Report on an unannounced inspection visit to police custody suites in

Norfolk and Suffolk

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

14–25 May 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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Geographical area
Norfolk and Suffolk

Date of last police custody inspections
16–20 April 2012

Custody suites	Cell capacity
Wymondham	30 cells
Aylsham	8 cells
King's Lynn	24 cells
Great Yarmouth	30 cells
Bury St Edmunds	24 cells
Martlesham	30 cells

Annual custody throughput
22,672 (2017–18) (Norfolk)
11,669 (2017–18) (Suffolk)

Joint custody staffing
61 custody sergeants
85 custody detention officers

Health service provider
Group 4S Medical

[1] Data supplied by the force.

Executive summary

S1 This report describes the findings following an inspection of six custody facilities. The inspection was conducted jointly by HM Inspectorate of Prisons (HMIP) and HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) in May 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 forces' 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 Norfolk and Suffolk Police in 2012. This inspection found that of the 17 recommendations made during that previous inspection, 10 had been achieved, five had been partially achieved and one had not been achieved. One recommendation was no longer relevant.

S4 To aid improvement we have made two recommendations to the forces (and the Police and Crime Commissioner) addressing key causes of concern, and have highlighted an additional 18 areas for improvement. These are set out in Section 6.

Leadership, accountability and partnerships

S5 Norfolk and Suffolk constabularies made efforts to achieve the recommendations made at our previous inspection and demonstrated progress in many areas. This inspection of custody facilities in Norfolk and Suffolk was positive overall. We identified two causes of concern and a number of areas requiring improvement, which we were confident that the forces' leadership arrangements would enable them to address.

S6 The collaboration agreement between Norfolk and Suffolk constabularies provided for a strong governance structure and clear, joint accountability for custody services. We found custody provision that was streamlined, where generally well trained custody sergeants and custody detention officers worked in facilities across both counties. Demand dictated the level of staff deployment in custody suites. This often meant relying on minimum staffing, which meant that staff were stretched when suites were busy.

S7 A comprehensive performance framework was in place, but there were gaps and some data we received were unreliable, notably on the use of force. Some good work was carried out to address areas of potentially disproportionate treatment, but at times it was undermined by inaccuracies or incomplete data, including in information on self-defined ethnicity (disclosed by detainees themselves) and waiting times for appropriate adults. These gaps prevented the forces from identifying trends, informing organisational learning and holding their external partners to account.

S8 We found a number of instances, which are detailed throughout this report at paragraphs 1.12, 3.43, 3.44, 4.15 4.28 and 4.30, where the forces did not consistently comply with the Police and Criminal Evidence Act 1984 (PACE), covering the detention, treatment and questioning of suspects, or some of its codes of practice. This was having an adverse impact on outcomes for some detainees and was a cause of concern.

S9 The constabularies placed an emphasis on protecting and diverting vulnerable people from custody and worked proactively with a range of external partner agencies to achieve this

priority. Partnership arrangements to support people with mental ill health were good and the number detained under section 136 of the Mental Health Act had decreased significantly. However, other partner agencies' lack of capacity or capability meant, for example, that too many children who were charged and had bail refused were detained in custody overnight when alternative accommodation should have been provided.

S10 The constabularies had highlighted their concerns about the unsatisfactory arrangements for those attending virtual courts to their partner agency, HM Courts and Tribunal Services (HMCTS). Despite ongoing discussions with partners, outcomes for some detainees dealt with by virtual courts were not good enough and many spent longer than necessary in police custody.

Pre-custody: first point of contact

S11 Frontline officers had a good understanding of vulnerability and were confident about taking it into account when deciding whether to arrest someone or take alternative action.

S12 The information provided by the call centre to inform these decisions was variable. Although initial information was usually adequate it was not always updated promptly enough, and officers told us they sometimes needed to guide call handlers to find out specific information to help them deal with an incident.

S13 Mental health professionals in both forces' call centres provided invaluable support, and in Suffolk they accompanied police officers in police vehicles to provide triage for those with mental health problems. Where possible, frontline officers diverted mentally unwell people from custody.

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

S14 Custody staff treated detainees respectfully. Interactions were good and took place in reasonably well screened areas that offered a degree of privacy, which helped ensure that detainees' complex needs and vulnerabilities could be identified at an early stage.

S15 Despite only receiving limited training around equality and diversity, custody sergeants generally met the individual and diverse needs of detainees in their care. Custody staff were aware of their mental and developmental needs and made good use of health and liaison and diversion staff. Arrangements for assisting detainees with disabilities were generally satisfactory. Staff made sure detainees could observe their faith. Staff's approach to the distinct needs of women and those who identified as transgender was inconsistent.

S16 Risks were generally assessed and managed well. However, set observations levels did not always reflect all the risks posed. The practice of removing detainees' clothing to manage their risks was often used as a first response and was often accompanied by low levels of observation, which was not reflective of the perceived level of risk posed. However, other strategies, including setting more frequent observation levels might have offered detainees the support they needed more effectively. Detainees were checked as often as required and checks that involved rousing intoxicated detainees were conducted properly but not always recorded clearly.

S17 The grounds and necessity for arrests were clearly explained before custody sergeants authorised detention. Most cases were progressed quickly in an effort to complete them within the initial 24-hour detention period so that detainees did not need to be released under investigation or on bail. However, some detainees spent too long in custody waiting

for appropriate adults or interpreters to arrive or sometimes for charging decisions by the Crown Prosecution Service. Detainees had their rights and entitlements explained, generally in a format and language they could understand.

S18 There were weaknesses in the way inspectors conducted reviews of detention. Many reviews were very early and they were not always carried out in line with requirements, or in the best interests of the detainee. As a result of our observations, we referred a number of poor or misleading reviews back to the forces so they could consider them. Bail was applied and managed well.

S19 Custody staff's knowledge of the complaints procedures was mixed. Detainees' right to complain about their treatment was not always facilitated well enough and complaints were not always dealt with before they left custody.

In the custody cell, safeguarding and health

S20 The standard of the custody estate in Norfolk and Suffolk was very good – cells and communal areas were clean and well maintained and there were no identified potential ligature points or graffiti.

S21 Staff dealt with challenging detainees well and often de-escalated situations so that force was not required. However, when used, the forces did not have adequate mechanisms in place to ensure that they, their respective police and crime commissioners and the public could be confident that the use of force in detention and custody was always safe and proportionate.

S22 Few staff involved in the use of force, particularly those who worked in custody, submitted forms to justify why they had used force against detainees. Many of the cases we reviewed highlighted a range of concerns. For example: we were not always satisfied that the use of force was proportionate to the risk or threat posed by the detainee; poor techniques were used, such as leaving detainees lying face-down (prone) for prolonged periods, which could have been dangerous and increased the risk of harm to the detainee; clothing was forcibly removed without adequate justification; and handcuffs were not removed from compliant detainees at the earliest opportunity. We referred about half of the cases we reviewed back to the forces so lessons could be learned.

S23 Data we received suggested that the number of detainees who were subject to a strip-search was high. Our observations and examination of case records showed that strip-searching was not always justified, or properly recorded/authorised in custody records.

S24 Although most detainees received a sufficient range of food and drinks at regular intervals, detainee care did not extend much beyond this. Access to facilities including showers, exercise and distractions, such as reading material, was limited and generally not offered routinely.

S25 Officers and custody staff had a good understanding of their safeguarding responsibilities towards children and vulnerable adults. However, once in custody, detainees did not always receive support from appropriate adults promptly. While custody sergeants focused on minimising detention times for children, not all cases were progressed quickly. However, interactions with children were positive and they received good care during their time in custody.

S26 Some aspects of health services had improved since our last inspection, although some areas of clinical governance required improvement. Working relationships, between the police in both constabularies and agencies that provided health services, were generally effective.

Clinical areas were of a high standard. Patient care was generally good, but detainees at Aylsham did not have prompt access to health services. Substance misuse services were no longer embedded in custody suites and therefore only limited provision was available. Detainees and custody staff appreciated the embedded mental health liaison and diversion services. It was positive that since December 2017, no one had been detained in custody under section 136 of the Mental Health Act as a place of safety. However, some detainees with mental ill health who were taken into custody waited too long for assessments under the Mental Health Act and several subsequently waited too long before they were conveyed to a mental health unit.

Release and transfer from custody

S27 Custody sergeants ensured detainees released from custody had a safe onward journey, particularly those identified as being the most vulnerable.

S28 Children and vulnerable adults were sent to court to appear in person, and these arrangements worked effectively. However, many detainees waited a long time in custody before being presented to the virtual court and, where they were remanded, they often spent too long in police custody including overnight, before their onward journey to prison.

