Report on an unannounced inspection visit to police custody suites in

Merseyside

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

11–21 June 2018

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

Glossary of terms

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Force
Merseyside Police

Chief Constable
Andy Cooke

Police and Crime Commissioner
Jane Kennedy

Geographical area
Merseyside

Date of last police custody inspection
1–5 October 2012

Custody suites	Cell capacity
St Anne Street	33 cells
Wirral	32 cells
Copy Lane	24 cells
Wavertree Road (Business continuity suite)	20 cells

Annual custody throughput
25,125 detainees (1 June 2017–31 May 2018)

Custody staffing
1 chief inspector
6 inspectors
48 custody sergeants
92 detention officers

Health service provider
CRG Medical Services

[1] Data supplied by the force.

Executive summary

S1 This report describes the findings following an inspection of Merseyside custody facilities. The inspection was conducted jointly by HM Inspectorate of Prisons (HMIP) and HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) in June 2018, as part of their programme of inspections covering every police custody suite in England and Wales.

S2 The inspection assessed the effectiveness of custody services and outcomes for detained people throughout the different stages of detention. It examined the force's approach to custody provision in relation to safe detention and the respectful treatment of detainees, with a particular focus on vulnerable people and children.

S3 We last inspected custody facilities in Merseyside Police in 2012. This inspection found that of the 29 recommendations made during that previous inspection, nine had been achieved, 12 had been partially achieved and eight had not been achieved.

S4 To aid improvement we have made three recommendations to the force (and the Police and Crime Commissioner) addressing key causes for concern, and have highlighted an additional 32 areas for improvement. These are set out in Section 6.

Leadership, accountability and partnerships

S5 Overall this inspection of police custody facilities in Merseyside found that the provision of custody services and outcomes for detainees were mixed. The force had made some progress since our last inspection in 2012 and we found some positive elements, notably in health services and the approach to the use of force in custody. However, we identified three areas that gave us cause for concern and a number of areas requiring improvement.

S6 The governance structure provided clear accountability, but the service delivered to detainees did not reflect the force's strategic objectives. The force had concentrated on strategic issues, particularly identifying demand for custody, but the focus on safe detention was not always sufficient. Although there were sufficient staff, there was a reliance on officers working overtime to meet demand, and they were not always deployed effectively. The force had adopted *Authorised Professional Practice* (APP) on detention and custody as set by the College of Policing[2], which it had supplemented with local policies. Initial training for custody staff was good and there was a commitment to ongoing development. Despite this we found examples of practice that did not follow APP guidance.

S7 The force mostly collated comprehensive data on custody, but there were some gaps, for example in some data on detention times and the time detainees waited for appropriate adults (AAs) (independent individuals who provide support to children and vulnerable adults in custody) to attend, preventing the force from informing organisational learning and holding external partners to account.

S8 Adequate mechanisms were in place to assure the force, the Police and Crime Commissioner and the public that the use of force in custody was safe and proportionate to the risk or threat posed.

S9 The force did not always comply with some aspects of the Police and Criminal Evidence Act (PACE) 1984 on the detention, treatment and questioning of detainees, or some of its codes of practice, which had an adverse impact on outcomes for some detainees and was a cause

[2] https://www.app.college.police.uk/app-content/detention-and-custody-2/

for concern. These are detailed throughout the report in paragraphs 1.3, 1.12, 3.25, 3.26, 3.40, 3.43, 3.45, 3.47, 3.50, 3.54, 3.55, 3.57, 3.58, 3.66 and 4.29.

S10 Custody records were not always good enough. Important information was not always recorded and staff often relied too much on dropdown menus, failing to provide sufficient information to substantiate key decisions.

S11 The force focused well on its public sector equality duty and had proactively worked with community organisations and special interest groups to better meet the diverse needs of detainees with protected characteristics as defined by equality legislation. External scrutiny from independent custody visitors (ICVs) was generally effective.

S12 The force focused on diverting children and those with mental ill health away from custody. Good joint working took place with mental health services, and custody was never used as a place of safety for people detained under section 136 of the Mental Health Act. There were also some good joint working and monitoring arrangements with local authorities concerning children in custody. However, too many children who were charged and had bail refused remained in custody overnight when local authorities who should have provided alternative accommodation failed to do so.

Pre-custody: first point of contact

S13 Frontline officers had a good understanding of vulnerability and took it into account when deciding whether to arrest people. They were, however, hindered by the variable and often limited information they received from the call centre.

S14 Officers sought alternatives to avoid taking children into custody. Good support was available from the mental health triage car, which helped officers deal with people with mental ill health when responding to incidents. However, officers told us that when the service was not operating, it was difficult to get support that offered health-based solutions as an alternative to an arrest and custody.

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

S15 Custody staff were mindful of maintaining detainees' dignity and adopted a respectful and empathetic approach to those in their care. They displayed a generally good understanding of how to identify and meet detainees' individual and diverse needs. The booking-in areas lacked sufficient privacy making it difficult for detainees to disclose sensitive or confidential information. Privacy was also compromised by visible CCTV screens showing detainees in cells. Detainees with disabilities received some good care, but the facilities were not accessible to all, and the needs of women were not always met.

S16 The force's approach to managing detainees' risks was inconsistent and some practices were unsafe. Detainees waiting to be booked in were not prioritised to manage the risks they posed in the holding rooms and custody staff did not have a good understanding of the observation levels they should set to manage risks posed by intoxicated detainees who needed to be roused. Cell visits were also carried out by different detention officers, making it harder for them to notice any changes in a detainees' behaviour or mood over time, cell call bells were not always answered promptly, and not all staff carried anti-ligature knives. Clothing with cords and footwear were routinely removed without individually assessing the detainee to see if this was necessary, and anti-rip clothing was often used to manage risks when enhanced observation levels might have been more appropriate. However, custody staff showed a good understanding of vulnerability when assessing detainees' risks and

interacted well with detainees. Cell visits were generally carried out at the required frequency.

S17 Some detainees spent too long waiting to be booked in, and sometimes their overall detention time was lengthened because of delays in progressing cases or strict adherence to rest periods. While a number of aspects of detainees' individual rights did not comply with the PACE codes of practice, staff did ensure that detainees understood the reasons for their detention and most custody sergeants explained their rights and entitlements well.

S18 Detention reviews were generally not good enough and many did not comply with PACE requirements. Many reviews were conducted early or while detainees were asleep and records reflected little focus on detainees' welfare.

S19 Bail was managed well. However, little emphasis was placed on the detainee's right to complain while in custody. We were not satisfied that complaints were logged or dealt with before a detainee had left custody.

In the custody cell, safeguarding and health

S20 The custody estate was dated and lacked standard facilities, such as in-cell basins and adequate CCTV coverage. Despite the age of the custody estate, the suites had improved since our last inspection and they were now generally clean and free of graffiti. At the end of the inspection we provided the force with a comprehensive report detailing the potential ligature points we had identified. The force responded positively to the report.

S21 Staff generally dealt well with challenging detainees and de-escalated many situations without resorting to force. During our review of CCTV footage, most cases were managed well and we were confident that force was used as a last resort. However, officers did not always submit individual use of force forms to justify why they had used force against detainees. We identified some lessons that could have been learned and referred one case back to the force. Handcuffs were removed promptly from compliant detainees. Strip-searching was only undertaken when warranted and was properly authorised.

S22 Detainees we spoke to said they were treated well while in custody. Detainees generally received sufficient food and drinks. There was, however, little evidence that staff offered detainees other amenities, such as reading material and access to outside exercise and showers. The force had sufficient stocks of suitable replacement clothing, but paper clothes were routinely given out instead, and it was unclear why.

S23 Safeguarding children and vulnerable adults was a clear priority for the force and officers understood their responsibilities. Custody sergeants focused on minimising detention times for children, although they did not always achieve it. The force was proactively monitoring children detained overnight or for long periods and was using the information with partners to identify how improvements could be made.

S24 Children were generally cared for and treated well during their stay in custody, but the force could not show that it was meeting the legal requirement to assign a female officer to care for girls while in custody. Some children and vulnerable adults waited a long time before receiving support from an AA. Requests were not always made promptly and often AAs only attended at the time the interview was scheduled.

S25 The health provision was better than at our last inspection and was good overall. Clinical governance arrangements were appropriate. There were, however, sometimes significant delays before the forensic medical examiner (FME) could be seen. The clinical environment

had improved but a lack of adequate rooms sometimes meant clinical assessments were delayed. Patient care was generally good and embedded health care professionals in each suite had improved response times and were valued by custody staff. Medication management was good and opiate substitution treatment was now provided. However, the lack of nicotine replacement treatment could have exacerbated the distress of detainees who smoked.

S26 Most detainees had good access to substance misuse services. Criminal justice liaison and diversion (CJLD) services provided excellent support to detainees with vulnerabilities, particularly those with mental ill health. However, a small but significant number of detainees experiencing a mental health crisis had to wait for too long to be assessed and transferred to mental health facilities. This was mainly because of the requirement to be assessed by an FME before being referred for a mental health assessment, external partner agencies' lack of specialist staff to perform the assessment, bed shortages and ambulance delays. Nobody had been detained in police custody under section 136 of the Mental Health Act for five years.

Release and transfer from custody

S27 Other than for children, adequate attention was not always paid to releasing detainees safely, and arrangements for helping detainees get home were limited. Detainees were involved in their pre-release risk assessment, but the assessments did not always reflect risks that had been identified at the beginning or during the detainee's stay in custody, which meant that any concerns or safeguarding issues might not have been addressed. Support leaflets were limited and were not routinely handed out and custody sergeants relied on the CJLD to direct detainees to relevant support agencies.

