilities in the suites. The suites also had night checks to review areas in use during the day. There was, however, no schedule for checking the panic strips/buttons in the suites. Any defects in the suites were reported online to the estates department and minor issues were quickly rectified. The daily cleaning service was effective.

4.4 Staff knowledge of fire evacuation procedures was limited. Not all shifts had been involved in fire drills, and record keeping of drills was poor. The suites had sufficient zip-tie handcuffs to escort detainees in an emergency evacuation.

4.5 Resuscitation equipment was available, ready for use and checked daily. There was good preparedness for medical emergencies. All custody staff had been trained to use appropriate emergency equipment, and that available included automated external defibrillators (AEDs), oxygen and airways that could improve detainees' outcomes in a medical emergency. First aid and emergency equipment was standardised across the suites and maintained in readiness, but had been withdrawn at the Glossop contingency suite.

Area for improvement

4.6 Fire drills should be recorded and documented accurately.

Safety: use of force

4.7 Most staff were up to date with their officer safety training. However, many did not submit individual recording forms to justify why they needed to use force against detainees, including two cases where custody officers had drawn an irritant spray.

4.8 The use of force was not always explicitly recorded on the custody record, and the forms we reviewed did not contain sufficient information to assess its proportionality. There was no structured approach for sampling CCTV footage following the use of force. (See recommendation S40.) However, we found one case where a custody officer had recognised risks regarding a prone restraint, and in our CCTV review we found some cases where health care professionals had assisted officers when requested.

4.9 In our case audits and observations we identified and reviewed 10 recent cases involving the use of force, and cross-referenced these against CCTV footage. Use of force was not proportionate in all these cases, and we referred some back to the force for review. Most of the force or restraint used was to enable the removal of clothing to prevent self- harm (under section 54 of the Police and Criminal Evidence Act). In some cases, staff justified this only on the basis that the detainee did not answer the risk assessment questions (see also paragraph 3.19), and in two of those cases the detainee's clothing was cut off. We had raised concerns about the rationale and justification for use of anti-rip clothing at our previous inspection.

4.10 Force data showed that 507 detainees (3%) had been subject to a strip search in the year to 31 March 2018. We saw just one strip search authorised during the inspection, which was based on appropriate grounds. There was limited use of strip searching of detainees where they were suspected of concealing items such as drugs, weapons or those they could use to self-harm. In most of the cases we reviewed on CCTV, clothing was removed with sufficient privacy and attention to maintaining detainee dignity by covering them with replacement clothing when they left the cell.

4.11 As at our 2013 inspection, most detainees arrived in custody wearing handcuffs, which were not always removed quickly enough from compliant detainees. We were told handcuffs should be checked by the custody officers before removal but, generally, this did not happen (see paragraph 3.17).

Areas for improvement

4.12 Every member of staff involved in using force against a detainee should submit an individual use of force form.

4.13 Handcuffs should be removed from compliant detainees at the earliest opportunity.

Detainee care

4.14 There was very good attention to providing detainees with food and drinks regularly and on request. Our custody record analysis showed that 79% of detainees were offered a meal, as were all those in custody more than 24 hours. However, other detainee care needs were rarely met.

4.15 Although there were exercise yards with fresh air and natural light in all the custody suites, exercise was rarely offered to detainees. In our custody record analysis, only 3% of detainees, and only a third of those held longer than 24 hours, were offered outside exercise. Showers for detainees were clean, well maintained and some provided partial privacy, but they were not often offered or used. In our custody record analysis, only 3% of detainees, and under half of those held over 24 hours, were offered a shower. Our case audits and observations showed a similar picture. Custody staff told us that showers were

not actively offered, even though some detainees were kept in custody for long periods or overnight.

4.16 There was limited reading material for detainees, including non-English speakers and children, and it was not actively offered to detainees who had nothing to occupy their time in cell.

4.17 There were adequate supplies of comfortable replacement clothing for detainees but underwear was of poor quality.

4.18 Although cells contained pillows, these were routinely removed before a detainee was held there, with no individual risk assessment of the detainee. When detainees requested a pillow they were often given blankets to use instead.