Causes of concern and recommendations

S29 **Cause of concern:** There were too many areas where the force did not comply with legislation or guidance, notably code C of the Police and Criminal Evidence Act (PACE) codes of practice. 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.**

S30 **Cause of concern:** The governance and oversight of the use force in custody was not adequate, data were unreliable and some use of force was disproportionate to the risk posed. Norfolk and Suffolk constabularies did not record all incidents involving force in the custody suites.

Recommendation: **The constabularies should strengthen their governance of use of force by ensuring that all incidents involving force in custody are properly recorded and are in line with recommendations from the National Police Chiefs Council. Incidents should be cross-referenced to CCTV to demonstrate that the force used is proportionate and justified.**

Introduction

This report is one in a series of inspections of police custody carried out jointly by HM Inspectorate of Prisons (HMIP) and HM Inspectorate of Constabulary & 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*.[2] 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*.[3]

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 Norfolk and Suffolk forces we analysed a sample of 138 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

2 http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/inspection-criteria/
3 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 Norfolk and Suffolk constabularies had a clear governance structure for the delivery of custody. As part of a well embedded collaboration agreement under section 22 of the Police Act 1996, the overall responsibility for custody lay with a jointly funded assistant chief constable who covered both forces. The responsibility for custody lay with a member of police staff who was head of the criminal justice department and a chief superintendent who was the head of the joint justice department, supported by two chief inspectors.

1.2 These joint arrangements provided clear accountability for safe custody. The assistant chief constable (ACC) reported to the joint chief officer team and had monthly meetings with the local policing ACCs in each force, which ensured that the chief officers in both forces had oversight of, and accountability for, their custody services. The chief superintendent chaired a monthly leadership team meeting and reported to both forces' management boards, where she was held accountable for the safe delivery of custody.

1.3 Custody services were integrated across six police investigation centres (PICs) covering the two force areas. The PICs were interoperable and staff from either force could perform duties within each PIC. Two chief inspectors were responsible for overseeing the day-to-day operational management of the PICs – one oversaw custody functions, the other custody investigation units (CIUs). During the inspection both posts were held by Norfolk officers, but to ensure full integration at managerial level, there were plans for the CIU post to be held by a Suffolk chief inspector in future.

1.4 Senior officers had good oversight of custody and effective meeting structures were in place. A meeting chaired by the custody chief inspector took place every eight weeks to review the PICs' performance and ensure working practices were consistent.

1.5 The forces had made good progress against our previous inspection recommendations and it was clear they were committed to delivering further improvements. The leadership and governance arrangements provided reassurance that custody services would continue to improve.

1.6 The custody estate was well maintained and facilities were good. Staffing levels at each custody suite were based on demand. This normally meant running on minimum staffing levels, which affected capacity when the suites became busy and detainees were diverted to other suites, if necessary. Frontline officers trained in custody provided additional support, but the forces' reliance on them was closely monitored. A dedicated inspector was responsible for each custody suite, which provided the service with a good level of support and oversight. However, operational inspectors took over their responsibilities when they were off duty, often recording on custody records that they were too busy to attend the suites. Some inspector reviews of detention were carried out by sergeants who had been given acting inspector status for the shift, and it was not clear from custody records whether

these officers were sufficiently qualified to carry out these duties in line with section 107 of the Police and Criminal Evidence Act 1984 (PACE), which covers the detention, treatment and questioning of suspects. (See recommendation S29.)

1.7 Initial training for sergeants and custody detention officers was good. All staff were expected to complete a nationally accredited training course and fulfil a minimum of 80 hours shadowing more experienced officers before taking up their duties. Training for custody sergeants took three weeks and four weeks for custody detention officers. This was complemented by a competency-based workbook that had to be completed and signed off by an inspector. Refresher training kept custody staff updated, but most staff we spoke to said opportunities for wider training were more limited.

1.8 Both forces had adopted the College of Policing's *Authorised Professional Practice* (APP)[4] on custody. In addition, a single custody policy provided staff with comprehensive guidance. While most practices we saw complied with APP, they were sometimes applied inconsistently across the custody suites.

1.9 The forces focused on diverting vulnerable people away from custody. They had a 'custody promise' that set out the principles by which custody services would be delivered, which included diverting children elsewhere and using custody only as a last resort.

Accountability

1.10 A comprehensive performance management framework was in place, however the extent and quality of information to support the framework required improvement. While a range of data was available, including on overall detention times and waiting times at each custody suite, there were some gaps in key areas of activity, which prevented the forces from assessing how well they were doing, identifying trends and informing organisational learning.

1.11 The forces did not have adequate mechanisms in place to ensure they, their respective police and crime commissioners and the public could be confident that the use of force in detention and custody was always safe and proportionate. While data on incidents in the custody suites were available, the initial figures provided were not reliable, and not all incidents involving force were recorded on the custody record. Although some governance and oversight processes were in place, including some cross-referencing to CCTV, the lack of recording did not assure us that they were sufficiently robust.

1.12 In many areas, the forces did not comply with PACE or its codes of practice. For example, where reviews of detention were conducted by phone, reviewing officers did not always record where they were or why the review could not be conducted face to face (contrary to section 15.14 of code C). Detainees were not being informed that a review had taken place while they had been asleep (as stipulated in section 15.7 of code C) and some reviews of vulnerable detainees' and children's cases were completed over the phone, which was poor practice (section 15.3C of code C). Neither was it always clear how the forces were complying with section 31 of the Children and Young Persons Act 1933, which states that girls in detention should have access to a named female officer. (See recommendation S29.)

1.13 In other areas, compliance was good. The forces ensured they explained to detainees why their arrest was necessary, and the code G necessity test was recorded in detail on custody records to show it was appropriately justified.

1.14 Overall, custody records required improvement. Custody staff often relied on drop-down menu options and then added their own text, which made many detention log entries

[4] https://www.app.college.police.uk/

confusing. Custody staff recorded multiple cell checks at a time, which meant there was a lack of focus on individual detainee care. In addition, our case audits showed that important information was not being recorded at all, for example, the justification for removing detainees' clothing, using restraint or force to do so, or details about when appropriate adults were called and the time they arrived.

1.15 The forces met the public sector equality duty and had shared joint strategic equality action plans with their police and crime commissioners. While there were no specific custody objectives in these plans, both forces had a commitment to improve services for those with mental ill health, which had an impact on custody services. The forces had conducted a review following publication of the Lammy report[5], demonstrating their commitment to identifying potential disproportionate treatment. However, a significant gap in the recording of self-defined ethnicity data (ethnicity information disclosed by detainees) made it difficult for either force to assess whether detainees were treated fairly.

1.16 The forces were open to external scrutiny. Effective independent custody visitor (ICV) schemes operated in Norfolk and Suffolk. ICVs' concerns were generally addressed and received an appropriate response.

1.17 There had been one death in custody since the last inspection, which occurred in Suffolk in 2015. The coroner's findings were awaited.

Areas for improvement

1.18 The forces should ensure that the accuracy, collation and monitoring of data on key areas of custody is sufficient to assess performance, identify trends and drive improvements.

1.19 The forces should ensure that custody records are comprehensive and clear and that all decisions are appropriately justified and clearly recorded. Multiple cell checks should not be entered in individual detainee detention logs.

Partnerships

1.20 Good work with partners helped protect and divert vulnerable people away from custody. Clear policies underpinned the approach and set out joint responsibilities (see also paragraph 1.9).

1.21 Partnership arrangements for supporting detainees with mental ill health were good. The constabularies had good strategic and operational working arrangements with mental health services, which helped ensure individuals with mental ill health were not held in custody. Comprehensive data showed a reduction in the number of detainees brought into custody as a place of safety under section 136 of the Mental Health Act 1983.

1.22 The forces and partners had all signed the concordat on children in custody[6]. There was a clear commitment to achieving the aims of the concordat, but too many children were charged and had bail refused, continuing to remain in custody overnight when alternative accommodation should have been provided. (See also paragraph 4.38.)

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[5] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/643001/lammy-review-final-report.pdf

[6] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/655222/Concordat_on_Children_in_Custody_ISBN_Accessible.pdf

1.23 There were pathways for preventing vulnerable people from entering the criminal justice system or reoffending. A women's pathfinder scheme Wonder + had seen some positive outcomes during a pilot phase and was being rolled out across Norfolk. It was not available for women in Suffolk, however. Both forces made referrals to Nova, a diversion scheme for detainees who had been in the armed forces. Positive work with the Youth Offending Service in both forces helped prevent the criminalisation of children.

1.24 Virtual courts (court sessions via video link) had been introduced in all custody suites. However, some of aspects of the arrangements meant many detainees spent longer periods of time in police custody than necessary. The forces were working with HM Courts and Tribunals Service to resolve these difficulties to improve outcomes for detainees, but only limited progress had been made. (See section on courts.)