S28 Local magistrates' court cut-off times varied and we were not satisfied that all detainees were presented at the first available court, which meant some detainees remained in police custody for longer than necessary.

Causes of concern and recommendations

S29 **Cause of concern:** The force did not comply with PACE or its codes of practice in several areas, which needed to be addressed urgently.

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

S30 **Cause of concern:** The force did not always manage detainees' risks effectively enough to ensure their safe detention. Detainees in holding rooms were not prioritised, custody staff did not always understand that observation levels needed to reflect the risks posed, and some were set inappropriately. Some staff were also unaware of the need to rouse intoxicated detainees, and cell visits were carried out by different detention officers, which limited their ability to notice any changes in a detainee's behaviour or mood over time.

Recommendation: The force should ensure that detainees' risks are managed effectively by using observation levels that reflect the risks posed. Staff should carry them out appropriately and observations should be improved by having staff dedicated to this role.

S31 **Cause of concern:** The force's approach to managing the demand for custody was not effective, which meant some detainees spent longer in custody than necessary. The force depended on officers working overtime, but available resources were not always deployed in the most effective way. The force did not effectively allocate detainees, which meant St Anne Street often became too busy when spaces were available in other nearby suites.

Recommendation: **The force should ensure that it has the capacity and resources to meet fully its custody demand and that an effective detainee allocation process is in place to spread demand across available suites, ensuring detainees do not spend any longer in custody than necessary.**

Introduction

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

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

Our assessments are made against the criteria set out in the *Expectations for Police Custody*.[3] These standards are underpinned by international human rights standards and are developed by the two inspectorates, widely consulted on across the sector and regularly reviewed to achieve best custodial practice and drive improvement.

The *Expectations* are grouped under five inspection areas:

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

The inspections also assess compliance with the Police and Criminal Evidence Act 1984 (PACE) codes of practice and the College of Policing's *Authorised Professional Practice - Detention and Custody*.[4]

The methodology for carrying out the inspections is based on: a review of a force's strategies, policies and procedures; an analysis of force data; interviews with staff; observations in suites, including discussions with detainees; and an examination of case records. We also conduct a documentary analysis of custody records based on a representative sample of the custody records across all the suites in the force area open in the week before the inspection was announced. For Merseyside Police force we analysed a sample of 146 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

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HM Chief Inspector of Prisons

[3] http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/inspection-criteria/
[4] https://www.app.college.police.uk/app-content/detention-and-custody-2/

Section 1. Leadership, accountability and partnerships

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

Leadership

1.1 Merseyside Police had a clear governance structure. An assistant chief constable was responsible for custody overall, while a chief superintendent oversaw the criminal justice department. A superintendent and chief inspector led the day-to-day operation of custody. This structure provided clear accountability for the safe delivery of custody.

1.2 The force had a good understanding of the demand for its custody services, but it did not meet it effectively. The force had three fully operational suites – St Anne Street, Copy Lane and the Wirral – but they did not have the capacity to meet additional demands at weekends, or caused by arrests made following proactive policing operations. The continuity suite at Wavertree Road was used to manage additional demands, particularly at weekends, but it relied entirely on staff working overtime, which was unsustainable.

1.3 The force also dealt with busy periods by allocating detainees more evenly across the suites. However, the system was not always effectively managed and detainees waited a long time at some suites, particularly St Anne Street, while others were less busy and sometimes better resourced. In some cases, the decision to divert detainees to other suites was not taken on arrest and some were transferred on arrival at a custody suite or even once they were already in a holding room. Neither of these arrangements complied with section 2.1A of PACE code C, and lengthened the amount of time detainees spent in custody. (See recommendation S29.)

1.4 While the number of staff at suites was generally sufficient to meet the force's minimum staffing level, they were not always deployed effectively. For example, custody inspectors were not available after 2am, which affected their ability to carry out timely reviews of detention, and detention officers were not allocated specific roles, which led to a reactive approach to their workload.

1.5 Some practices within the force were not sufficiently focused on safe detention. While there was a good strategic approach to managing detention, it did not always translate into operational practices. There were some weaknesses in the management of risks and some detainees were put on inappropriate observation levels. Staff did not understand what some risk management levels meant, particularly the requirement to rouse intoxicated detainees, and cell visits were not consistently carried out by the same custody detention officer when detainees were checked and their behaviour assessed to establish if the risks they posed had changed.

1.6 The force had adopted the College of Policing's *Authorised Professional Practice* (APP) on detention and custody, which was complemented by additional local policies. However, not all practices we observed followed APP.

1.7 Initial training for sergeants and detention officers was good. All staff were expected to complete a nationally accredited training course and shadow more experienced officers before taking up their duties. They also had to complete a competency-based workbook that had to be signed off by an inspector. Additional training was provided every eight weeks within the shift pattern.

1.8 An interactive learning technique (Hydra) enabled staff to undertake training in an environment that was similar to custody. Staff could understand the pressures of the custody environment and experience the demands of the role through simulated exercises.

Area for improvement

1.9 The force should ensure that staff understand and follow APP guidance.

Accountability

1.10 There was a comprehensive performance management framework in place, and information to support it was generally good. A sufficient range of data was available to enable the force to assess how well it was doing. However, there were some gaps in the information collected, including on the length of detention post-charge and the time it took to secure the services of appropriate adults (AAs) (independent individuals who provide support to young people and vulnerable adults in custody), which hindered the force's ability to inform organisational learning and hold external providers to account.

1.11 Sufficient mechanisms were in place to assure the force, the Police and Crime Commissioner and the public that the use of force in detention and custody was always safe and proportionate. Governance and oversight were better than in most other forces inspected. Data on incidents occurring in the custody suites were available, and all incidents involving force or restraint that we reviewed were accurately recorded on the custody record, although a number did not have use of force forms completed by individual officers involved in the incidents. Governance and oversight processes were in place, but were not enhanced by regular cross-referencing to CCTV to ensure they were sufficiently robust.

1.12 The force did not always comply with code C of the PACE code of practice on the detention treatment and questioning of persons (detailed throughout this report). Particular concerns related to reviews of detention. Some officers did not always explain the reasons or necessity for the person's arrest and failed to record the information on the custody record, which meant they did not comply with code G. (See recommendation S29.) However, we were assured that the force had accepted this and was taking steps to address the deficiencies.

1.13 Custody records required improvement. Custody staff relied too much on dropdown menu options, standardised text options were not deleted when they should have been and they did not add much of their own text to provide further details. As a result, entries were confusing and potentially inaccurate. Some key information was often not recorded at all, for example, the time AAs were called and when they arrived. Some multiple recording of cell checks on individual records also took place, which was poor practice.

1.14 The force had a good understanding of its public sector equality duty and had specific objectives relating to custody. The force demonstrated a commitment to understanding the impact of custody on vulnerable people and those with protected characteristics. It had proactively worked with local communities to address issues that might have affected

individual groups to improve services. However, the force did not always gather or monitor sufficient data around self-defined ethnicity (see paragraphs 1.10 and 3.10).

1.15 Independent custody visitors (ICVs) said they had a good relationship with the force. The ICVs documented issues raised by detainees, which were addressed at regular meetings between the force and the ICV coordinator. An independent advisory group was also involved in scrutinising aspects of custody to improve services.

Areas for improvement

1.16 The force should ensure that data on key areas of custody are collated and monitored comprehensively to enable performance to be assessed effectively, trends to be identified and improvements to be made.

1.17 Custody records should be improved and detention logs should clearly record all action taken and decisions made.

Partnerships

1.18 The force focused on protecting vulnerable people and diverting them away from custody, which all staff understood. Statutory partners, however, did not always have enough capacity or capability to ensure that this priority led to better outcomes for detainees. Although the force worked well with partners, too many children who were charged and had bail refused, were detained in custody overnight, when alternative accommodation should have been provided.

1.19 Partnership arrangements for supporting detainees with mental ill health worked well and nobody detained under section 136 of the Mental Health Act had been held in custody as a place of safety for five years (see paragraph 2.6). Joint working arrangements provided arresting officers with advice and assistance through jointly staffed triage cars (see paragraph 2.4).

1.20 Embedded custody liaison and diversion services provided support to prevent reoffending. Specific diversion services were also available through Women's Turnaround and Tomorrow's Women, although they did not cover all of Merseyside and frontline officers' knowledge of them was limited.

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. They described how factors such as mental ill health, learning difficulties, age and disability, along with a person's specific circumstances, could make someone vulnerable at a particular time. Children were regarded as vulnerable because of their age, and officers understood that custody should be avoided where possible to prevent them from entering the criminal justice system. Officers took a person's vulnerability into account when they decided whether to arrest them or take alternative action.

2.2 Frontline officers had received training on vulnerability, although some officers expressed the view that there was an overreliance on e-learning packages, which they had little time to complete and which might not have been a suitable way of learning about the topics covered. Officers were aware of a range of detailed guidance available on various subjects, but did not always have time to read it. They felt they would benefit from more training on mental health to help them deal with people on the street.

2.3 Information from the call centre to support frontline officers making decisions when attending incidents was variable. Officers told us that call centre staff did not always have the time to obtain information about the people involved in an incident, and sometimes there were not enough radio channels for them to be able to relay the information. Officers sought further information from staff in the call centre, but they did not always receive it promptly enough for it to contribute to decision-making at the scene. They could access a wide range of information on their mobile devices, but did not always have the time to do this, especially if they were the only officer attending the scene. Officers told us that information sometimes came to light later that would have influenced their initial decision.