Areas for improvement

4.19 Detainees, particularly those held for more than 24 hours, should be offered exercise and a shower. (Repeated recommendation 4.40)

4.20 The range of reading material for children and non-English speaking detainees should be extended and routinely offered.

4.21 Pillows should be provided in all cells, subject to individual risk assessment.

Safeguarding

4.22 Frontline and custody officers had a good understanding of safeguarding children and vulnerable adults, along with the referral and multiagency arrangements to deal with any concerns. Most officers we spoke with had received training to identify safeguarding issues, including child sexual exploitation and modern-day slavery. This was supplemented by guidance bulletins and information on the force intranet.

4.23 However, the role of custody in safeguarding was restricted to detainee care and safe release. Custody officers relied on frontline or investigating officers to make safeguarding referrals to the force's specialist teams, and had no responsibility for overseeing this or ensuring that any necessary actions had been taken. In the custody records we looked at, there were few or no entries to show that any safeguarding concerns had been discussed or used to inform the approach to custody or release. Custody officers told us that they would always ensure that vulnerable adults and children were released to the care of a responsible person to be taken home. Although our observations showed that this happened, it was not recorded on most of the records we looked at. The force could not, therefore, demonstrate that it consistently released children and vulnerable adults safely.

4.24 Children were seen by the nurses and/or youth workers in the Criminal Justice Liaison and Diversion (CJLD) service to assess any risks and help needed. The team liaised with other agencies, made safeguarding referrals where needed, and offered or arranged support for the child after they had left custody. There were some entries on custody records detailing the outcome from their discussions with the child, but this was not consistent, and it was not always clear that custody officers were informed of issues that had arisen. Although it was force policy for the CJDLT to see all children, this was not monitored, and children in custody outside the team's working hours did not benefit from this support.

4.25 The force's custody action plan included actions for children in custody. However, custody officers had little awareness of these, and not all were always implemented operationally. For

example, all children should have been given pillows but not all custody officers were aware of this and did not differentiate between adults and children when making this decision. The approach to meeting the needs of children in custody was weak in some areas.

4.26 Although custody officers interacted well with children, who were usually placed in juvenile detentions cells away from the other cells, there was little attention to keeping them separate from adult detainees in the holding rooms or at the booking-in desk. We observed two children brought in as co-suspects. It was their first time in custody, both children were clearly upset, and one of them waited to be booked in for over an hour in the holding room with adult detainees.

4.27 Children were regularly offered food and drink, but in the cases we looked at none had been offered a shower or outside exercise. There was limited age-appropriate reading material, and this was not routinely offered (see area for improvement 4.20). The easy-read rights and entitlements information was not always issued. Although custody officers told us that all girls were assigned a female officer, this was not evident from the custody records we looked at and meant that the force could not show that it met its legal obligation under the Children and Young Persons Act 1933.

4.28 Children and vulnerable adults did not always receive early support from appropriate adults (AAs). In some of the cases we looked at, and observed in the custody suites, vulnerable adults and children waited too long for an AA to arrive. Long waiting times were mainly due to delays in requests, and AAs were often only asked to attend for the interview stage, which could be many hours into detention. This did not comply with Police and Criminal Evidence Act (PACE) code C. (See recommendation S36.)

4.29 In our custody record analysis, the average wait between a detainee arriving in custody and their AA attending was about seven hours, with a wide variation in between. In some cases, AAs were called and attended promptly, or were present from the start of detention, but some detainees waited too long, with one child waiting over 19 hours.

4.30 Custody officers contacted family members or friends in the first instance to act as AAs, and in some cases arresting officers assisted by making arrangements at the point of arrest. Where family members were not available, the force had arrangements with The Appropriate Adult Service (TAAS) for a 24-hour service, with a target to attend within one hour of being called. Although this performance was not monitored, custody officers said that the AAs arrived promptly. This meant the waiting times described above could often have been preventable had requests been prompt.

4.31 AAs were called and attended for most vulnerable adults and children. In some cases, AAs did not attend and some custody processes, such as fingerprinting, were carried out without an AA present, which was contrary to PACE code D. (See recommendation S37.)