Section 2. Pre-custody: first point of contact

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

Assessment at first point of contact

2.1 Frontline officers had a good understanding of vulnerability. Officers recognised that a range of factors, such as age, mental health, physical disabilities and drug or alcohol dependencies made a person vulnerable. However, they also understood that a person might be vulnerable because of the circumstances in which they found themselves. All children were regarded as vulnerable because of their age. Both forces had definitions for vulnerability and additional guidance. Officers used their own experience and judgement well in determining a person's vulnerability, and took this into account when deciding whether to arrest them or find alternative solutions.

2.2 Frontline officers felt training supported them well to carry out their role. Vulnerability was included in all training courses, and a number of officers had received training on domestic abuse. A range of topics were also covered through e-learning. There were some gaps in officers' knowledge, for example, the forces had autism champions, but the officers we spoke to had little awareness of autism and had not had received any specific training.

2.3 Frontline officers told us that the information from call handlers in the call centres designed to help officers deal with incidents was variable. Officers felt the information they received depended on individual call handlers and how busy they were. While the initial information was generally satisfactory and included warning markers and any known vulnerabilities, subsequent information, gathered as the incident progressed, was not always forwarded quickly enough. Officers told us they sometimes had to contact call handlers to ask them to find out specific information. They also carried out their own intelligence checks and could obtain extensive information on their mobile devices. On balance, officers felt they had enough information to inform their decision-making at the scene of an incident, including decisions on whether arresting an individual was the most appropriate course of action.

2.4 Arrangements for diverting people away from custody were effectively implemented. Frontline officers never took individuals detained under section 136 of the Mental Health Act into custody as a place of safety, and only thought this would happen in very exceptional circumstances. Officers had positive working relationships with staff in mental health facilities into whose care detainees were transferred (see also paragraph 1.21). Officers sometimes waited with detainees at health facilities mainly because they were intoxicated or violent. However, officers reported that the handover of detainees worked well.

2.5 The main challenge was waiting for ambulances so detainees could be transported from the scene of an incident to health services. Sometimes officers obtained an inspector's authority to transport a detainee in a police vehicle, which was not in line with the forces' policies that ambulances should always be used. However, these decisions were taken in the best interests of the detainee.

2.6 Frontline officers in both forces received good support from mental health professionals in call centres. In Suffolk, a mental health professional also worked with a police officer while

they were responding to incidents to provide triage for those with mental health problems. These services were not available 24 hours a day, but the Norfolk call centre service had recently been extended to cover Fridays and Saturdays nights.

2.7 Frontline officers found the advice and assistance from the mental health professionals invaluable when dealing with incidents involving people with mental ill health on the street. They felt it meant they did not have to detain some people under the Mental Health Act as other arrangements were put in place. It also enabled them to divert people with mental ill health who had committed offences that did not necessarily require an arrest, by putting alternative solutions in place, such as interviewing them at a later stage with a mental health professional.

2.8 When help from mental health professionals in the call centre was not available, officers relied on other health and ambulance service staff, but they were not always available immediately, which meant it took longer to deal with an incident. Officers were confident about making assessments about whether a person had the mental capacity to make their own decisions in accordance with the Mental Capacity Act 2005, but where possible obtained advice from health professionals.

2.9 When individuals with mental ill health were arrested, which was sometimes necessary because of the nature of their offence, they were taken into custody where their mental health needs could be assessed and dealt with. Officers assessed each person they dealt with on a case-by-case basis to determine the most appropriate course of action.

2.10 Children were only arrested as last resort. Frontline officers sought a range of alternatives to custody. They included, for example, taking the child to another relative in the case of a domestic incident, carrying out interviews with the child and parents at the home address at the same time, arranging a voluntary interview or considering restorative justice (programmes where offenders consider the consequences of their offending for all parties and can offer an apology or reparation) or community resolutions. (See also paragraph 1.22.)

2.11 Officers recognised the importance of not criminalising children and regularly referred children to the Youth Offending Service so they could participate in interventions (see paragraph 1.23). Children were only taken to custody after all other options had been exhausted and when they were serious or repeat offenders. Information provided by the force showed that in the three years prior to 30 April 2018, the number of children entering custody had declined by 13% in Norfolk and 14% in Suffolk.

2.12 Detainees were transported to custody in police cars or vans, depending on the outcome of a risk assessment of the detainee.

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 Detainees were generally treated with respect, even when presenting challenging behaviour. We observed many positive interactions during the booking-in process, where custody sergeants, supported by arresting officers, worked skilfully with detainees, to obtain important information concerning their often complex needs and vulnerabilities. This helped improve both safety and outcomes.

3.2 Open cubicles at each custody desk were used during the booking-in process. Although conversations could be overhead, the cubicles helped reduce distractions and created more effective exchanges with detainees. Although separate private booking-in rooms were available in each suite (except in Aylsham) they were not used often.

3.3 Custody staff interacted positively with detainees and we observed staff making extra efforts to provide support, such as checking detainees' upcoming probation appointments and making calls to families. However, we also saw some working practices that undermined detainees' dignity. They included: detainees walking barefoot or only in socks around the custody suite (see paragraph 4.20); having to ask for, instead of being offered, toilet-paper; not being asked if they wanted to wash their hands and only being offered a shower in limited circumstances (see paragraph 4.21).

Meeting diverse and individual needs

3.4 Custody staff were aware of detainees' diverse needs. They were particularly aware of the mental health issues that could arise and worked closely with liaison and diversion services and health care professional teams, which helped them manage detainees' behaviour and provided them with links to external services.

3.5 All suites were wheelchair accessible and disabled toilets and showers were available in all suites. A wheelchair was available in each suite and we observed detainees with mobility issues being offered chairs during the booking-in process and in cells. Bed plinths were low, but thicker mattresses were available on request and could be doubled up. All cells had blue lines around the walls to assist those with visual impairments and hearing loops were available in all suites. However, there were no lowered call bells.

3.6 A programme was being rolled out to improve the identification of those with autism and help staff understand how to treat autistic detainees. This positive initiative had resulted in some staff being trained as 'autistic champions', and was raising awareness of autism, and its impact on detainees, across the forces.

3.7 Detainees were asked about their religious needs on arrival, there was a good stock of religious items covering a range of beliefs available in all suites and staff could be flexible in accommodating religious practices. For example, a detainee observing Ramadan was given food during the booking-in process before the day's fast started. However, in the year prior to our inspection, in 66% of cases, detainees' ethnicity was recorded as 'not stated' in custody records and we noted detainees were not always asked their ethnicity during the booking-in process.

3.8 The specific needs of women detainees were not consistently met. Women were routinely offered sanitary products but not the option of having an assigned female staff member unless they were under 18. In a custody record we reviewed, one woman disclosed concerns about her 13-year-old son being at home alone, but the custody record reflected that no action was taken for several hours. However, a breast-feeding mother was informed she could either have her baby brought into the unit or have access to equipment so she could express milk.

3.9 When children were detained, they were booked in at the front custody desk, rather than in the more appropriate private booking-in rooms.

3.10 Despite there being a policy on how to treat transgender detainees, the understanding of staff and approach was inconsistent and depended on the attitude of the particular custody sergeant on duty.

3.11 A telephone interpreting service to assist detainees who did not speak English was available, however we were not confident it was always used. Dual handsets were not available and staff had to use speaker phones, which compromised privacy. A face-to-face interpreting service was available, but there were sometimes delays before an interpreter arrived, which made it difficult to progress investigations (see paragraph 3.28).

3.12 Detainees had access to information outlining their legal rights and entitlements in a range of languages and in Braille. Easy-read formats were also available and suites in Suffolk had recently acquired colour overlays which, when placed over print, reduced visual stress and made reading easier for some people with dyslexia or autism. However, staff told us they did not always know they were available. Leaflets providing details of organisations that could offer support on release were also provided in the most common European languages (see also paragraph 5.3).

Area for improvement

3.13 All staff should ensure that the individual and diverse needs of detainees are consistently met, particularly those of female and transgender detainees.

Risk assessments

3.14 Custody officers processed detainees promptly on arrival and, in most cases, custody officers prioritised booking in detainees who were vulnerable. At peak times, however, custody officers did not always check holding areas to identify vulnerable detainees who should have been prioritised, which would have increased risks for them.

3.15 All staff wore utility belts with anti-ligature knives, gloves, velcro restraints, a respiratory mask, cell keys and a security card. They were all capable of responding to the immediate risks detainees posed.

3.16 We saw many detainees being treated with respect and custody staff behaving patiently and considerately, carrying out their work well. Custody staff used a range of police information sources to help them develop detainee risk assessments and set care plans. Risk assessments were conducted well, but initial observation levels did not always reflect the risks.