2.4 Frontline officers told us that the support they received when dealing with incidents involving mental ill health was inconsistent. The force and its mental health service partners operated a triage service – a trained frontline response officer was accompanied by a mental health professional operating from three police vehicles, who offered advice and attended incidents. Frontline officers regarded this as a valuable service that helped them decide whether an arrest should be made or alternatives found. Officers felt the service enabled them to divert individuals with mental ill health away from custody by obtaining more appropriate solutions.

2.5 When the triage cars were not available, frontline officers said they often found it difficult to obtain advice and assistance from mental health services. The triage cars operated between 2pm and midnight. In recognition of this, the force was actively discussing with health partners ways of extending the scheme. Outside these hours, or if the triage car was too busy to attend, officers depended on advice from wider mental health services or crisis teams, but there was no clear system and some tried to contact services directly, while others asked call centre staff to make contact. They felt the advice and support they received in these circumstances was limited and were sometimes unable to obtain any advice at all. Officers told us that there were occasions when an individual arrested for a minor offence

might have not have been brought into custody if a mental health triage car had been available to help in their initial assessment.

2.6 Individuals with mental ill health detained under section 136 of the Mental Health Act 1983 for their own or others' safety were never taken to custody as a place of safety. Officers told us that when the triage car was on duty they had to wait for it to attend so they could inform their decision on whether to detain a person under these powers. This enabled decisions to be made based on medical advice, although officers reported it could mean people were detained at the incident for longer periods.

2.7 Detainees subject to section 136 were taken to health-based places of safety for a mental health assessment. They should have been transported by ambulance in line with national and force policy, but officers said there were sometimes long waits for ambulances and they often sought an inspector's authority to use their own police vehicle instead. Once at the hospital, depending on the risks posed, officers could have further long waits with detainees awaiting their assessment.

2.8 Frontline officers placed a strong emphasis on finding alternatives to custody for children. Although the nature or persistence of a child's offence sometimes meant that an arrest and custody were appropriate, it was clear that they were used as a last resort.

2.9 Alternatives, such as voluntary attendance, restorative justice and cautions, were used well with children, and practical informal solutions were put in place for minor offences. Officers felt youth offending services supported them well – they referred children directly to them for support and other interventions to stop them going into custody and being drawn into the criminal justice system. Information provided by the force showed that in the three years prior to 31 May 2018 the number of children entering custody had been reduced by 20%.

Area for improvement

2.10 The force should ensure that frontline officers consistently receive a good standard of information from the call centre to help them deal with incidents and easy access to advice and support from mental health professionals on a 24/7 basis.

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 Most custody staff we observed had a respectful, empathetic approach when interacting with detainees. They also spoke respectfully about detainees when discussing their cases with colleagues or other professionals in the custody suite. We found several examples during incidents involving force and strip-searching where staff were particularly mindful of maintaining detainees' dignity (see paragraphs 4.16 and 4.18).

3.2 Staff often provided extra support to detainees to reassure them and help them cope better while in custody. For example, we saw a challenging detainee being allowed to make additional phone calls to his family, which helped calm him and led to better interactions between him and custody staff. The detention officers we met and observed also generally tried to establish a friendly rapport with detainees and were aware of their role in looking after and protecting them. First names were also used regularly. However, there were some isolated examples where custody staff displayed less respectful behaviour and a poor attitude.

3.3 Booking-in areas across the force's custody suites were not private enough for detainees to disclose sensitive or confidential information to custody staff. The areas were small and cramped – there were multiple booking-in terminals close together and there was little screening between them or space away from other detainees and visitors passing through the custody suite. Staff said that during busy periods, noise levels made it difficult to hear or communicate clearly. Only one custody suite (St Anne Street) had a separate, private book-in desk, but custody staff used it for administrative purposes rather than processing detainees. Although signs (in English only) were displayed at all the suites' booking-in areas advising detainees that they could speak to staff privately if they wanted to, staff did not reinforce the information verbally.

3.4 Detainees' privacy was also compromised by the use of large whiteboards at all suites, which were directly in front of booking-in desks. They prominently displayed detainees' offence and the first three letters of their surname. The system remained in place despite a recommendation at our last inspection that they be removed or relocated.

3.5 Screens displaying CCTV camera footage from inside cells were also inappropriately located – they could generally be seen by detainees who were being booked-in or moving through the main custody area, which further compromised detainees' dignity and potentially safety (see also paragraph 4.4). We observed some detainees watching the screens when they were standing at the custody desk. Toilets in cells were generally obscured on monitoring screens, but detainees were not routinely told this was the case.

3.6 Detainees also had to ask for toilet paper, which was undignified and did not meet the College of Policing's *Authorised Professional Practice* (APP) guidelines. (See area for improvement 4.24.)

Area for improvement

3.7 Privacy for detainees in custody should be improved wherever possible. It should include withdrawing custody area whiteboards, relocating in-cell CCTV monitoring screens and informing detainees that cell toilets are obscured on CCTV.

Meeting diverse and individual needs

3.8 Custody staff generally demonstrated that they knew and understood how to identify and manage the individual and diverse needs of those who arriving in custody. This included providing examples of first-hand experience or appropriate explanations of how they would search transgender detainees or manage a person's religious needs within the custody environment.

3.9 Since our last inspection custody staff had received a very good range of classroom training on diversity subjects, such as autism, learning disabilities, dementia and women's sanitary needs. However, it had been delivered some time ago and the force had more recently relied on e-learning packages or staff's professional experience. Custody staff valued the professional expertise provided by the liaison and diversion teams in each custody suite to help them to better understand and manage some detainees' mental health and other needs.

3.10 During our inspection, we did not see custody staff ask detainees to disclose their ethnicity when they booked them into custody, as they should have (see paragraphs 1.10 and 1.14). There were also inconsistencies in how custody staff established detainees' individual needs during this process. Although detainees were usually asked about their dietary or religious needs, other issues, such as disabilities or care dependencies were not mandatory questions and the individual sergeant conducting the assessment decided whether the information should be captured.

3.11 Religious worship arrangements were mostly satisfactory. A good range of religious faith artefacts were stocked, except for Jewish Torah texts, and were stored respectfully alongside guidance for staff on their use and context. Dry cells in all suites also had ceiling markings showing the direction of Mecca to assist with Muslim worship, which was good.

3.12 Detainees with mobility impairments had access to wheelchairs at all suites and staff said they were used regularly. All custody suites had a mixture of high and low bed benches and supplies of extra mattresses to give detainees extra physical support, which offset the lack of extra supportive orthopaedic mattresses at the suites (which only Copy Lane stored). We saw one disabled detainee at Copy Lane who was handled well while being booked into custody – he was physically supported by staff, continually asked about his welfare, provided with a seat to make him more comfortable and subsequently placed in a suitable cell closest to the front desk where, based on his individual risk assessment, he could retain his walking aid.

3.13 Coloured band markings for visually impaired detainees were on the walls of most cells (except at Wavertree Road) and there were some enhanced markings on a small number of cell privacy screens to guide detainees. Braille versions of the detainee *Rights and Entitlements* document were available at all suites, but many staff were unaware of them or could not find

them on request. Hearing loops were also now available, an improvement since our last inspection, but many staff did not know how to use them.

3.14 However, the custody suites were not suitable for those with physical impairments because of the step-access to most toilets, showers, exercise yards and entrances to the suites themselves. Cell call bells were also too high or too far away from benches for them to be within easy reach.

3.15 The needs of women detainees were not consistently met. Staff did not always offer them access to a female member of staff to discuss gender-specific issues. Nor did they routinely offer them sanitary products, even though there was an appropriate supply at all suites. Some male custody sergeants that we spoke to said they were uncomfortable enquiring about sanitary products and left these discussions to their female detention officer colleagues, which meant they might not take place as not all custody shift teams had female staff members.

3.16 Provision for foreign national detainees was adequate. Legal rights and entitlements documents were available in a range of foreign languages and custody staff knew how to access them. Recent changes to the custody phone systems meant that interpretation services could now be accessed through dual handsets, rather than speakerphones that were used previously. Handsets could be taken into nearby private booths.

Area for improvement

3.17 Detainees should be routinely asked to define their own ethnicity.

3.18 Women detainees should always be able to speak with a female member of staff to discuss their care needs and routinely be offered sanitary products.

Risk assessments

3.19 The force's approach to managing detainees' risks to themselves and others was inconsistent. Some aspects were poor and practices potentially unsafe.

3.20 Arresting officers were not required to inform custody sergeants routinely when they were transporting a detainee to custody, which meant custody sergeants had no specific information about the detainees before their arrival. There was no system enabling custody sergeants to liaise with arresting officers so they could prioritise detainees waiting in the holding rooms who were most at risk or vulnerable, including children. All detainees queued until it was their turn. During busy periods, we observed some long delays and several detainees waited with police officers in the holding areas before they could be booked in.

3.21 Custody staff treated most detainees well during the booking-in process. Custody staff assessed detainees' risks calmly and patiently. The questions they asked were part of a standardised risk assessment and custody sergeants asked further questions if detainees highlighted any issues to obtain a full understanding, for example about specific ailments, their medication needs or addictions. Staff routinely and promptly referred to the police national computer and historical information on the custody record system to obtain details about warning markers or other information to inform the risk assessment and care plan.

3.22 Custody staff had a good general understanding of vulnerable detainees and those that might have been suffering from mental ill health. Criminal justice liaison and diversion (CJLD)

services staff working at the suites also helped identify vulnerabilities and provided custody staff with guidance on drawing up care plans.