4.32 The force did not monitor how effectively AAs were supporting vulnerable adults and children, and record keeping on the use of AAs was poor. Request and arrival times were not consistently recorded. Waiting times could often only be assessed on the time that the rights and entitlements were re-read to the detainee in the AA's presence. Inspectors who reviewed detentions under PACE requirements did not always identify that an AA had not been called when this was required. (See recommendation S37.)

4.33 The National Appropriate Adult Network advice leaflet was available in the suites as guidance for AAs. This was not always given out but custody officers told us they would explain the role to any relative or friend acting as an AA.

4.34 The force had a clear strategy to divert children away from custody. Between 1 April 2015 and 31 March 2018, the number of children entering custody had reduced by 26%. Although

custody officers were focused on minimising detention times, some children spent a long time in custody. Our custody record analysis showed that children spent an average of almost 13 hours in custody, with the longest detention at 22 hours 36 minutes.

4.35 There were few entries on the custody record to show that investigations of children were progressed quickly to minimise detention times, and there was not always sufficient rationale to show why a child was detained overnight. We saw a 14-year-old boy who had been brought into custody in the early hours of the morning. An AA was not called until late afternoon, and there had been no action to chase the investigation. He was later released under investigation, having admitted the offence, after spending about 18 hours in custody.

4.36 Children charged and denied bail continued to remain in custody rather than be transferred to alternative accommodation arranged through the local authority, as per their statutory responsibility. Force data for the year to 31 March 2018 showed that 19 children were charged and refused bail. Requests for alternative accommodation were made and these children should have been moved. However, only two of the 13 requests for secure accommodation were met, as were only three of the six requests for non-secure accommodation, which was a poor outcome. (See recommendation S41.)

4.37 Although there were procedures to escalate cases to senior officers in the force and in the local authority to ensure that children were moved as required, custody officers did not follow these procedures in all cases, and the escalation arrangements had not resulted in any improvement. Juvenile detention certificates were completed for children who were not moved so that the court could be informed.

4.38 There was no monitoring of performance information for children. Custody inspectors were notified daily of all children entering custody so that they could look at all cases where children were detained overnight to assess whether all action had been taken to avoid this, and clear rationale for the custody officer's decision was recorded. However, this information was not used to show overall performance for the force to assess how well it met its strategic objectives for children in custody. There was no monitoring with partner agencies, in particular the provision of alternative accommodation, to identify where the problems lay and how to address these to improve outcomes for children. (See recommendation S41.)

Area for improvement

4.39 The force should strengthen its safeguarding of children in custody by keeping children away from adult detainees wherever possible. Custody officers should be aware of any safeguarding referrals made, and this information should be used in caring for the child while they are in custody and on their release.

Governance of health care

4.40 Castlerock Recruitment Group Medical Services (CRG) had provided primary health services since June 2017. Health provision had improved since our last inspection and was very good.

4.41 Joint working between the police and CRG was effective, supported by regular meetings. The service contract had been enhanced with clear performance measures and penalties for underachievement. CRG achieved 93.4% compliance on responding within one hour, against a target of 90%. However, performance at Buxton was under target at 56% due to the longer distances involved.

4.42 Clinical governance systems were robust and the Radar incident system was used to share lessons learned from adverse incidents and complaints. Clinical auditing had begun, as had 'Have your say' service user satisfaction sampling, both of which were essential initiatives in improving services. Health care professionals (HCPs), competent doctors, nurses and paramedics, provided the service. Nurses and paramedics undertook some enhanced interventions usually carried out by doctors - including fitness for interview, Taser barb removal and fitness for release - which was efficient. HCP were embedded in the busier suites at Chesterfield and Derby over 24 hours, and the HCP at Chesterfield responded to calls from Buxton. Although a doctor was available 24 hours a day to the force, they were sometimes unavailable to the custody suites while attending the sexual assault referral centre.

4.43 Most detainees who required a HCP were seen quickly, usually within minutes in busier suites and around 60 to 75 minutes at Buxton. In our custody record analysis, detainees requiring a HCP waited an average of 74 minutes, which was close to the one-hour target.