3.17 Care plans and risk assessments were reviewed while detainees were in custody and adjustments made to meet their needs. Each custody record had an audit trail of the changes made so that custody staff could track the progress of risk assessments in preparation for pre-release risk assessments. Both processes helped safeguard detainees while they were in custody.

3.18 All custody staff demonstrated an understanding of the effects and presentations of mental ill-health, vulnerability and self-harm, and in most cases, responded effectively. However, some custody detention officers perceived aggressive behaviour to be an indicator of a mental health condition. Uncommunicative and withdrawn behaviour was not always seen as a possible sign of mental ill-health, and the forces had not sufficiently developed staff's understanding of this aspect of mental ill-health behaviour.

3.19 Clothing with cords and footwear were routinely removed from all detainees, without an individual risk assessment, which was a disproportionate response to managing risks. The use of anti-rip clothing to manage non-compliant detainees or those with a history of self-harm without an individual risk assessment was often accompanied by a low level of observation. This did not reflect the suggested risks that required clothing to be removed. We also observed a small number of detainees being forcibly placed in anti-rip clothing, without good justification before risk assessments had been completed. Records of these incidents lacked information about the decision to use force in this way (see paragraph 4.13).

3.20 Custody staff were aware of the requirements of each of the observation levels. Checks on detainees were timely and 'rousing' checks (on detainees brought into police custody while intoxicated) were completed well. However, staff checking detainees through observation panels rather than cell hatches could not be confident detainees were safe and well. We also observed staff recording multiple cell checks into each detainee's custody record after they had visited them, which was poor practice. (See area for improvement 1.19.)

3.21 Handover briefings took place regularly, were undertaken well and correctly focused on risks to detainees and action to mitigate those risks, including outlining directions for medical care. In most cases, all custody staff starting a shift attended handover briefings, which custody sergeants delivered in each custody suite. However, health care professionals and liaison and diversion staff were rarely at handover briefings, which meant the opportunity to enhance the care and attention detainees received by sharing information with all staff was missed.

Area for improvement

3.22 Anti-rip clothing should only be used in exceptional circumstances and following an individual risk assessment.

Individual legal rights

3.23 Arresting officers explained well the circumstances of and need for the detainee's arrest to custody sergeants in the presence of the detainee. Custody sergeants clearly explained the reasons for authorising their detention so that detainees understood them and recorded them clearly on the custody record. Sergeants told us they rarely refused detention once a

person had been brought to the custody suites, primarily because of discussions they had with officers before the detainee arrived. However, they were confident about refusing detention if the circumstances did not justify it.

3.24 Alternatives to custody were available through restorative justice (programmes where offenders consider the consequences of their offending for all parties and can offer an apology or reparation), fixed penalty notices, and community resolutions. Voluntary attendance was also increasingly being used. Data from the forces showed that in the year to 30 April 2018 in Norfolk, 1,218 voluntary attendees were interviewed, compared with 612 in the previous year, an increase of 50%; while in Suffolk, 667, compared with 297 were interviewed, an increase of 44%.

3.25 Custody sergeants carried out a short risk assessment for voluntary attendees to ensure their safety and well-being while in the custody suite and carried out and recorded several other processes in line with current policy. However, the approach failed to meet the objective of diverting individuals from custody, as many continued to be brought into custody suites. There were inconsistencies between the forces' approaches towards voluntary attendees and a review was being carried out to address this.

3.26 Our custody record analysis showed an average waiting time of 12 minutes before being booked in, which was significantly lower than elsewhere. This meant investigations could start promptly, potentially reducing the time detainees spent in custody. However, we observed some cases where detainees waited too long, often in handcuffs (see paragraph 4.14).

3.27 We observed some custody sergeants liaising with investigating officers to ensure cases were prioritised, particularly those involving children. There was an emphasis on finalising investigations during the detainee's first period of detention, so that they did not have to be released or bailed pending an investigation.

3.28 However, not all investigations were progressed promptly. Delays were often due to the lack of available interpreters or appropriate adults (AAs). There were also delays while waiting for evidential review officers or the Crown Prosecution Service to decide whether to charge or release a detainee. Our analysis of custody records showed that, on average, detainees were kept in custody for 15 hours.

3.29 Data provided by the forces showed that 60 immigration detainees had been held in Norfolk in the year to 30 April 2018, compared with 61 in the previous year and 89 compared to 106 in Suffolk over the same periods, which was a marginal reduction.

3.30 Custody staff said they had a good relationship with Home Office immigration enforcement officers and told us most immigration detainees were moved to immigration removal centres (IRC) within 12 to 18 hours of being served with authority to detain notification. We saw two immigration detainees held overnight at Bury St Edmunds custody suite after they had entered the country illegally. They were transferred to an IRC within 13 hours of the authority to detain notices being served.

3.31 Data provided by the forces showed shorter detention times. For the year ending April 2018, the average length of detention for immigration detainees once the notice had been served before they were transferred to an IRC, was eight hours and 10 minutes in Norfolk and three hours and 10 minutes in Suffolk.

3.32 During the booking-in procedure, custody sergeants gave detainees a full explanation of their three main rights (to have someone informed of their arrest, to consult a solicitor and have access to free independent legal advice, and to consult the PACE codes of practice). We saw one detainee being booked-in who could not recall his mother's phone number. The custody

sergeant instructed the arresting officers to visit his mother's home promptly and inform her of her son being in custody, which ensured his right to have someone informed was complied with.

3.33 All detainees we observed during the booking-in process were offered free legal representation and were told that if they declined they could change their mind at any time. All the custody suites had sufficient interview or consultation rooms so detainees could consult their legal representatives in private. Those wishing to speak to their legal representatives on the phone could do so in private in their cells. When legal representatives arrived, they immediately received a printout of their client's custody record front sheet.

3.34 We saw detainees being told while they were booked in that they could read the PACE codes of practice, and custody sergeants routinely explained them and offered detainees the opportunity to read them. There were sufficient up-to-date copies of the information at all the custody suites to facilitate this.

3.35 A written leaflet setting out detainees' rights and entitlements was routinely offered to all detainees, and some accepted it. It was also available in other languages and had been pre-printed in languages that were most frequently used. At most of the suites the leaflet was also available in easy-read formats and Braille.

3.36 Some custody sergeants were aware that other translated documents, such as those on detention authorisation or charges, were also available and could be downloaded from a website in a pre-printed format.

3.37 Large posters, advertising detainees' right to free legal advice, were prominently displayed in all the suites. Most of the suites had multilingual posters in the booking-in cubicles informing detainees of their right to free legal advice.

3.38 Processes regarding the storage and transportation of DNA samples were good. In some suites, they were collected every day and in others every other day to be taken to the laboratories.

Areas for improvement

3.39 The forces should make suitable alternative arrangements for voluntary attendees so they do not have to be brought into custody.

3.40 Delays in progressing investigations while waiting for interpreters and/or AAs should be minimised.

PACE reviews

3.41 The overall approach to PACE reviews required improvement. PACE reviews were carried out by dedicated custody inspectors and frontline operational inspectors. Custody staff told us that due to the combined geographical size of both forces and operational reactive inspectors' other responsibilities, reviews could not always be carried out in person in line with good practice.

3.42 In our analysis of PACE review custody records, only 36 of the 101 initial reviews took place face to face, while only 32 of the 58 second reviews were conducted in person. In addition, a significant number of these reviews were carried out too soon after detention was authorised and it was often unclear why, as no rationale or explanation had been recorded.

Our analysis showed that 50 out of 101 of first reviews were conducted early with an average time of four hours and 30 minutes after detention had been authorised. Similarly, where a second review was required (due nine hours after detention has been authorised), 25 out of 58 took place early – an average time of seven hours and 31 minutes following detention authorisation. We found some cases where reviews took place only two hours after detention authorisation.

3.43 Where reviews were conducted by phone, not enough detail was recorded about why inspectors had not been able to attend the suite for a face-to-face review, contrary to PACE code C section 15.14 (see recommendation S29). In six telephone reviews we observed, reviewing inspectors recorded inaccurate information about why the detainee had not been seen in person, stating also that the custody sergeants had been informed of the review when this was not the case. We referred these cases back to the forces so they could address our concerns. Reviews for children were not always carried out in person contrary to section 15.3C of PACE code C (see recommendation S29).

3.44 Our analysis of custody records showed that nearly a third of initial reviews took place while the detainee was asleep. Little evidence was recorded on the detention log to demonstrate that once detainees were awake, they were reminded that a review had taken place or about their ongoing rights and entitlements. Custody staff informed us that although an 'inform of review' task was set on the computerised custody record prompting custody staff to inform the detainee of the review, it was not always carried out promptly enough and the details were not always recorded. This was contrary to PACE code C section 15.7 (see recommendation S29).

3.45 Most reviews were perfunctory and although they met the legal requirements, they did not always cover all aspects of detention, such as the detainee's care and welfare needs. Although we did observe some that were well conducted, took place promptly and covered these needs, overall the approach was inconsistent.