3.23 Clothing with cords and footwear were routinely removed from all detainees before they were placed in a cell, without an individual risk assessment being undertaken to determine whether this was necessary to prevent self-harm. The approach was disproportionate. However, detainees were generally treated respectfully when their clothing was removed.

3.24 Anti-rip clothing was also used to manage detainees' risks, but staff could not always explain the rationale for its use, and detainees in anti-rip clothing were often placed on minimal observations, suggesting that their risks were not significant enough to justify the use of this type of clothing. In some cases, anti-rip clothing was used simply because the detainee did not answer the risk assessment questions. Using anti-rip clothing to manage non-compliant detainees or those with a history of self-harm without carrying out an individual risk assessment was not an effective way of minimising risks. Risks could have been better manged by increasing observation levels. In addition, the clothing used, which staff called gowns/smocks or nighties, was outdated and unsuitable and often failed to preserve detainees' dignity. The justification for using anti-rip clothing was not always adequately recorded in custody records, which did not comply with section 8.9 of PACE code C. (See recommendation S29.)

3.25 Custody staff did not have a good understanding of the observation levels used to manage detainees' identified risks. Their understanding of level 2, which requires intoxicated detainees be roused and engaged with every 30 minutes, was limited, and the observation level was not always applied when the risks posed warranted it. Custody sergeants often recorded these observations as level 2 intermittent 15-minute checks, but they did not always involve rousing the detainee, and detention officers were unsure about what was required of them. Custody staff often failed to understand the importance of rousing intoxicated detainees. We found several instances in our case audits and observations in which level 2 rousals were not set when they should have been, and were not always carried out properly. We saw staff carrying out checks through spy holes, rather than through the cell door hatch or entering the cells in line with annex H of PACE code C. (See recommendation S29.)

3.26 The observation of detainees was rotated between different detention officers on an hourly basis, making it hard for detention officers to build a rapport with detainees and identify any behaviour or mood changes that could affect their safety. It posed significant risks particularly to detainees who were intoxicated or under the influence of other substances. However, detention officers mostly adhered to required observation frequency levels, and when they did interact with detainees, they did it well.

3.27 Other than at Copy Lane and Wavertree Road, suites had CCTV covering all the individual cells. However, they were installed above the booking-in desks, which meant it was impractical to observe constantly detainees that might have posed specific risks. There were no other arrangements that would allow an officer to observe a detainee adequately as part of a level 3 CCTV constant watch, which can be an effective means of managing detainees' risk.

3.28 Most custody staff did not carry anti-ligature knives while they were in the custody suites or carrying out cell checks. Some said they had not been personally issued with them. The knives were mostly kept behind the booking-in desks and in other places where they were not readily available. Custody staff did not understand the importance of carrying them at all times while they were in the custody suites. As a result, staff's ability to respond effectively to emergency situations was hampered. They did, however, all have cell keys and could enter the cell if required.

3.29 Call bells were not always answered promptly. We observed on some occasions delays of between three and five minutes, posing a significant risk to detainees who required assistance (see paragraph 4.5).

3.30 Shift handovers were poor. They were generally carried out between the incoming and outgoing sergeants using handover sheets as a briefing document. A collective handover between all the incoming and outgoing custody staff did not always take place to ensure all the information about the detainees could be discussed fully and understood. At the start of a new shift, sergeants did not routinely visit all detainees in their care, which we would have expected to see. Although handovers were recorded on CCTV, there was no evidence of managers carrying out dip-sampling to monitor them and provide feedback.

Area for improvement

3.31 Clothing with cords and footwear should not be routinely removed from detainees without undertaking an individual risk assessment. Anti-rip clothing should only be issued following an individual risk assessment and it should be justified on the custody record.

3.32 All custody staff should carry anti-ligature knives routinely while in the custody suites.

3.33 Cell call bells should be answered promptly.

3.34 Handovers between shifts should include all custody staff to ensure that the information shared about detainees is comprehensive and well understood.

Individual legal rights

3.35 Arresting officers explained the grounds for the arrest in the presence of the detainee when they were being booked into custody. However, we observed occasions when the necessity for the arrest, for example, to allow the offence to be investigated promptly and effectively, was not fully explained in the presence of the detainee or clearly recorded on the custody record. This did not comply with section 4.3 of PACE code G or section 3.4a of PACE code C. (See recommendation S29.)

3.36 Custody sergeants took take great care to explain to detainees why their detention was being authorised and checked they understood what was being said. Custody sergeants told us they rarely refused detention once a person had been brought into the custody suites, but were confident about doing so if necessary. We observed one case in which a custody sergeant appropriately refused to authorise a person's detention after considering the circumstances of the arrest.

3.37 When detention officers booked detainees into custody, custody sergeants did not always provide sufficient oversight, and often simply looked at the custody record. Although custody sergeants authorised detention, they did not always interact with the detainee well enough to ensure they understood the reasons for their detention.

3.38 The force could use alternatives to custody in the form of restorative justice processes, fixed penalty notices, community resolutions and voluntary attendance. The force's data indicated that the number of people attending police stations on a voluntary basis had decreased by 5% (384 fewer attendees) in the 12 months up to 31 May 2018, compared with the same period the previous year.

3.39 Our analysis of custody records showed that the average waiting time between arrival and detention authorisation was 27 minutes. Our observations showed that some detainees were taken straight through to the custody suite booking-in desks, but we also saw detainees waiting up to two hours or more in holding rooms, which was too long.

3.40 The force had sought to reduce waiting times for detainees, but not always appropriately. We saw detainees arriving at St Anne Street custody suite, but because it was busy, police officers then decided to take them to another suite that was less busy. On one occasion, an inspector authorised detainees already in the holding room to be moved to another suite. These practices were contrary to section 2.1A of PACE code C (see recommendations S29 and S31). They also increased the time between arrival at the custody suite and the time detention was authorised, lengthening the overall period these detainees spent in custody.

3.41 The relevant time for the purposes of recording the time a detainee spent in custody was not always correctly recorded. Detainees arrested at St Anne Street but taken to the Wirral custody suite to be booked in as part of the force's approach to managing demand, often had their relevant time incorrectly recorded. The recorded time of arrival was the time the detainee arrived at the Wirral custody suite, when it should have been the time of arrest at St Anne Street. This practice breached section 41 of the Police and Criminal Evidence Act 1984, could have affected the integrity of investigations and lengthened the time detainees spent in custody. (See recommendation S29.)

3.42 We were told and observed that investigations were not always progressed promptly. Delays were attributed to the lack of available appropriate adults (independent individuals who provide support to young people and vulnerable adults in custody), legal representatives, interpreters and on occasion investigating officers.

3.43 Detainees were regularly placed on eight-hour rest periods. Custody sergeants and inspectors did not always recognise the impact this had on the time the detainee spent in custody. Custody officers told us they were reluctant to disrupt rest periods for any reason other than medical requirements. This approach was not always in the best interests of detainees who should have had their investigation progressed promptly and their time in custody minimised. It also failed to comply with section 12.2 of PACE code C. (See recommendation S29.)

3.44 There had been a 40% increase in the number of immigration detainees (totalling 99 cases) brought into custody in the 12 months to 31 May 2018. While the force monitored overall detention times for immigration detainees, they did not monitor the time between an immigration detention warrant being served and the time of the detainee's transfer to alternative immigration facilities.

3.45 During the booking-in process, we regularly observed custody sergeants treating detainees with dignity and respect, and explaining in full their three main rights (to have someone informed of their arrest, to consult a solicitor and access free independent legal advice, and to consult the PACE codes of practice). We also saw them checking that detainees had understood what they were told.

3.46 Custody sergeants explained detainees' right to free legal advice, but we observed that where a detainee did not wish to seek the services of a solicitor, custody sergeants did not explore the reasons for the refusal with the detainee or record on their custody record why they did not wish to exercise this right.

3.47 The pre-printed notice outlining detainees' rights and entitlements was out of date (July 2011) and did not contain all the information regarding rights and entitlements required by the PACE codes of practice. Our observations at all three custody suites showed that custody sergeants did not routinely provide detainees with a copy of the notice or time to

read it, choosing instead to point to a pre-printed notice that was either left on or fixed to the custody desk. This did not comply with section 3.2 of PACE code C (see recommendation S29). However, we did see a custody sergeant providing an easy-to-read version of the notice to a vulnerable adult and explaining the document.

3.48 At the beginning of the inspection custody staff were often unable to locate copies of PACE code C booklets immediately. We found that when they had been located, most copies of the booklet were out of date and that when up-to-date versions were available there were not enough copies of them. Up-to-date PACE code C booklets were distributed across the custody estate and the old copies removed during our inspection.

3.49 Multilingual posters informing detainees of their right to free legal advice were not displayed in any of the custody suites, which did not comply with section 6.3 of PACE code C. (See recommendation S29.)

3.50 Many custody sergeants we spoke to were not aware of PACE code C annex M, which requires non-English speaking detainees to be provided with a range of written translated documents in their own language. This was despite these documents being readily available through the force's IT system (see main recommendation S29)

3.51 During our inspection, we observed custody sergeants appropriately providing authorisation for DNA samples to be taken and informing detainees how they would be used, retained or disposed of. The system for collecting DNA and other samples was effective, but we noticed that not all sample fridges were locked and secured, which did not protect the integrity of stored samples.

Areas for improvement

3.52 Custody sergeants should ensure there is adequate oversight when detention officers are booking detainees into custody.