4.44 Clinical leadership was evident and HCPs said they felt supported. Staff inductions included regular supervision and mentorship, which ensured consistent decision making. HCPs had good access to mandatory training and appropriate clinical supervision.

4.45 There were relevant custody-specific policies and sources of clinical evidence in each suite. All the clinical staff we spoke with demonstrated a good understanding of safeguarding issues and procedures. There had been no complaints about the service since June 2017.

4.46 The medical room at Buxton was poor and the one at Chesterfield was dated, but the room at Derby was impressive. Infection prevention and control standards were consistently met. Medical rooms were generally clean and free from dust. They all contained necessary clinical equipment and stock, although we found some expired items in some suites; these were removed while we were present. HCPs wiped down surfaces before forensic testing to minimise cross-contamination.

4.47 CRG medical emergency equipment and drugs were readily available in each medical room, and checked daily.

Patient care

4.48 In our custody record analysis, 26% of detainees required help from a HCP, of whom over 90% were seen face to face. Custody staff referred detainees to HCPs based on identified need, risk or the detainee's request, and detainees we spoke with were satisfied with their care.

4.49 We observed excellent partnership working between custody staff, HCPs, mental health and substance misuse workers. We saw HCPs providing evidence-based, good and compassionate care, as well as custody staff carefully following guidance left by HCPs on the Niche police records management system.

4.50 CRG consistently offered detainees an HCP of a gender of their choice, and professional interpreting service were available for those with limited English.

4.51 All health professionals completed some paper clinical records, including written consent to care, and the CRG electronic clinical record. The clinical records we examined were very good. Clinical staff summarised their consultation on to custody records, which supported continuity of care without breaching medical confidentiality. All clinicians had some of their clinical records audited regularly to assure quality and consistency of practice.

4.52 Medicines management had improved and was very good. Securely stored drug cupboard keys were only accessible to health staff. Standardised stock medicines were stored tidily in all suites, regularly reconciled and date checked. Discarded medicines were recorded to reduce the likelihood of discrepancy.

4.53 Police retrieved medication from detainees' homes as necessary, and HCPs assessed the detainee and the medicine appropriately before administration. There were reliable systems to obtain critical medicines if the detainee did not have their own supplies. Most HCPs prescribed and administered medicines using an appropriate range of patient group directions, including symptomatic relief for drug and alcohol withdrawal. They also assisted detainees to take opiate substitutes as prescribed, following necessary checks. Detainees' medication was stored securely with their property at all suites. We were told that medicines for administration while detainees were in court were not sent with them, which risked medical complications for those treated for alcohol withdrawal.

4.54 At Buxton, where HCPs were not embedded, the custody staff held a few medicines that could be administered once a doctor had authorised their use. Storage of these medicines was appropriate, as were stock checks and monitoring arrangements.

4.55 Nicotine replacement therapy had ceased in June 2017. Both HCP and custody staff expressed concern that it was no longer available as it could lead to agitation and withdrawal effects if the detainee was held for a long time. The police procurement and contract manager agreed to review the situation.

Areas for improvement

4.56 Medications due for administration while detainees are at court should be sent with them.

4.57 Nicotine replacement therapy should be available to detainees.

Substance misuse

4.58 Support for detainees with substance misuse needs had improved since our previous inspection. Derbyshire Healthcare NHS Foundation Trust drug arrest referral workers (ARWs), who covered the county, were embedded at Chesterfield and Derby suites, with a Phoenix ARW also at Derby for city residents. The Chesterfield ARW provided a telephone support and signposting service to the Buxton custody suite. The trust's ARWs were members of the mental health liaison and diversion teams, and the trust contracted Phoenix community treatment programmes. Despite the complexity of these arrangements, all ARWs shared SystmOne (electronic clinical record), and those at Derby were co-located so that detainees experienced seamless substance misuse and mental health services.