3.46 Several reviews were carried out by acting inspectors. There were no details on custody records indicating they were appropriately qualified to do so as required by section 107 of PACE, which stipulates there should be authorisation if a staff member carries out the duties of a higher rank (see recommendation S29).

Area for improvement

3.47 The force should strengthen its approach to PACE reviews by ensuring:

- **all PACE reviews include the detainee's care and welfare needs, which are fully and accurately recorded**
- **that acting inspectors are authorised to carry out duties of a higher rank when conducting detention reviews in accordance with section 107 of PACE.**

Access to swift justice

3.48 Bail was managed effectively and supported by a detailed policy that provided staff with guidance. When detainees were released without charge, bail was used appropriately in accordance with the applicable bail periods (ABPs) as set out in legislation. ABPs were strictly adhered to and were proportionate to the complexity of investigations. Appropriate investigative plans were in place.

3.49 A joint bail management team actively monitored the ABPs and sent timely reminders to investigating officers to ensure enquiries were pursued. The bail management application enabled officers and supervisors to record, monitor and update information about detainees on bail. Processes for managing suspects on bail were good at both forces.

3.50 Arrangements for detainees 'released under investigation' (RUI) were not as good. In many cases, the forces were unsure about the progress or status of the investigation. Although data were collected on the total number of RUI suspects, they were not analysed to determine how long they had been released for, which could have helped ensure investigations were dealt with as quickly as possible. Investigative plans and supervisory reviews were in place, but suspects were not routinely updated about the status of the investigation. Staff informed us that it was not part of their case management role to update RUI suspects unless suspects contacted them.

3.51 We saw custody sergeants provide RUI detainees with notices about their status. They explained what RUI meant and the consequences they might face if they attempted to interfere with the course of justice.

3.52 The forces dip-sampled several cases each month where there might have been potential safeguarding issues. The process was used to check that RUI was used correctly rather than bail, and that the detainee did not pose a risk to others.

3.53 Data provided by the forces between 3 April 2017 and 30 April 2018 showed there had been a total of 8879 detainees. Of these, 5689 had had their investigations completed during their first period of detention. This meant that 64% of detainees knew the outcome of their case and did not need to be bailed or subject to release under investigation, which helped ensure detainees had access to swift justice.

Area for improvement

3.54 The forces should ensure that responsible individual officers update RUI suspects and that there is effective supervision to ensure investigations are conducted as quickly as possible.

Complaints

3.55 Colour posters were prominently displayed in reception areas of each custody suite, and in five of the six suites, there were Independent Police Complaints Commission (IPCC) booklets in standard and easy-read formats for detainees to read. While the content was largely still relevant, custody staff had not replaced the booklets with up-to-date literature bearing the IPCC's new name Independent Office for Police Conduct (IOPC).

3.56 Custody staff's knowledge of the forces' complaints procedures was mixed. Custody detention officers knew that they should inform custody officers if a detainee wanted to make a complaint. However, some custody sergeants said they would advise detainees wanting to make a complaint to do so after they had left custody and would urge them to complain about their arrest to a police district inspector, rather than take the complaint while they were in custody.

3.57 We followed one complicated case and saw an inspector comply with the complaints procedure and respond proportionately and promptly to a complaint made by a detainee while they were in custody. Many custody sergeants correctly told us that they would take a

complaint in the absence of an inspector and pass the report to an inspector for prompt investigation.

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 in the Norfolk and Suffolk custody suites were very good. The suites were about seven years old but were well maintained and there was a notable lack of potential ligature points and graffiti in the cells across the estate. The cleaners cleaned and tidied cells and communal areas every day, including at the weekend. Custody detention officers were also expected to clear and wipe down cells when necessary. When biological hazards had been present in a cell, cleaners used specialist equipment, which they had been trained to operate, to remove the material promptly and carried out a 'deep clean'.

4.2 Cells were clean, had natural light and a suitable temperature and were in good condition. All had an in-cell toilet, a hand basin (except in some dry cells), CCTV camera and an intercom system where phone calls could be transferred directly to detainees.

4.3 The suites' maintenance was managed well. Custody detention officers at Bury St Edmunds carried out daily checks of all cells and the communal areas. They had a daily checklist, but some tasks on the list had not been completed. Elsewhere daily checks had been devolved to cleaning staff. Sergeants carried out an additional check of the suite's facilities as part of their shift handover. Any damage or faults were recorded locally and reported to the facilities manager at each location or to a central call desk. Most faults received a prompt response unless specialist equipment from external sources needed to be ordered.

4.4 Facilities managers checked the emergency cell call bell system and affray alarms every week, and all the bells we pressed were in working order. Custody sergeants and custody detention officers explained to detainees what the call bell was for and how to activate it from inside their cell. Staff answered call bells promptly.

4.5 Custody staff knew how and where to evacuate detainees to in an emergency, but some told us they had not been involved in a fire drill in the previous year, despite them being held on a quarterly basis, which records onsite confirmed. Well-equipped emergency evacuation boxes were easily accessible in all suites. They contained equipment and instructions on how to evacuate the suites in the case of an emergency. The custody suites had sufficient sets of handcuffs so that cells could be evacuated safely if required.

4.6 Emergency medical equipment had improved, was to hand and checked every day. The chief pharmacist had indicated in 2017 that some items, such as the concentration of adrenalin, were inconsistent with the health care provider's policy and the inconsistency remained. Some healthcare professionals felt the kit should have been more extensive because of the clinical risks associated with custody users who experienced alcohol-related seizures.

Area for improvement

4.7 Drugs for use in medical emergencies should align with the health care provider's policy, and the range of kit should be reviewed to ensure it is suitable.

Safety: use of force

4.8 Data on the use of force were collated and disaggregated for custody, however the governance and oversight of the use of force were inadequate. We found that data on the use of force were inaccurate, incidents were not properly recorded on custody records and did not always provide meaningful information about the need to use force. Most custody staff had had up-to-date personal safety training.

4.9 Custody staff generally dealt patiently and sensitively with some challenging detainees. Most of the custody sergeants routinely carried personal safety equipment, including PAVA (an incapacitant spray) and batons, which we do not routinely see in controlled custody environments.

4.10 In addition to handcuffs and PAVA, restraint equipment was available to custody sergeants in the form of emergency restraint belts (in Norfolk only), limb restraints and spit guards. We found a lack of clarity among staff about how long they should be applied or on whom, for example, they did not know if they should be used on children or pregnant women.

4.11 Through our case audits, custody record analysis and conversations with staff, we identified 14 cases where force had been used since 1 April 2018. We reviewed them in depth and cross-referenced them against CCTV footage. Individual use of force forms where used, however they were not always submitted or completed by all the officers directly involved in the incidents. None of the custody staff involved in these cases had submitted individual forms to justify the use of force. We had concerns in 12 of these cases and referred over half back to the constabularies so lessons could be learned.

4.12 Our analysis indicated that many staff were patient, calm and reassuring when dealing with challenging detainees, and that force was generally only deployed as a last resort following efforts to de-escalate situations. However, we were concerned about the incidents we reviewed that were depicted in CCTV footage. Some techniques were poorly deployed and detainees were restrained in the prone position (lying face-down) for too long and spit guards were used but not always recorded on the custody record or on use of force forms.

4.13 In six of the cases we reviewed, force was used to remove the detainees' clothing so it could be replaced with anti-rip clothing. There was often insufficient justification for the removal of the clothing or any entries confirming that force had been used to remove or cut off the clothing. We were concerned that the almost routine use of anti-rip clothing without an individual detainee risk assessment being carried out, meant force was used when it could have been avoided if the detainee's clothing had not been removed (see paragraph 3.19).

4.14 Many detainees we observed arrived in custody wearing handcuffs, mostly for compliant transportation. In some cases, they were removed promptly while the detainee was in the holding room, but they sometimes continued to be used on compliant detainees for too long while they were waiting to be booked in, which could on occasion take between 20 to 30 minutes. This was disproportionate particularly in the controlled custody environment (see also paragraph 3.26).

4.15 We referred one case back to Norfolk Constabulary for review when we found that a detainee at King's Lynn, who was suspected of concealing drugs internally, had been held in

their cell for several days while restrained in handcuffs. This was disproportionate as the detainee remained under the constant supervision of an officer throughout this time. It was not clearly recorded on the custody record that restraints where being used or why they were necessary, which did not comply with section 8.11 of the Police and Criminal Evidence Act 1984 (PACE) code C. (See recommendations S29 and S30.)