3.53 The force should minimise delays in progressing investigations.

PACE reviews

3.54 Overall the force's approach to PACE reviews was not good enough. Reviews did not comply with the PACE codes of practice in several areas, and they were inconsistently and insufficiently recorded on custody records.

3.55 Many PACE reviews were conducted early – on one occasion the detainee had their detention reviewed after 26 minutes in custody. Our analysis of custody records showed that nearly half of all first reviews took place early.

3.56 A significant number of reviews took place without the inspector speaking to the detainee because they were asleep. Some occurred when the detainee was on a rest period, but entries for cell visits on the custody record indicated that the detainee might have been awake, which meant the review could have been conducted face to face. Our analysis of custody records showed that 67% of first reviews were conducted while the detainee was asleep. Custody staff often failed to remind detainees at the earliest opportunity that a review of their detention had taken place, which did not comply with section 15.7 of PACE code C. (See recommendation S29.)

3.57 Children and vulnerable adults should have their reviews carried out in person. However, we found a number had been conducted by phone. Inspectors did not as a matter of routine consider the welfare, health, age or vulnerability of the detainee when deciding whether it was appropriate to carry out a face-to-face review, rather than a phone review of their detention. This did not comply with section 15.3C of PACE code C. Where phone reviews had taken place, the inspectors did not clearly explain or record on the custody record why they did not attend the station to conduct the review in person. This did not comply with section 15.14 of PACE code C. (See recommendation S29.)

3.58 We observed custody inspectors carry out several reviews both in person and by phone and detainees were treated respectfully. Although reviews met legal requirements, custody inspectors did not always explore other aspects of the detainees' detention, particularly their welfare. The recording of the reviews was often perfunctory.

3.59 The number of reviews that custody inspectors on the day shift carried out, the shift system itself and working practices associated with it, meant that a large number of reviews were conducted by phone. Many of them were conducted early and a substantial number while detainees were sleeping. On one occasion over a period of 4.5 hours, one custody inspector had carried out 30 reviews of detainees' detention. This did not allow the inspector to consider or meet the needs of vulnerable detainees, which undermined the effectiveness and purpose of the detention review (see paragraphs 3.54–3.58).

Area for improvement

3.60 The force should ensure that reviews of detention take the detainee's welfare into account and that custody record entries are sufficiently detailed.

Access to swift justice

3.61 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 applicable bail periods set out in legislation. They were strictly adhered to and proportionate to the complexity of investigations. When bail conditions were applied, they focused on safeguarding victims and preventing reoffending. A bail management team monitored individuals who were released on bail and officers were sent timely reminders to ensure enquiries were pursued and investigations progressed.

3.62 The arrangements for detainees who were released under investigation were not sufficient. In many cases, the force was unclear about the progress or the status of these cases' investigation. Suspects were not routinely updated about the progress of their cases while they remained under investigation.

3.63 We observed custody sergeants providing detainees with notices about being released under investigation. However, they did not receive a clear verbal explanation about what it meant and any consequences they might have faced if they interfered with evidence, intimidated witnesses or attempted to pervert the course of justice.

Areas for improvement

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

3.65 When handing notices to suspects who are being released under investigation custody sergeants should explain what it means and the consequences should they interfere with the course of justice.

Complaints

3.66 Little emphasis was placed on detainees' right to complain. No information on the complaints process was displayed in any of the custody suites. Most custody staff told us they would direct detainees who wished to make a complaint to the force website page, where complaints could be registered. A few staff said they would make a record that the detainee wished to make a complaint and inform the custody or duty inspector. However, we were informed that other commitments meant inspectors were not always available to deal with complaints and in most instances, they would make an appointment at a later date with the detainee to discuss the complaint. This meant detainees did not have the opportunity to have their complaints dealt with prior to leaving custody.

Area for improvement

3.67 Notices providing detainees with information on how to make a complaint should be prominently displayed in all custody suites, and there should be arrangements for them to do so while they are in custody.

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

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

Physical environment is safe

4.1 Merseyside's custody estate was dated, but had been reduced significantly since our inspection in 2012. There were now three full-time designated suites at St Anne Street, Wirral and Copy Lane and one part-time contingency suite at Wavertree Road.

4.2 Despite the age of the custody estate, cleanliness across the suites was good. Some of the problems we identified in 2012, such as considerable amounts of graffiti, had been almost eradicated. When cells had biological hazards that required a deep clean, they were removed promptly and efficiently by an external contractor. All cells had natural light and the temperature was suitable.

4.3 Work had been carried out in all suites to improve their condition. Nevertheless, the estate still lacked facilities, such as in-cell hand-washing basins, discrete booking-in desks, communal toilets and accessible showers and toilets. Two of the suites had no privacy screening at the booking-in desks.

4.4 CCTV coverage in communal areas and cells varied across the estate. It was available in only four cells in the smaller suites at Copy Lane and Wavertree Road, while every cell at St Anne Street and Wirral had CCTV. The position of CCTV monitors at the booking-in desks meant detainees and visitors to the suites could see them, which was inappropriate and did not adequately maintain detainees' dignity or privacy (see also paragraph 3.5).

4.5 The cell call bells we tested were working, but during the inspection we observed that the intercom system was sometimes poor. At two of the suites we saw staff responses to call bells were delayed when they were busy, which compromised detainee safety (see paragraph 3.29).

4.6 Despite the requirement for daily checks of the physical environment to be conducted, they were only carried out on a weekly basis. The checks were basic and we could not access all the records, which meant we could not be confident they were completed comprehensively. All damage and faults were recorded and most faults were fixed promptly.

4.7 During the inspection, we identified many potential ligature points in cells and communal areas across the estate. We provided the force with a comprehensive illustrative report at the end of the inspection. The force addressed the potential ligature points during the inspection.

4.8 Most custody staff were aware of emergency evacuation procedures. However, they told us they had not been involved in a fire drill in the previous 18 months, which contravened legal

requirements. There were enough sets of handcuffs in the custody suites for an evacuation of the cells to take place safely.

4.9 Custody staff were trained in first aid and to use the easily accessible automated external defibrillators. The embedded health care professional (HCP) provided prompt support in medical emergencies. First aids kits were not standardised across the suites and checking processes were inadequate. We found expired items at the Wirral and Wavertree Road suites.

Areas for improvement

4.10 Staff should conduct daily cell checks, which should be recorded, along with any potential ligature points that are identified. Ligature points should be dealt with promptly to eliminate any risks.

4.11 The force should ensure an annual fire drill takes place in all custody suites.

4.12 Custody staff in all suites should have easy access to standardised well-checked first aid kits.

Safety: use of force

4.13 Separate data were available to show when force was used during custody. However, of the 19 incidents we requested documentation for, we did not receive any use of force forms for nine of these cases and only a limited number of forms for the other cases. This demonstrated that not all staff involved in incidents involving force completed the electronic use of force forms, as required. However, a lot of information was recorded in custody records to justify using force. Where force was used to remove clothing, a clear rationale was recorded.

4.14 Data showed that 10% of custody sergeants and 22% of detention officers had not had up-to-date personal safety training. Some were booked on to refresher courses, but it was not acceptable that not all staff had had this training.

4.15 We saw staff dealing well with challenging detainees and de-escalating many situations, only using force as a last resort.

4.16 We reviewed in depth 14 cases where force had been used against detainees in custody and cross-referenced them against CCTV footage. CCTV recordings were kept for 90 days at the larger suites, but we could not view the footage at either Copy Lane or Wavertree Road because of difficulties in accessing the CCTV systems. Most incidents were managed well overall and detainees were treated sensitively. In two cases, lessons could have been learned. We had concerns in one further case about the proportionality of the response to the risk posed. The case was referred to the force so it could review it in light of the use of non-approved techniques. We were advised that managers did not review CCTV footage, which meant they could not be confident that the force used was proportionate to the risks posed or identify any lessons that could be learned.

4.17 Detainees did not routinely arrive in custody wearing handcuffs. Where handcuffs were applied to compliant detainees, they were generally removed promptly on arrival at the custody suites.

4.18 In the previous 12 months, 1,376 detainees (5%) had been subject to a strip-search in custody, which was relatively low. We saw few strip-searches taking place during the inspection, but they were for valid reasons and were appropriately authorised. Searches were conducted in cells, but where relevant, staff ensured that CCTV monitors were switched off to maintain privacy (see paragraph 3.1).

Areas for improvement

4.19 All staff should be trained in personal safety techniques that are appropriate for a custodial setting at least every 12 months, including the requirement to complete individual use of force forms each time force is used against a detainee.

4.20 Incidents involving force should be quality assured and cross-referenced with CCTV.

Detainee care

4.21 The detainees we spoke to said staff treated them well. Detainees were regularly provided with food and drinks, even outside designated meal times and in large quantities, as custody staff were aware of their low calorific content. However, intoxicated detainees did not receive any food, which was not formal police or force policy or in the detainees' best interests. Stocked foods were within their expiry dates and catered for a range of diets, including halal, vegan and gluten-free. Sealed alternatives could be brought in by detainees' friends or family depending on their individual circumstances.

4.22 However, other amenities were not readily available. Detainees were still not generally offered reading material or the opportunity to exercise outside. Supplies of reading material were also minimal and poor quality, little of it being suitable for children or available in commonly used foreign languages (except at Wirral). Staff said they would always try to arrange for detainees to have a shower if they were held overnight, but many said they were frequently declined one. In our case audits and custody record analysis, we found little evidence of detainees being offered or provided with a shower, exercise or reading material, including where one detainee was held for over 29 hours. Detainees held over longer periods could not have visits from friends or family, even though some suites (Copy Lane and Wavertree Road) had facilities for visitors. Detainees could, however, have their own clothes brought in, particularly when they were attending court.