4.59 Detainees had very good access to ARWs. The workers checked all new detainees (including those at Buxton) on Niche daily, accepted referrals from custody staff and visited the cells at Derby and Chesterfield daily. They spoke to all detainees during cell visits and engaged them in services or signposted them to more appropriate services. They also saw children and referred them to specialist teams. ARWs also worked in the local courts and provided reports on detainees to assist the court and support detainees subject to court requirements for drug and/or alcohol rehabilitation. Needle exchange and naloxone (to manage substance misuse overdose) were available from Phoenix community services, and detainees were made aware of these services, as indicated.

Good practice

4.60 *Drug arrest referral workers screened all new detainees through the Niche police records system to ensure they were aware of all those with indicators of addiction.*

Mental health

4.61 Derbyshire Healthcare NHS Foundation Trust provided the CJLD service. Custody staff we spoke to demonstrated an understanding of mental health issues and had received mental health awareness training in the last year, which was impressive. This had resulted in appropriate referrals to the CJLD service.

4.62 CJLD services in the custody suites were very effective with mental health professionals embedded each day at Chesterfield and Derby suites. The Chesterfield CJLD team offered telephone support to Buxton, and visited when requested. However, CJLD staff screened all new detainees (including those at Buxton) through Niche to identify potential markers of mental disorder or those already in treatment; this was good practice.

4.63 The CJLD team offered an inclusive service and saw all adults and children who presented with mental ill health, physical ill health, homelessness or substance misuse needs, and all female detainees. Detainees who had been charged with a sexual offence were also seen due to an increased risk of self-harm and suicide. Custody staff reported very positively on how the CJLD team supported detainees in custody at Chesterfield and Derby.

4.64 Custody, CRG and CJLD staff told us that detainees waited too long to receive a Mental Health Act assessment in custody or transfer to a hospital, although the force did not collect information about this. Our custody record analysis showed that four detainees had waited over 20 hours for transfer to a hospital bed and one more than 24 hours. Delays were said to be due to waits for approved mental health professionals, section 12 approved doctors, beds and ambulances to transport patients, and the complexity of coordinating the assessment. (See area for improvement 1.20.)

4.65 The local Mental Health Act section 136 policy[11] reflected the changes in the Policing and Crime Act 2017, and police custody had been used as a place of safety only once in the 12 months to the end of March 2018, which was appropriate.

4.66 The force had a mental health coordinator and regular, minuted meetings supported good joint working arrangements between the police and Derbyshire Healthcare NHS Foundation Trust. Street triage had been replaced by an embedded 'mental health triage' hub in the communication room that provided telephone triage of referrals and could link the detainee and police officers with local crisis services (see paragraph 2.7). We were told that some officers visited the hub to speak directly with mental health professionals if they had concerns about a member of the public, which demonstrated close partnership working.

Area for improvement

4.67 Detainees should have equitable access to liaison and diversion services across the force area.

[11] Enabling a police officer to remove someone from a public place, and take them to a place of safety – for example, a police station.

Good practice

4.68 *The screening all new detainees by telephone at the hub and through Niche ensured that Criminal Justice Liaison and Diversion professionals were aware of all those in custody with indicators that required their services.*

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 our case audits and in the pre-release risk assessments (PRRAs) we reviewed, records lacked rigour. For example, release arrangements were not recorded routinely and did not clearly demonstrate how a detainee planned to travel home after release. PRRAs were completed routinely and in most cases by sergeants who asked a standard set of questions. However, the questions were not wide enough to elicit sufficient information from detainees to ensure their safe release. Custody sergeants therefore asked a range of additional questions to assess detainee risk, which led to inconsistencies in the PRRAs across the force. Before a detainee's release, most staff checked their initial risk assessment in the custody records to cross reference with the PRRA, which was good. However, some PRRA completions were perfunctory, and too many were completed after the detainee had left custody, which was poor practice.

5.2 We observed custody staff discussing vulnerable detainees and safeguarding issues before release in relevant cases. Despite this, they relied too much on investigating officers to liaise with the relevant agencies to make a safeguarding referral or the necessary arrangements for a safe release. In the custody records we reviewed, there were very few or no entries to evidence that any arrangements relating to safeguarding concerns had been discussed or used to inform the decisions that custody sergeants made on a detainee's release.