4.16 Data showed that 1,037 detainees in Norfolk and 1,490 detainees in Suffolk had been strip-searched in the previous 12 months to 30 April 2018[7], which was high. We discovered that these figures were not accurate and included the removal of clothing for reasons of safety consistent with a section 54 search[8], but inconsistent with a strip-search under PACE code C. Strip-searching and removing clothing for other reasons were not always justified or recorded well enough (see paragraph 3.19). When they did take place, strip-searches were conducted in private in dedicated rooms, but clothing was routinely removed in cells when CCTV was in the view of other staff in the custody suite, although staff often ensured detainees' dignity was maintained during the process.

Detainee care

4.17 Detainees received an adequate range of microwave food and drink at regular intervals during their detention, although this was not always recorded in the custody record. However, for detainees held over several days, the food was likely to have been nutritionally inadequate. Custody detention officers told us that in such circumstances, take-way food might be brought in for the detainee. However, we observed this practice to be inconsistent.

4.18 Detainees who were particularly struggling with being placed in closed cells were sometimes located in cells with glass doors or allowed to use the exercise yards with fresh air and natural light, which helped calm them down.

4.19 Detainees were mainly permitted to retain their own clothing, although cords were removed routinely without an individual risk assessment (see paragraph 3.19). Where detainees' own clothing was removed, alternative clothing provided was in reasonable condition, although there was a shortage of the largest sizes, which meant some detainees had to wear clothes that were too small.

4.20 Footwear was routinely removed with replacement plimsolls offered only in limited circumstances. Detainees were seen walking in their socks or in bare feet, which was a health and safety risk and affected their well-being and dignity (see paragraph 3.3).

4.21 Detainees were frequently required to ask for toilet paper, which was contrary to the College of Policing's *Authorised Professional Practice*. They were also not routinely offered other aspects of detainee care as we would expect, including access to hand-washing facilities, showers (unless going to court), exercise, or reading material, even though there was a good range in several languages. Although staff told us detainees could have access to these amenities, if they asked for them, they did not always know to ask.

4.22 Most shower doors provided only partial privacy and were unsuitable for women. Although each suite had one shower that provided complete privacy, it was not always made available.

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7 Annex A PACE code C states a strip-search may take place only if it is considered necessary to remove an article which a detainee would not be allowed to keep and the officer reasonably considers the detainee might have concealed such an article. Strip-searches should not be routinely carried out if there is no reason to consider that articles are concealed.

8 Section 54 of PACE states that clothes and personal effects may only be seized if the custody officer believes that the person from whom they are seized may use them to cause physical injury to himself or any other person.

Area for improvement

4.23 The forces should offer detainees replacement shoes when their own footwear is removed and access to showers, hand-washing facilities, exercise and a selection of reading materials. Toilet paper should be in their cells except where there are risk assessment indicators.

Safeguarding

4.24 All the officers we spoke with had a good understanding of safeguarding for vulnerable adults and children. They believed everyone had a responsibility to identify safeguarding concerns and refer them to multi-agency teams so that appropriate action could be taken. Although no specific training on safeguarding other than e-learning packages had been offered, they had been included as part of other training to support officers in their roles.

4.25 The responsibility for making safeguarding referrals rested mainly with arresting or investigating officers. Custody sergeants were also aware of issues that might arise or be disclosed by a detainee in custody and made referrals, where necessary. Details were not normally recorded on the detainee's custody record, but information detailing previous concerns about an individual was held on custody computer systems.

4.26 Children and vulnerable adults did not consistently receive early support from appropriate adults (AAs) following their arrival in custody. In some cases, AAs were requested quickly and arrived promptly. Arresting officers sometimes set up the arrangements at the time of arrest or while on their way to custody. However, our observations and some of the cases we examined revealed that children and vulnerable adults waited too long before obtaining advice and support from an AA.

4.27 Custody sergeants contacted family members or friends in the first instance to act as AAs. Where this was not possible, both forces had effective AA schemes in place and custody sergeants said AAs arrived promptly after the request was made. However, the schemes did not have the same working arrangements across the suites. Suffolk custody suites had access to AAs round the clock, seven days a week, but there was no overnight provision at two of the Norfolk suites. This meant that in these suites detainees could remain in custody longer while they waited for an AA.

4.28 The arrival of AAs was often delayed because requests were not made early enough once a detainee had arrived in custody. Practices varied – some custody sergeants told us that an AA would only be requested once the detainee interview had been arranged. Detainees' rights and entitlements would then be read to the detainee again with the AA present, but this could often be many hours into detention. This failed to comply with PACE code C section 3.15, which sets out that AAs should be asked to attend the custody suite to support the detainee as soon as practicable (see recommendation S29).

4.29 Our analysis of custody records showed that the time detainees waited for an AA to arrive varied widely – ranging from 21 minutes to just over 18 hours. Detention log entries did not always show when AAs were first called, any subsequent calls or when they arrived. This made it difficult to understand the reasons for the delays and meant that the forces could not accurately assess how well they were ensuring that detainees had appropriate and timely support.

4.30 We also found a case where a child had been finger-printed and photographed without an AA present. Custody sergeants in one suite told us that this happened if an AA was not available or did not arrive in time. It was not always clear on the custody record whether an

AA had been present during various custody processes. This was contrary to PACE code D 2.12. (See recommendation S29.)

4.31 Custody sergeants were confident about determining whether an adult detainee was vulnerable and required an AA. Health care practitioners and liaison and diversion workers helped them make these decisions by providing them with advice, often carrying out their own assessments. Custody sergeants erred on the side of caution and obtained an AA if there were any doubts.

4.32 The custody suites held an information leaflet describing AAs' responsibilities, but it was not routinely handed out to those who might have been unfamiliar with the role. Custody sergeants we spoke with told us they would explain the role verbally rather than hand out the leaflet, missing the opportunity to offer a source of additional information.

4.33 Custody staff's approach to dealing with children was positive – they interacted with them well, explaining what would happen, providing them with an easy-read rights and entitlements document, and offering reassurance. There were no designated cells for children, but custody sergeants recognised the importance of keeping them separate from adult detainees, where possible. Custody sergeants told us that children could wait in a consultation room with their AA instead of being put in a cell, and we observed this happening in one case. Children received good care as well as drinks and food, but details were not always recorded on the custody record and they were not generally offered games or reading material that were appropriate for their age to keep them occupied. Staff made sure children were returned home safely and into the care of a responsible adult.

4.34 The policy framework set out how children should be treated in custody, for example, they had to be prioritised during the booking-in process and the liaison and diversion officer needed to see all children. However, these steps were not always taken. Not all custody sergeants were aware that children were a priority during the booking-in process, and when it was busy in one suite we observed that they were treated the same as adult detainees and there was little use of private booking-in areas. The liaison and diversion team did not have the capacity to see all children and the service was not available overnight.

4.35 Custody sergeants were aware that all girls should be assigned a named female officer to ensure their care and welfare needs were met, but it was not always recorded on the custody record, which meant the force could not demonstrate in every case that it met the requirements under the Children and Young Person's Act 1933. Although some female custody detention officers we spoke with understood their role as the assigned female officer, staff did not always pay enough attention to meeting girls' specific needs (see paragraphs 3.8 and 3.9).

4.36 Custody sergeants focused on minimising detention times for children and where possible avoiding overnight detention. They refused detention unless it could be robustly justified and sought to progress cases promptly, especially if it meant the child did not have to remain in custody overnight. However, not all cases were dealt with swiftly and some children stayed in custody a long time pending an investigation, some overnight. Inspectors' PACE reviews of detention did not always demonstrate that children's needs were addressed, or that there had been sufficient focus on having the case dealt with as quickly as possible.

4.37 Monitoring of outcomes for children was good. At a strategic level, there were partnership meetings, chaired by an assistant chief constable. The forces and partners were working to the principles of the concordat on children in custody (see paragraph 1.22) and monitored performance information to identify any trends and where improvements were needed. For example, forces and care homes had worked together to try and reduce the number of 'looked after' children entering custody.

4.38 The forces also monitored performance information on children by suite which included: arrival time at the suite and the time their detention was authorised; time spent in custody; and the number of children moved to alternative accommodation after being charged and refused bail. Every month, custody inspectors reviewed five cases of children entering custody to assess how well they had been dealt with. However, children held overnight pending an investigation were not monitored, which meant the forces were unable to show whether they were succeeding in preventing overnight detention in these circumstances.

4.39 The lead inspector for children in custody met the managers of the Youth Offending Service regularly to discuss children who had been charged and refused bail. In these cases, the local authority had a statutory duty to move them to appropriate alternative accommodation. This joint working had led to some improvements, for example securing an additional foster carer to provide accommodation for these children.

4.40 However, there was very limited alternative accommodation available and no secure accommodation within a reasonable distance, and very few children were moved, as required under the statutory duty. Information provided by the force showed that in the year up to 30 April 2018, across both forces 114 children were charged and refused bail. Requests for alternative accommodation were made in all cases, which included 21 for secure accommodation, but only seven children were moved, and none went to secure accommodation.