4.23 Supplies of replacement clothing, bedding and toiletries were generally adequate, although disposable razors and underwear were still not routinely offered to detainees. Shoes were automatically removed from detainees, but they were routinely offered replacement footwear. Disposable 'paper' replacement trousers and tops were widely stocked, which many staff said was routinely given to detainees instead of the more appropriate tracksuit clothing. The reasons for providing them with paper clothing were unclear especially as suitable alternative clothing was available, demonstrating little progress since our last report.

Areas for improvement

4.24 Detainee care should be improved. In particular, detainees should be routinely offered toilet paper, toiletries, a shower for those held overnight, and reading material. All custody suites should provide detainees with access to outside exercise facilities and fresh air.

4.25 Detainees should be provided with suitable replacement clothing.

Safeguarding

4.26 The force prioritised safeguarding children and vulnerable adults. All the officers we spoke with had a good understanding of their safeguarding responsibilities. We were told that arresting and investigating officers routinely made referrals to multi-agency specialist teams, although they were not recorded on custody records. Custody sergeants contacted social care services directly when they had concerns about a child or vulnerable person while they were in custody, and the detention officers we spoke with were alert to safeguarding concerns that might be disclosed to them during their interactions with detainees.

4.27 Children and vulnerable adults did not consistently receive prompt support from appropriate adults (AAs) (independent individuals who provide support to young people and vulnerable adults in custody). Family members or friends were sought in the first instance. Otherwise AAs were provided through local authority social care services for children and a contracted service for vulnerable adults, which offered prompt 24-hour provision and could attend to support children if necessary. However, despite these arrangements, there were some long delays before AAs attended to support these detainees.

4.28 We found in some cases that custody sergeants attempted early on in detention to arrange an AA by contacting family members by phone or by sending arresting officers to the home address. Sometimes arresting officers arranged for an AA to attend at the time of the arrest. In other cases, there were considerable delays before an AA was requested, and often when the request was made, the AA was only asked to attend the suite when the detainee interview was scheduled. If social care staff acted as the AA, we were told they would only attend for the interview stage. This meant some children and vulnerable adults waited up to 20 hours or more before they received any support from their AA, which did not comply with section 3.15 of PACE code C, which stipulates that forces should secure an AA as soon as practicable (see main recommendation S29). Requests for an AA were inconsistently recorded on custody records and the force did not monitor how long detainees waited before receiving support. The force had recognised this issue and was seeking ways to address it.

4.29 The custody sergeants we spoke with were confident about deciding whether a vulnerable adult needed an AA, and felt the HCP based in the custody suites provided them with good support, when they made these decisions. However, we found some cases in which no AA had been requested for vulnerable adults when there was evidence to suggest it should have been considered. There were also cases in which children and vulnerable adults were fingerprinted and photographed without an AA present, and several where it was not clear from the record whether an AA was present, which did not comply with section 2.12 of PACE code D. (See main recommendation S29.)

4.30 Leaflets for AAs explaining their role were available but were not routinely handed out, although we saw custody sergeants explaining the role verbally to family members acting as AAs.

4.31 Children received some good care while in custody. Custody staff offered them reassurance and an explanation of what would happen and generally built a good rapport with children. Parents or nominated responsible adults were generally notified promptly of the child's arrival in custody. Children were offered food and drinks regularly and sometimes reading material, as well as the opportunity to use washing facilities and showers and to exercise. As part of the force's approach to understanding the views of the child, they had introduced a

survey for children and their AAs to gather their experiences of custody, and intended to use the findings to improve care.

4.32 Youth workers from the criminal justice liaison and diversion (CJLD) team screened all children entering custody and saw as many as possible to identify any concerns, provide additional re-assurance and put any follow-up support measures in place. Where practicable, children could sit with their AAs in consultation rooms or in the glass-fronted rooms in the booking-in areas rather than remaining in their cells. However, we observed that while they were in the glass-fronted rooms, they could see and hear what was happening with other detainees, which was inappropriate and potentially distressing for them. Children were released to a responsible adult to ensure they returned home safely, but this information was not consistently captured on the pre-release risk assessment or the custody detention log.

4.33 Some aspects of the force's care for children did not sufficiently focus on their welfare. Although they were usually placed in juvenile detention rooms to keep them away from adult detainees, staff did not attempt to keep them away from other detainees when they were waiting in the holding rooms and they were not prioritised during the booking-in process to ensure they were processed promptly. We saw one 14-year-old boy waiting for 62 minutes in the holding room with other detainees. Easy-read versions of rights and entitlements booklets were available in the suites but not all staff were aware of them and they were not routinely offered or handed out. Reviews of detention did not have a specific emphasis for children or assess, for example, whether they were receiving effective support from an AA.

4.34 All the custody staff we spoke with knew that girls should be assigned a female officer to look after their care needs. However, records did not consistently show that this happened, which meant the force could not demonstrate that it was meeting the requirements of the Children and Young Person's Act 1933.

4.35 Custody sergeants focused on minimising the time children spent in custody. In some cases, children were dealt with promptly and released, often avoiding overnight detention. In one case we examined, the custody sergeant authorised detention, but after establishing it was a first offence and speaking to the child's mother, released them after 23 minutes in custody and advising arresting officers to deal with the case through a voluntary attendance interview.

4.36 However, not all cases were dealt with promptly and some children spent a considerable time in custody before being charged, often overnight after being placed on a period of rest. The force closely monitored all children detained overnight or who had spent 15 hours or longer in custody. They were discussed at daily custody management meetings. Weekly performance meetings, chaired by the deputy chief constable also monitored child arrests, overnight detentions and the average length of time children spent in detention.

4.37 In addition, a custody inspector reviewed each case of overnight detention individually the following day to assess how well it had been dealt with, and the reasons for any delays that extended the child's time in custody. The reviews appropriately focused on the reasons for children not being moved to local authority accommodation, an area the force was actively seeking to improve. Reviews did not, however, address other concerns, such as waiting times for AAs or the appropriateness of the rest period, which lengthened the time children spent in custody. This information would have provided the force with a better understanding of any delays and strengthened monitoring arrangements.

4.38 The force and its partners were signed up, and worked to, the principles in the concordat on children in custody[5]. At an operational level, custody sergeants told us they rarely refused children bail after they had been charged, but when they did they started discussions with children social care services promptly to arrange for the child to be moved. If other accommodation was not available, they escalated cases in accordance with agreed procedures.

4.39 At a strategic level, the information gathered on children held overnight was used well to support discussions with partners at a joint monitoring forum. The meetings considered children held pre- and post-charge, but focused on children that had been charged and refused bail, who should be moved from custody to other appropriate accommodation. The force reported positive working relationships with partners, but despite this most children remained in custody. Data provided by the force showed that in the 12 months prior to 31 May 2018, 69 children had been charged and had bail refused, including 25 held on a warrant or remanded as a result of a breach of court bail, Of the 44 eligible to be found alternative accommodation, 10 requests were made for secure accommodation and no children had been moved as a result. 21 requests had been made for non-secure/appropriate accommodation which led to only three children being moved.

Areas for improvement

4.40 The force should improve care for children by minimising their exposure to the wider custody environment and demonstrate that it meets the requirements of the Children and Young Person's Act 1933, by assigning a female officer to all girls in custody.

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

Governance of health care

4.42 Castlerock Recruitment Group Medical Services (CRG) had provided custody health services since January 2015. The force managed the contract well and joint working with the CRG was very good. Complaints from the force were investigated and received a prompt response. Lessons learned from audits, clinical record reviews, clinical incidents and complaints were shared with health staff and the force and drove service improvements.

4.43 An HCP was embedded in all operational suites and an additional HCP provided mobile support when staffing allowed. A forensic medical examiner (FME) provided cover across the suites. Staffing shortages were managed through consistent locum staff and overtime and did not affect service delivery.

4.44 Response times of between 60 and 120 minutes were linked to clinical and forensic priorities. CRG was asked to assess 14,233 detainees (52% of the total throughput) in the year to May 2018 and about a fifth of whom required repeated assessments. The CRG met its response times an average of 97% in the previous year, although this dipped to around 80% for FME only calls. HCPs were being trained so their roles could be extended to improve response times. In our custody record analysis, the average response time was two hours but the longest was almost 15 hours, which was excessive.

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

4.45 Clinical governance arrangements were good. An experienced lead nurse and FME provided effective clinical leadership. Registration and required criminal vetting was monitored appropriately. HCP access to training, supervision and appraisals was satisfactory. Training for HCPs on gluing wounds was planned. All HCPs and FMEs, including locums, had access to a system called RADAR, on which to report incidents, view policies and record audits. Practitioners received an email informing them of updates available on RADAR – they had to confirmed they had read them on the system, which provided a clear audit trail.

4.46 Posters in all clinical rooms, except Wirral, advised detainees they could complain directly to CRG about health provision or raise the matter with custody staff. The one detainee complaint received since 2015 received an appropriate response. Patient feedback forms were easily available in all clinical rooms and were confidential.

4.47 The clinical rooms in the three main suites had been refurbished since our last inspection and were suitable. The room in Wavertree Road was satisfactory. Cleanliness was acceptable and all had privacy screens. HCPs cleaned all areas prior to forensic sampling. All clinical rooms contained appropriate clinical equipment and in-date stock.