5.3 Custody sergeants did not have access to travel warrants and the suites had no petty cash to assist detainees to travel home safely after release. Although we observed that transport for vulnerable detainees and children was organised by custody staff, the custody records did not always record this and so the force could not demonstrate that it always released children and vulnerable adults safely (see paragraph 4.23). Custody sergeants were unclear about their obligation to ensure that all detainees travelled home safely after their time in custody. There was too much reliance on officers in charge of the case to arrange detainee travel after release.

5.4 An up-to-date and informative support leaflet was given to all detainees before their release, including those leaving for court. It included detailed information and contacts for a wide range of local and national support organisations, but was only available in English.

5.5 Too many of the person escort records (PERs) that we sampled included risk information that had not been dated, so a meaningful assessment of detainee risk was difficult. Confidential detainee medical information was routinely inserted inside the PER without an envelope, which was inappropriate.

Areas for improvement

5.6 Custody sergeants should take responsibility for arranging the safe release of all detainees leaving custody, including their transport home, and clearly document this in the custody records.

5.7 Confidential detainee medical information accompanying person escort records should be placed in a sealed envelope.

Courts

5.8 Custody staff told us that the local magistrates' courts generally accepted detainees until between 2pm and 3pm on most days, but they had sometimes been refused earlier than this. During our inspection, Derby Magistrates' Court contacted the custody suite on two days between 1pm and 2pm to say that there was a 'block' on accepting any further detainees but with no explanation about why this was the case. We saw two detainees, one from Derby and one from Chesterfield, who had been accepted late in the morning by Derby Magistrates' Court but who were returned to the police custody suite at 10.45am due to the lack of available court cells. This matter was not escalated to senior management for their attention. The two detainees were subsequently transferred to court at 1.25pm that day by GEOAmey, the local prisoner escort and custody service contractor. Staff told us that GEOAmey regularly transferred detainees from Derby after the initial morning court run. This was a better service than we have seen elsewhere, where the police force tends to be responsible for the transfer of late arriving detainees.

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

Causes of concern and recommendations

6.1 **Cause of concern:** There were a substantial number of potential ligature points in all the force custody suites. This posed a risk to detainees and the force, and required immediate remedial action.

Recommendation: The force should take immediate action to identify and deal with potential ligature points in all its custody suites. (S35)

6.2 **Cause of concern**: There were too many areas (15) where the force did not comply with legislation or guidance, notably code C of the Police and Criminal Evidence Act. This required immediate remedial action, with arrangements to demonstrate compliance.

Recommendation: The force must take immediate action to ensure that all custody procedures comply with legislation and guidance, and that officers consistently implement these. Quality assurance should be applied to test compliance with the legislative requirements. (S36)

6.3 **Cause of concern:** Children and vulnerable adults did not always receive early support from appropriate adults (AAs). The force failed to ensure, or monitor, that requests were made without undue delay, and that an AA was present at all key stages of the custody process.

Recommendation: Children and vulnerable adults should receive early, and ongoing, support from appropriate adults throughout their time in custody. (S37)

6.4 **Cause of concern:** The quality of custody records was poor, key decisions and justification for actions were often not recorded, and quality assurance arrangements were weak.

Recommendation: Custody records should be comprehensive with key decisions and the justification for actions clearly and properly recorded. Quality assurance processes should be robust to ensure that this is achieved and that outcomes for detainees are good. (S38)

6.5 **Cause of concern:** The collation and monitoring of data on key areas of custody were inadequate, and often unreliable. This did not support effective performance management.

Recommendation: **The force should have sufficient and accurate data to allow effective scrutiny across all areas of custody. There should be a clear performance management framework to review the data and performance information, and the force should use this to assess outcomes for detainees, hold statutory partners to account and improve services. (S39)**

6.6 **Cause of concern**: The governance and oversight of the use force in custody were not adequate, data were unreliable and not all instances where force was used in custody suites were recorded. Some use of force was disproportionate to the risk or threat posed.