Area for improvement

4.41 The forces should continue to work with partner agencies to ensure that children charged and refused bail are moved to alternative accommodation.

Governance of health care

4.42 The police continued to commission G4S Medical Services (G4S) to provide primary health care. Some aspects of the service had improved since our last inspection but others required improvement.

4.43 Joint working between the police and G4S was effective and there was a clear contract, regular minuted meetings and timely information on which to base decisions. G4S achieved over 90% compliance with the goal of attending within one hour, against a target of 90%. But at Aylsham, performance was under target at about 36%, which meant detainees there did not have equitable access to health care.

4.44 Clinical governance systems were deficient in several respects. We saw no evidence to show that lessons learned from adverse incidents were regularly disseminated. Health care professionals (HCPs) complained that their reports on adverse incidents or potential risks did not receive a prompt response. There was no regular, documented clinical supervision. HCPs were frustrated that some clinical supplies no longer arrived promptly, which meant stock soon exceeded its expiry date, as was the case, for example, with the glucometer calibration fluid at Aylsham.

4.45 There were competent doctors, nurses and paramedics, but they had no access to online electronic courses or clinical updates. Detainees we spoke with were satisfied with the service, but the company had no user satisfaction data on which to base to service developments. We were left with the impression that front line staff felt unsupported and lacked leadership, although the clinical lead staff member planned to address the issues from June 2018.

4.46 HCPs were embedded in all the custody suites, except Aylsham where the HCP from Wymondham responded to phone requests from the police. While a doctor was available to the forces 24 hours a day, they sometimes could not visit the suites within target times because of the distances involved and competing clinical demands.

4.47 There were relevant policies but none, other than resuscitation, had been tailored to the police custody environment. All the British National Formulary reference books were out of date and there was no access to the electronic version so up-to-date prescribing guidance was not to hand. All the clinical staff we spoke with demonstrated that they understood safeguarding issues and procedures. There had been no complaints about the service in the six months to March 2018.

4.48 The medical rooms were generally of a high standard and, with the exception of Aylsham, they had separate forensic sampling rooms. Infection prevention and control standards were consistently audited and met. However, at Aylsham, we found two used blood-stained syringes and needles (clearly marked as a bio-hazards) in a cupboard – they did not fit into a sharps container, and the sharps containers were not dated. Medical rooms were clean and free of dust. All of them contained necessary clinical equipment and stock, although we found some expired items in some suites, which were removed during the inspection. HCPs wiped down surfaces before forensic testing to minimise cross-contamination.

Areas for improvement

4.49 All detainees should receive equitable access to primary care services in custody suites.

4.50 Governance arrangements should be improved, including in areas of policy for police custody, leadership, responsiveness, clinical supervision, clinical supply chain reliability, access to online resources and service user consultation. Systems for clinical waste disposal should be suitable and labels completed.

Patient care

4.51 In our custody record analysis, 42% of detainees required help from an HCP and 98% were seen face to face. Custody staff referred detainees to HCPs based on their identified needs, risks or at the detainee's request. Most detainees who required an HCP were seen promptly, usually within minutes in most suites and in one to two hours at Aylsham. In our custody record analysis, detainees requiring an HCP or doctor waited an average of one hour 21 minutes, within a range of 0 minutes to nine hours and 57 minutes.

4.52 We observed excellent partnership working between all the custody suite care agencies and custody staff, although full communication had yet to be established between Change, Grow, Live (CGL), which provided substance misuse services, and some partners, because CGL's contract had just started. We saw HCPs provide good, evidence-based, compassionate care, and custody staff carefully follow guidance left by HCPs on the police records management system.

4.53 Detainees could see an HCP of a gender of their choice, although they had to wait longer before they arrived, and a professional interpreting service was available for those with limited English.

4.54 All HCPs completed paper clinical records, including documentation outlining detainees' written consent to receiving care. The clinical records we examined were very good. Clinical

staff summarised their consultations on custody records, which supported continuity of care, without breaching medical confidentiality. The clinical lead staff member sampled clinical records regularly to assure the quality and consistency of practice.

4.55 Medicines management had improved and was good. Only health staff had access to drug cupboard keys, which were securely stored, although at Aylsham everyone had access to the medicine cupboard key safe code, which was written down. This lapse was immediately fixed when we pointed it out. Standardised stock medicines were stored tidily in all suites, regularly reconciled and date checked. However, stocks of some medicines at Kings Lynn were excessive. Discarded medicines were recorded to reduce the likelihood of discrepancies.

4.56 Police retrieved medication from detainees' homes where necessary, and HCPs assessed the detainee and the medicine appropriately before it was administered. There were reliable systems for obtaining critical medicines if the detainee did not have their own supply. Most HCPs prescribed and administered medicines using an appropriate range of patient group directions (which authorise appropriate health care professionals to supply and administer prescription-only medicine), including those for symptomatic relief for drug and alcohol withdrawal. They also assisted detainees with prescribed opiate substitutes, following necessary checks. Nicotine replacement therapy was available. Detainees' medications were stored securely in individual dedicated lockers. We were told that medicines for administration while detainees were in court did not accompany them, which particularly meant those treated for alcohol withdrawal were at risk of medical complications.

4.57 Custody staff held a few medicines that could be administered once a doctor had authorised their use, although a signed prescription was not supplied for prescription-only-medicines administered in this way. These medicines were appropriately stored and stock checks and monitoring arrangements were suitable.

Areas for improvement

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

4.59 Custody officers should not administer prescription-only medication without a signed medical prescription.

Substance misuse

4.60 Drug arrest referral workers (ARWs) were no longer contracted to be present in the custody suites and detainees' access to substance misuse services was by referral only, which meant the provision was more limited than at the last inspection. In Suffolk, there was a 'test-on-arrest' scheme. The provider had written to the chief constable in Norfolk, suggesting the scheme be available there too.

4.61 In Norfolk, ARWs offered custody staff telephone support, but, in most cases, custody staff simply referred detainees to providers following a risk assessment. In Suffolk, ARWs made daily contact with the custody suites and visited when time allowed, but they were no longer contracted to do so. Mental health workers were available in the custody suites and talked with detainees with substance misuse issues, directing them to services. While this was on an informal basis, it assisted custody staff to help those in need.

4.62 Needle exchange schemes continued to be available at each suite and discussions were underway about the provision of naloxone, a drug to manage substance misuse overdose.

Area for improvement

4.63 Detainees with substance misuse issues should have access to specialist services.

Mental health

4.64 Custody staff we spoke to told us they had received training on mental health issues, which they found helpful. Control room staff and new recruits had also received instruction.

4.65 There were embedded mental health liaison and diversion practitioners in each custody suite, which detainees and custody staff appreciated. They provided an 'all age, all vulnerability' service, which included seeing women and child detainees as well as first time detainees. They could refer detainees directly to relevant services, advise them about community services and provided self-help material. Children were referred to specialist child and adolescent mental health services if required and positive joint working with the local youth offending team took place.

4.66 Many Mental Health Act assessments in custody suites were completed promptly. However, police dip-sampling and our case audits indicated that too many assessments and transfers were extensively delayed – it took over six hours for detainees to be assessed and a further 20 hours or more before they were transferred. The situation was unacceptable, as some detainees with urgent mental health needs were left in police cells without specialist help. The delays were caused by difficulties in obtaining an appropriately qualified doctor and accessing suitable mental health beds, as well as lengthy waiting times for ambulances to convey detainees to hospital.

4.67 The use of section 136 of the Mental Health Act reflected changes implemented in December 2017 as a result of the Policing and Crime Act 2017. Staff understood the changes and as a result nobody had been brought into custody under section 136[9] as an initial place of safety in the previous six months, which was appropriate.

4.68 Mental health nurses were based in both control rooms. They offered advice to front line officers who encountered people with suspected mental health issues. A street triage car, staffed by an officer and a mental health nurse, operated in Suffolk but not in Norfolk. The support and advice provided was valued by operational police officers (see paragraph 2.6).

4.69 Partnership working between the police and health and social care agencies was positive and local and monthly operational and strategic meetings looked at issues and delays in access to care.

Area for improvement

4.70 Detainees requiring Mental Health Act assessments should be seen promptly, and transfers to hospital facilities should be expeditious.

[9] Section 136 of the Mental Health Act enabled a police officer to remove someone from a public place and take them to a place of safety, such as a police station.

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 general, the forces' pre-release risk assessments were good. Detainees were present and involved in all pre-release risk assessments (PRRA), which were based on information obtained before and throughout their detention. Custody officers and, in a small number of cases, custody detention officers, releasing detainees from virtual courts (court sessions via video link), showed they were concerned with detainees' safety and well-being following their release.