4.48 A standardised emergency bag containing all essential equipment and medication was held in each clinical room and checked regularly. Oxygen and the automated external defibrillators were behind the booking-in desk and were checked daily.

Area for improvement

4.49 Detainees requiring an assessment by an FME should be seen within agreed response times.

Good practice

4.50 *The RADAR system supported effective clinical governance by providing a single platform for sharing information and reporting incidents, advising health staff of any updates and providing managers with assurance that updates had been read.*

Patient care

4.51 Health provision had improved since our last inspection and was good. Custody staff referred detainees to HCPs based on identified needs or if a detainee asked to be seen. Partnership working between custody and health staff was excellent. Custody staff were positive about the embedded HCP service, which had improved response times. Professional interpretation was used when required. Access to a same gender HCP was advertised in all clinical rooms.

4.52 The care and interactions we observed were good, but consultations lacked privacy as HCPs routinely left the door of the clinical room open during consultations. This was particularly a concern at Wavertree Road and Copy Lane, where the rooms were adjacent to the booking-in desk. Detainees sometimes experienced delays when both the HCP and FME required the clinical room.

4.53 HCPs completed clinical records on an electronic system, which supported effective continuity of care, and made a brief entry on the NICHE police custody computer system. Clinical records we examined were generally good. HCPs provided custody sergeants with a verbal handover and appropriate written care plans.

4.54 Medication management was good. Drug cupboard keys were only accessible to health staff. Standardised stock medicines were stored securely and tidily in appropriate cabinets in all suites. Date and stock checks were robust. All discarded medicines were recorded before being disposed of in a pharmacy bin.

4.55 Police tried to retrieve medication from detainees' homes and health staff appropriately assessed the detainee and checked the medicine before administration. Prescribers had no access to private prescriptions, which meant detainees sometimes had to be sent to hospital when medication could not be obtained in any other way. HCPs could provide an appropriate range of medicines without a prescription and administered most required medication. The force had a policy enabling custody staff to administer medication, if required.

4.56 Symptomatic relief for drug and alcohol withdrawal was appropriately prescribed, but was not sent with the detainee to court, which meant there could be a risk of medical complications, particularly for those withdrawing from alcohol. Since 13 June 2018, detainees on confirmed opiate substitution treatment could continue their prescription in custody if clinically appropriate, which was a positive development. Nicotine replacement therapy was not available, which might have exacerbated the distress of detention for those who smoked.

Areas for improvement

4.57 Detainees should be seen in private subject to an individual risk assessment.

4.58 Medication due for administration while detainees are at court should be sent with them and detainees who smoke should have prompt access to nicotine replacement therapy if clinically appropriate.

Substance misuse

4.59 Support for detainees with substance misuse issues remained good. Three substance misuse organisations provided services across the suites and courts. Substance misuse workers were embedded in two suites, but staffing shortages at Copy Lane meant practitioners usually attended for a few hours every day. A robust detainee referral systems was in place to cover times when practitioners were not in the suite.

4.60 Detainees were targeted for drug testing based on their offence and risk markers using a decision matrix. Detainees who tested positive for class A substances had to engage in two appointments with drug services. The service's performance was appropriately monitored. In the year to March 2017, 75% of the 2,887 drug tests completed were positive. A police coordinator oversaw the 'drug testing on arrest' service and chaired quarterly meetings with the substance misuse providers, but no minutes or action tracker was completed, which undermined their effectiveness.

4.61 Workers also offered services to other detainees when they had time and saw those referred by custody and health staff. Children received appropriate support, either from the substance misuse service or in partnership with the CJLD team. Joint working with health, custody and CJLD staff was good, but substance misuse workers could not record information on the NICHE system, which meant their input was not captured in the custody record. NICHE access was being addressed (see also paragraph 4.65). Sterile injecting equipment and naloxone (an opiate reversal agent) were available from community services but not in the suite.

Mental health

4.62 Custody staff we spoke to demonstrated a good understanding of mental health issues and said they received useful training and ad hoc input from the mental health practitioners.

4.63 An embedded CJLD service covering all ages and all vulnerabilities was available in the three main suites from 7am to 10pm every day and there were also court-based staff. Workers from St Anne Street supported Wavertree Road when it was operational. Mersey Care NHS Foundation Trust was based at all three suites. North West Boroughs Healthcare NHS Foundation Trust (NWB) was also based at Copy Lane and the two trusts there had developed an effective blended service.

4.64 CJLD staff screened all detainees to check if they were known to mental health services. They then prioritised assessments based on the severity of the detainee's vulnerability or clinical need. If time allowed all detainees were offered an assessment. Outcomes from assessments included liaising with community services and directing and referring detainees to relevant services. An outreach service supported people post-release to engage in required services, such as attending appointments. Most assessments were conducted in glass-fronted rooms near the booking-in desks, which lacked privacy.

4.65 Custody staff were positive about the CJLD service and it helped custody sergeants to identify and manage risks more effectively. Partnership working between the CJLD teams, the CRG, substance misuse and custody staff was excellent at all suites. Although CJLD staff could not record information on the NICHE system, which meant their interventions were not consistently recorded in the custody record, a written plan was drawn up for detainees with very complex needs. (See also paragraph 4.61.)

4.66 An FME had to assess all detainees who might have had to be admitted to a mental health hospital, even when the CJLD team was on site, which created significant delays. Some detainees experiencing a mental health crisis had their assessment for and transfer to mental health facilities delayed further for a range of reasons, such as the lack of specialist staff to carry out the assessment, bed shortages and ambulance delays. CJLD staff sometimes bypassed the FME process to support better outcomes for patients. The force monitored the time it took for all mental health assessments to be carried out and was working with all relevant partners to address the delays.

4.67 Nobody had been detained in the suites under section 136 of the Mental Health Act in five years (however, see paragraph 2.5). Force data indicated that people were regularly brought to a health service place of safety under section 136 without officers first consulting a mental health professional. The force was addressing the issue by providing enhanced training.

4.68 Partnership working between the force and all key community mental health stakeholders was effective. Three mental health triage cars staffed by a mental health practitioner and an officer attended incidents across Merseyside where a mental health crisis was suspected to be the primary factor. The service ran from 4pm to midnight every day (see paragraphs 2.4 to 2.6).

Area for improvement

4.69 Detainees with mental health issues should be assessed promptly and transfers to hospital facilities should be expedited in a timely manner.

Good practice

4.70 *The embedded CJLD service helped the force to identify and manage risks more effectively and provided vulnerable detainees with access to support on release.*

4.71 *The force monitored response times and outcomes for all mental health assessments from the time of referral to the time they left the suite and used the information to improve outcomes for detainees.*

Section 5. Release and transfer from custody

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

Pre-release risk assessment

5.1 Detainees were present and involved during pre-release risk assessments (PRRAs). However, the PRRAs did not always reflect the initial risk assessment, which was based on information obtained before and throughout their period in custody. In our case audits and review of PRRAs, we found some records lacked rigour. For example, release arrangements were not recorded routinely and did not demonstrate how a detainee planned to travel home after release, or how any safeguarding issues had been addressed.

5.2 Other than for children, little emphasis was placed on ensuring detainees got home safely. The arrangements for other detainees who were displaced from home were not always good enough. A standard set of questions was asked, but they were not broad enough to elicit sufficient information from detainees to ensure their safe release. Custody sergeants did not have access to travel warrants and the suites had no petty cash to help detainees travel home. Bus passes were available for those living locally (in the north west or Wales), but there were no travel warrants for those based outside the area. Custody staff informed us that if vulnerable people had no transport, they would ask police officers to take them home, but this depended on the availability of officers due to other operational commitments and should not be relied upon.

5.3 Support leaflets available were limited; they were only printed in English and they were not routinely handed out to detainees. Some custody sergeants assumed CJLD staff had given detainees the leaflet.

5.4 Many of the completed dip-sampled person escort records (PERs) we saw were good and included details of detainees' risks, including self-harm, and medication administered to the detainee. This assisted other organisations and escorting staff dealing with those detainees.

Area for improvement

5.5 The approach to release arrangements should be improved. Pre-release risk assessments for detainees should take account of all identified risks, and manage and offset these to ensure a safe release.

Courts

5.6 Detainees charged with offences were expected to appear at the nearest remand court. In Liverpool, if the detainee was considered to be vulnerable (for example, if they were known to secondary mental health services) they would be remanded to the complex cases court at Sefton Magistrates' Court. However, the facility was not available to detainees in the Wirral. Custody staff told us that Wirral Magistrates' Court usually accepted detainees until approximately 3pm on weekdays but Liverpool Magistrates' Court had recently introduced a

2pm deadline for accepting detainees, which was too early. This prevented the force from presenting detainees at the first available court and meant some detainees remained in police custody for longer than necessary.

Area for improvement

5.7 Merseyside Police should work with HM Courts and Tribunals Service to ensure that early cut-off times do not result in unnecessarily long stays in police custody.

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

Causes of concern and recommendations

6.1 **Cause of concern**: The force did not comply with PACE or its codes of practice in several areas, which needed to be addressed urgently.

Recommendation: The force must take immediate action to ensure that all custody procedures comply with legislation and guidance, and that officers implement them consistently. Quality assurance measures should be applied to test compliance with legislative requirements. (S29)

6.2 **Cause of concern:** The force did not always manage detainees' risks effectively enough to ensure their safe detention. Detainees in holding rooms were not prioritised, custody staff did not always understand that observation levels needed to reflect the risks posed, and some were set inappropriately. Some staff were also unaware of the need to rouse intoxicated detainees, and cell visits were carried out by different detention officers, which limited their ability to notice any changes in a detainee's behaviour or mood over time.