Recommendation: **All use of force in the custody suites should be recorded in line with the recommendations of the National Police Chiefs Council, and fully justified on the custody record. Governance and oversight of the use of force should ensure that all use of force is proportionate to the risk posed, and include comprehensive review of CCTV records. (S40)**

6.7 **Cause of concern**: Children charged and refused bail were not moved to alternative accommodation arranged through the local authority. The force did not monitor this with partner agencies to identify and agree on the improvements needed.

Recommendation: **The force should work with the appropriate partners to monitor data on children detained overnight and use this to improve outcomes for them. Requests for alternative accommodation and the reasons for children remaining in custody overnight should be clearly recorded on custody records. (S41)**

Areas for improvement

Leadership, accountability and partnerships

6.8 There should be a clear performance framework with regular governance meetings to ensure that senior management has clear oversight of all aspects of custody provision, and that outcomes for detainees are good. (1.10)

6.9 The training of custody staff should be sufficiently focused on the legislative requirements of custody to equip officers to fulfil the role. (1.11)

6.10 The force should work with its partner agencies to understand and address the reasons for delays for detainees with mental ill health, and minimise the time that they wait for mental health assessments and onward transfer to a mental health bed. (1.20)

Pre-custody: first point of contact

6.11 The force should continue to work with partners to ensure that frontline officers have effective support at the first point of contact in helping them divert people with mental ill health away from custody. Detainees held under section 136 of the Mental Health Act should be transported by ambulance, and officer waiting times with such detainees should be minimised. (2.9)

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

6.12 Replacement footwear should be provided to detainees to ensure their dignity, respect, health and wellbeing while in custody. (3.5)

6.13 Custody sergeants should enable detainees to disclose any confidential or sensitive information to them privately during their booking in. (3.6)

6.14 Detainees should be routinely informed that CCTV monitors provide pixilation of the in-cell toilets. (3.7)

6.15 The force should ensure that the distinct needs of women are consistently identified and met. Women detainees should have the opportunity to speak with a female member of staff to discuss their care needs, and be offered sanitary items routinely. (3.13)

6.16 There should be arrangements for disabled detainees to shower, and thicker mattresses should be available in all custody suites. (3.14)

6.17 Religious books and artefacts should be stored respectfully in accordance with the requirements of the specific faith. (3.15)

6.18 Any delays in obtaining professional interpreters should be escalated immediately to senior managers to intervene and ensure these services are promptly delivered. (3.16)

6.19 All detainees should be booked in without delay when they arrive at the custody suite. (3.24)

6.20 Custody sergeants should supervise civilian detention officers who book in detainees. (3.25)

6.21 The risk assessment template should include an appropriate range of questions to assess detainee risk effectively. (3.26)

6.22 Clothing with cords and footwear should not be routinely removed from detainees without an individual risk assessment, and anti-rip clothing should only be issued after an individual risk assessment. (3.27)

6.23 Observations levels should be set at an appropriate level commensurate with the risks posed, and the frequency of required observations should always be adhered to. (3.28)

6.24 Staff should carry anti-ligature knives at all time. (3.29, repeated recommendation 4.20)

6.25 The force should monitor the status of investigations for detainees released under investigation, and keep them informed about this. (3.50)

6.26 The force should ensure that detainees are able to make a complaint while they are in custody. (3.53)

In the custody cell, safeguarding and health care

6.27 Fire drills should be recorded and documented accurately. (4.6)

6.28 Every member of staff involved in using force against a detainee should submit an individual use of force form. (4.12)

6.29 Handcuffs should be removed from compliant detainees at the earliest opportunity. (4.13)

6.30 Detainees, particularly those held for more than 24 hours, should be offered exercise and a shower. (4.19, repeated recommendation 4.40)

6.31 The range of reading material for children and non-English speaking detainees should be extended and routinely offered. (4.20)

6.32 Pillows should be provided in all cells, subject to individual risk assessment. (4.21)

6.33 The force should strengthen its safeguarding of children in custody by keeping children away from adult detainees wherever possible. Custody officers should be aware of any safeguarding referrals made, and this information should be used in caring for the child while they are in custody and on their release. (4.39)