5.2 Detainees with drug and alcohol dependencies were again offered the services of liaison and diversion staff (when they were available) if they had not taken up the service already. All detainees were handed a leaflet with support services' contact information and given travel warrants if they had no transport or money. Police officers often took vulnerable detainees, particularly children, home if parents, guardians or carers were not available.

5.3 Every suite had an impressive and diverse range of support leaflets that charities and other services had provided. However, custody staff's knowledge of the content of the leaflets varied and whether or not detainees could access a service depended on whether staff releasing them were aware of all services available. The services provided and the leaflets that promoted them were invaluable but needed to be widely advertised.

5.4 We saw one pre-release risk assessment for a foreign national that was conducted patiently with an interpreter over a speaker phone. This was indicative of the good standard to which we consistently saw assessments taking place. Trained custody detention officers completed person escort records (PERs) well and in detail. PERs for detainees who were being transferred were accompanied by risk assessments and details of their medication requirements.

Courts

5.5 Detainees being transferred to court were not held in detention unnecessarily. These were mainly children and vulnerable detainees and the arrangements for transporting them to court worked effectively. However, those who were waiting for their virtual court appearance were frequently held in police custody for longer than necessary. The scheduling of virtual courts was not shared with custody staff in advance and custody cases were not always prioritised. We observed detainees who were ready for their court appearance by video link as early as 9.30am, but were still in police cells in the late afternoon. This meant detainees suffered from avoidable stress, potentially increasing the level of risk to them and custody staff.

5.6 We observed that detainees who had had their cases heard by video link and been remanded or received custodial sentences, were kept in police custody longer than necessary and in many cases, overnight. This jeopardised detainees' well-being and put unnecessary and

avoidable pressure on custody staff. Had these detainees attended a court in person they would have been transported to prison and received their rights and been cared for as a remanded prisoner. In addition, scheduling for transporting detainees to prison from custody suites following virtual courts was erratic. The forces recognised that this was leading to poor outcomes for detainees and were working with the courts to try and improve the position.

Area for improvement

5.7 The forces should continue to work with HMCTS to ensure that the time detainees wait for virtual court appearances is minimised, with cases prioritised appropriately. Where detainees are remanded to prison they should be transported there without undue delay.

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

Causes of concern and recommendations

6.1 **Cause of concern:** There were too many areas where the force did not comply with legislation or guidance, notably code C of the Police and Criminal Evidence Act (PACE) codes of practice. 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. (S29)

6.2 **Cause of concern:** The governance and oversight of the use force in custody was not adequate, data were unreliable and some use of force was disproportionate to the risk posed. Norfolk and Suffolk constabularies did not record all incidents involving force in the custody suites.

Recommendation: The constabularies should strengthen their governance of use of force by ensuring that all incidents involving force in custody are properly recorded and are in line with recommendations from the National Police Chiefs Council. Incidents should be cross-referenced to CCTV to demonstrate that the force used is proportionate and justified. (S30)

Areas for improvement

Leadership, accountability and partnerships

6.3 The forces should ensure that the accuracy, collation and monitoring of data on key areas of custody is sufficient to assess performance, identify trends and drive improvements. (1.18)

6.4 The forces should ensure that custody records are comprehensive and clear and that all decisions are appropriately justified and clearly recorded. Multiple cell checks should not be entered in individual detainee detention logs. (1.19)

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

6.5 All staff should ensure that the individual and diverse needs of detainees are consistently met, particularly those of female and transgender detainees. (3.13)

6.6 Anti-rip clothing should only be used in exceptional circumstances and following an individual risk assessment. (3.22)

6.7 The forces should make suitable alternative arrangements for voluntary attendees so they do not have to be brought into custody. (3.39)

6.8 Delays in progressing investigations while waiting for interpreters and/or AAs should be minimised. (3.40)

6.9 The force should strengthen its approach to PACE reviews by ensuring:

- all PACE reviews include the detainee's care and welfare needs, which are fully and accurately recorded
- that acting inspectors are authorised to carry out duties of a higher rank when conducting detention reviews in accordance with section 107 of PACE. (3.47)

6.10 The forces should ensure that responsible individual officers update RUI suspects and that there is effective supervision to ensure investigations are conducted as quickly as possible. (3.54)

In the custody cell, safeguarding and health care

6.11 Drugs for use in medical emergencies should align with the health care provider's policy, and the range of kit should be reviewed to ensure it is suitable. (4.7)

6.12 The forces should offer detainees replacement shoes when their own footwear is removed and access to showers, hand-washing facilities, exercise and a selection of reading materials. Toilet paper should be in their cells except where there are risk assessment indicators. (4.23)

6.13 The forces should continue to work with partner agencies to ensure that children charged and refused bail are moved to alternative accommodation. (4.41)

6.14 All detainees should receive equitable access to primary care services in custody suites. (4.49)

6.15 Governance arrangements should be improved, including in areas of policy for police custody, leadership, responsiveness, clinical supervision, clinical supply chain reliability, access to online resources and service user consultation. Systems for clinical waste disposal should be suitable and labels completed. (4.50)

6.16 Medications due for administration while detainees are at court should be sent with them. (4.58)

6.17 Custody officers should not administer prescription-only medication without a signed medical prescription. (4.59)

6.18 Detainees with substance misuse issues should have access to specialist services. (4.63)

6.19 Detainees requiring Mental Health Act assessments should be seen promptly, and transfers to hospital facilities should be expeditious. (4.70)

Release and transfer from custody

6.20 The forces should continue to work with HMCTS to ensure that the time detainees wait for virtual court appearances is minimised, with cases prioritised appropriately. Where detainees are remanded to prison they should be transported there without undue delay. (5.7)

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.

National issue

Appropriate adults should be available to support without undue delay juveniles aged 17 in custody, including out of hours. (2.17)	**No longer relevant**

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

Provisions for ensuring that detainees with mobility problems can sit or lie down comfortably in the cells should be improved. (4.8)	**Partially achieved**
Detainees who are intoxicated should not be routinely breathalysed. In such cases a risk assessment should be conducted and an appropriate care plan put in place. (4.18)	**Achieved**
Norfolk and Suffolk police service should collate and analyse data on strip-searching, and on use of force in accordance with the Association of Chief Police Officer's policy and National Policing Improvement Agency guidance. (4.25)	**Partially achieved**

Individual rights

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

Recommendation

Norfolk Constabulary and Suffolk Police should engage with the local authority to ensure the provision of secure and non-secure beds for juveniles who have been charged to appear in court but cannot be bailed. (5.8)	**Partially achieved**
Appropriate adults should be available out of hours for juveniles and vulnerable adults and to support juveniles aged 17. (5.9)	**Partially achieved**

Detainees should be able to make a complaint about their care and treatment, and be able to do this before they leave custody; data about complaints should be monitored. (5.21)	**Partially achieved**

Health care

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

Recommendation

Medical rooms should be compliant with contemporary standards of infection control. (6.6)	**Achieved**
Custody officers should not administer prescription-only medications without a signed medical prescription. (6.7)	**Not achieved**
The practice of secondary dispensing of medicines should cease. (6.8)	**Achieved**
G4S should review the content of the red emergency bags in light of revised cardiopulmonary guidance. (6.9)	**Achieved**
Suction units should be assembled and ready for use in case of emergency. (6.10)	**Achieved**
Methadone should be available to detainees in line with national guidelines, when clinically indicated. (6.19)	**Achieved**
Detainees needing medical attention should be seen promptly by a health services professional. (6.20)	**Achieved**
There should be equity of access to needle exchange. (6.24)	**Achieved**
Police custody suites should not be used as places of safety for section 136 assessments and police officers should not have to wait for extended periods at NHS section 136 suites for mental health assessments to begin. (6.29)	**Achieved**

Appendix II: Methodology

Police custody inspections focus on the experience of, and outcomes for, detainees from their first point of contact with the police and through their time in custody to their release. Our inspections are unannounced and we visit the force over a two-week period. Our methodology includes the following elements, which inform our assessments against the criteria set out in our *Expectations for Police Custody*.[10]

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.[11] 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.[12]

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 custody. For example, the quality of the risk assessments, whether observation levels are met, the

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

[11] 95% confidence interval with a sampling error of 7%.

[12] 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.

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 staff 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

Norma Collicott	HMICFRS inspection lead
Adrian Gough	HMICFRS inspection officer
Patricia Nixon	HMICFRS inspection officer
Vijay Singh	HMICFRS inspection officer
Kellie Reeve	HMIP team leader
Fran Russell	HMIP inspector
Fiona Shearlaw	HMIP inspector
Paul Tarbuck	HMIP health services inspector
Joe Simmonds	HMIP researcher
Patricia Taflan	HMIP researcher
Dee Angwin	CQC inspector
Matthew Tedstone	CQC inspector