Recommendation: The force should ensure that detainees' risks are managed effectively by using observation levels that reflect the risks posed. Staff should carry them out appropriately and observations should be improved by having staff dedicated to this role. (S30)

6.3 **Cause of concern:** The force's approach to managing the demand for custody was not effective, which meant some detainees spent longer in custody than necessary. The force depended on officers working overtime, but available resources were not always deployed in the most effective way. The force did not effectively allocate detainees, which meant St Anne Street often became too busy when spaces were available in other nearby suites.

Recommendation: The force should ensure that it has the capacity and resources to meet fully its custody demand and that an effective detainee allocation process is in place to spread demand across available suites, ensuring detainees do not spend any longer in custody than necessary. (S31)

Areas for improvement

Leadership, accountability and partnerships

6.4 The force should ensure that staff understand and follow APP guidance. (1.9)

6.5 The force should ensure that data on key areas of custody are collated and monitored comprehensively to enable performance to be assessed effectively, trends to be identified and improvements to be made. (1.16)

6.6 Custody records should be improved and detention logs should clearly record all action taken and decisions made. (1.17)

Pre-custody: first point of contact

6.7 The force should ensure that frontline officers consistently receive a good standard of information from the call centre to help them deal with incidents and easy access to advice and support from mental health professionals on a 24/7 basis. (2.10)

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

6.8 Privacy for detainees in custody should be improved wherever possible. It should include withdrawing custody area whiteboards, relocating in-cell CCTV monitoring screens and informing detainees that cell toilets are obscured on CCTV. (3.7)

6.9 Detainees should be routinely asked to define their own ethnicity. (3.17)

6.10 Women detainees should always be able to speak with a female member of staff to discuss their care needs and routinely be offered sanitary products. (3.18)

6.11 Clothing with cords and footwear should not be routinely removed from detainees without undertaking an individual risk assessment. Anti-rip clothing should only be issued following an individual risk assessment and it should be justified on the custody record. (3.31)

6.12 All custody staff should carry anti-ligature knives routinely while in the custody suites. (3.32)

6.13 Cell call bells should be answered promptly. (3.33)

6.14 Handovers between shifts should include all custody staff to ensure that the information shared about detainees is comprehensive and well understood. (3.34)

6.15 Custody sergeants should ensure there is adequate oversight when detention officers are booking detainees into custody. (3.52)

6.16 The force should minimise delays in progressing investigations. (3.53)

6.17 The force should ensure that reviews of detention take the detainee's welfare into account and that custody record entries are sufficiently detailed. (3.60)

6.18 The force should monitor the status of investigations for detainees released under investigation, and keep them informed. (3.64)

6.19 When handing notices to suspects who are being released under investigation custody sergeants should explain what it means and the consequences should they interfere with the course of justice. (3.65)

6.20 Notices providing detainees with information on how to make a complaint should be prominently displayed in all custody suites, and there should be arrangements for them to do so while they are in custody. (3.67)

In the custody cell, safeguarding and health care

6.21 Staff should conduct daily cell checks, which should be recorded, along with any potential ligature points that are identified. Ligature points should be dealt with promptly to eliminate any risks. (4.10)

6.22 The force should ensure an annual fire drill takes place in all custody suites. (4.11)

6.23 Custody staff in all suites should have easy access to standardised well-checked first aid kits. (4.12)

6.24 All staff should be trained in personal safety techniques that are appropriate for a custodial setting at least every 12 months, including the requirement to complete individual use of force forms each time force is used against a detainee. (4.19)

6.25 Incidents involving force should be quality assured and cross-referenced with CCTV. (4.20)

6.26 Detainee care should be improved. In particular, detainees should be routinely offered toilet paper, toiletries, a shower for those held overnight, and reading material. All custody suites should provide detainees with access to outside exercise facilities and fresh air. (4.24)

6.27 Detainees should be provided with suitable replacement clothing. (4.25)

6.28 The force should improve care for children by minimising their exposure to the wider custody environment and demonstrate that it meets the requirements of the Children and Young Person's Act 1933, by assigning a female officer to all girls in custody. (4.40)

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

6.30 Detainees requiring an assessment by an FME should be seen within agreed response times. (4.49)

6.31 Detainees should be seen in private subject to an individual risk assessment. (4.57)

6.32 Medication due for administration while detainees are at court should be sent with them and detainees who smoke should have prompt access to nicotine replacement therapy if clinically appropriate. (4.58)

6.33 Detainees with mental health issues should be assessed promptly and transfers to hospital facilities should be expedited in a timely manner. (4.69)

Release and transfer from custody

6.34 The approach to release arrangements should be improved. Pre-release risk assessments for detainees should take account of all identified risks, and manage and offset these to ensure a safe release. (5.5)

6.35 Merseyside Police should work with HM Courts and Tribunals Service to ensure that early cut-off times do not result in unnecessarily long stays in police custody. (5.7)

Examples of good practice

6.36 The RADAR system supported effective clinical governance by providing a single platform for sharing information and reporting incidents, advising health staff of any updates and providing managers with assurance that updates had been read. (4.50)

6.37 The embedded CJLD service helped the force to identify and manage risks more effectively and provided vulnerable detainees with access to support on release. (4.70)

6.38 The force monitored response times and outcomes for all mental health assessments from the time of referral to the time they left the suite and used the information to improve outcomes for detainees. (4.71)

Section 7. Appendices

Appendix I: Progress on recommendations from the last report

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

Main recommendations

Detainee risk assessment and care planning should be prioritised, with effective quality assurance, to ensure that all significant risks are identified and managed. (2.35)	**Partially achieved**
Staff should be trained and supported to recognise and provide for the individual needs of detainees, particularly women and those who are vulnerable or have disabilities. (2.36)	**Partially achieved**

National issues

Appropriate adults should be available at all times to support without undue delay detained juveniles aged 17, provided that informed consent has been given. (2.37)	**Partially achieved**

Strategy

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

Recommendation

The force should introduce regular custody refresher training for custody sergeants and detention officers. (3.15)	**Achieved**

Treatment and conditions

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

Recommendations

A hearing loop should be available in all booking-in areas and all custody staff should know how to use it. (4.10)	**Partially achieved**
Whiteboards should be removed from booking-in areas or placed where they cannot be seen by detainees. (4.11)	**Not achieved**
Staff should be trained in risk assessment, proportionate care planning and making observations. (4.29)	**Partially achieved**
Detainees should only be placed in safety smocks and paper clothing where strictly necessary, and detainees whose own clothing has been removed should be given normal replacement clothing where possible. The use of strip-clothing should be monitored and over use addressed. (4.30)	**Not achieved**
There should be one handover for each shift change, which includes all staff working in custody and covers issues relevant to the detainees held. (4.31)	**Not achieved**
The quality and consistency of pre-release risk assessments should be improved and made subject to dip-sampling. (4.32)	**Partially achieved**
Merseyside Police should collate use of force data in accordance with the Association of Chief Police Officers' policy and National Police Improvement Agency guidance. (4.33)	**Partially achieved**
Cells should be clean, free of graffiti and properly maintained. (4.40)	**Achieved**
Cell checks should be thorough, regular, documented and consistently applied at all custody suites. (4.41)	**Partially achieved**
Unreliable call bell systems should be replaced or refurbished. (4.42)	**Partially achieved**
Mattresses, blankets and pillows should be routinely provided to all detainees. (4.51)	**Achieved**
There should be a stock of disposable razors for detainees who wish to save before attending court, subject to risk assessment. (4.52)	**Partially achieved**
Replacement underwear should be available at all suites. (4.53)	**Partially achieved**
Detainees should be offered outside exercise, especially those held for longer periods, and all exercise yards should be kept clean and free from ligature points. (4.54)	**Not achieved**
Custody suites should hold and offer a range of reading material, including books and magazines suitable for young people and in foreign languages. (4.55)	**Not achieved**
Visits should be facilitated in exceptional cases for detainees held for long periods, particularly if they are vulnerable. (4.56)	**Not achieved**

Individual rights

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

Recommendations

Merseyside 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. (5.14)	**Partially achieved**
Detainees should be able to make a complaint about their care and treatment, and be able to do so before leaving custody. (5.29)	**Not 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.

Recommendations

There should be robust infection control procedures for all the clinical rooms, which should be regularly cleaned, appropriately equipped and able to be used to take forensic samples. (6.7)	**Achieved**
Resuscitation equipment in the medical rooms and in the booking-in areas in custody suites should be standardised. (6.8)	**Achieved**
All clinical options associated with treatment of wounds, and all clinically indicated medications, should be available. (6.16)	**Not achieved**
Clinical records should be kept in accordance with legal requirements. (6.17)	**Achieved**
Medicine cabinets should be constructed and installed to the required standards. (6.18)	**Achieved**
Dispensed medications should be supplied in labelled containers and stored securely. (6.19)	**Achieved**
There should be complete and accurate data on the use of section 136 of the Mental Health Act 1983. (6.30)	**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*.[6]

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.[7] 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.[8]

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

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

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

8 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 people 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
Marc Callaghan	HMICFRS inspection officer
Anthony Davies	HMICFRS inspection officer
Patricia Nixon	HMICFRS inspection officer
Vijay Singh	HMICFRS inspection officer
Kellie Reeve	HMIP team leader
Fiona Shearlaw	HMIP inspector
Majella Pearce	HMIP health services inspector
Laura Green	HMIP researcher
Joe Simmonds	HMIP researcher
Dee Angwin	CQC inspector