6.34 Medications due for administration while detainees are at court should be sent with them. (4.56)

6.35 Nicotine replacement therapy should be available to detainees. (4.57)

6.36 Detainees should have equitable access to liaison and diversion services across the force area. (4.67)

Release and transfer from custody

6.37 Custody sergeants should take responsibility for arranging the safe release of all detainees leaving custody, including their transport home, and clearly document this in the custody records. (5.6)

6.38 Confidential detainee medical information accompanying person escort records should be placed in a sealed envelope. (5.7)

Examples of good practice

6.39 Drug arrest referral workers screened all new detainees through the Niche police records system to ensure they were aware of all those with indicators of addiction. (4.60)

6.40 The screening all new detainees by telephone at the hub and through Niche ensured that Criminal Justice Liaison and Diversion professionals were aware of all those in custody with indicators that required their services. (4.68)

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.

Main recommendations

As a priority, chief officers should resolve the inadequacies of the custody IT system to ensure outcomes for detainees are not adversely affected. (2.25)	**No longer relevant**
Custody staff should only use safety clothing following a risk assessment, and its use should be monitored for rationale and justification and to identify any staff training needs. (2.26)	**Not achieved**
Strip searching needs to be authorised and justified. Custody staff should be monitored for rationale and justification and to identify any staff training needs. (2.27)	**Achieved**
Custody staff should review the use of a breathalyser as the only determining factor for assessing someone's suitability for interview. Risk assessments should consider the detainee's demeanour and understanding. (2.28)	**No longer relevant**
The meaning and standard of level three observations should be explained to all custody staff. (2.29)	**Achieved**
The use of form F142 should be reviewed, and the detainee should be present when the arresting officer explains the reason for their arrest to the custody sergeant. (2.30)	**Not achieved**

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.

Recommendations

The Police and Crime Commissioner or chief officer group should discuss with local authority partners at a strategic level how to address the lack of local authority accommodation for children and young people refused bail at police stations. (3.10)	**Not achieved**
The sample of custody records quality assured at the busier suites should be increased. (3.16)	**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

Custody sergeants at Derby should maintain better control of the number of staff waiting in the booking-in area. (4.9)	**Not achieved**
Custody suites should be accessible to detainees with disabilities, and booking-in areas should be fitted with hearing loops and custody staff know how to use them. (4.10)	**Partially achieved**
Staff should carry anti-ligature knives at all times. (4.20)	**Not achieved** (repeated as area for improvement 3.29)
Detainees should only be handcuffed in holding areas when a risk assessment indicates this is necessary for the safety of staff and others. (4.25)	**Not achieved**
Only custody staff should visit cells or, if necessary, accompany such visits. (4.30)	**Not achieved**
Suitable alternative clothing for detainees should be available in all the custody suites at all times. (4.39)	**Achieved**
Detainees, particularly those held for more than 24 hours, should be offered exercise and a shower. (4.40)	**Not achieved** (repeated as area for improvement 4.19)

Health care

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

Recommendations

All staff should have access to clinical supervision. (6.5)	**Achieved**
All medical equipment should be checked regularly. (6.6)	**Achieved**
Detainees' documented consent should be obtained for all clinical interventions. (6.14)	**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*.[12]

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.[13] 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.[14]

Case audits

We carry out in-depth audits of approximately 40 case records (the number may increase depending on the size and throughput of the force inspected) 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

[12] http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/inspection-criteria/

[13] 95% confidence interval with a sampling error of 7%.

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

custody. 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.

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 coordinator 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 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	HMI Prisons team leader
Fionnuala Gordon	HMI Prisons inspector
Fiona Shearlaw	HMI Prisons inspector
Norma Collicott	HMI Constabulary and Fire & Rescue Services inspection lead
Viv Cutbill	HMI Constabulary and Fire & Rescue Services inspection officer
Patricia Nixon	HMI Constabulary and Fire & Rescue Services inspection officer
Vijay Singh	HMI Constabulary and Fire & Rescue Services inspection officer
Paul Tarbuck	HMI Prisons health services inspector
Dee Angwin	Care Quality Commission inspector
Kathleen Byrne	Care Quality Commission inspector
Joe Simmonds	HMI Prisons researcher
Patricia Taflan	HMI Prisons researcher