Report on an unannounced inspection visit to police custody suites in

City of London

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

5–15 November 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
City of London

Commissioner
Ian Dyson

Chair of the City of London Police Committee
Douglas Barrow

Geographical area
City of London

Date of last police custody inspection
18–20 June 2012

Custody suites
Bishopsgate

Cell capacity
15 cells

Annual custody throughput
1,731 (2017–18)

Custody staffing[2]
10 designated detention officers
29 trained custody officers
20 trained police constable gaolers

Health service provider
G4S Health Services

1 Data supplied by the force.
2 Other than designated detention officers, the force did not have officers dedicated solely to custody. This is the number available to be called on to perform the role.

Executive summary

S1 This report sets out the findings from an inspection of City of London Police custody facilities in November 2018. This was conducted by HM Inspectorate of Prisons (HMIP) and HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS). This inspection assessed the effectiveness of custody services and outcomes for detained people throughout the different stages of detention. It examined the City of London Police'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.

S2 We last inspected custody facilities in the City of London Police in 2012. We noted that, of the 24 recommendations made during that inspection, 12 had been achieved, eight had been partially achieved and four had not been achieved.

S3 To assist the force to improve, we have identified a number of key areas for concern and areas for improvement. This report provides one recommendation to the force (and the City of London Corporation Court of Common Council) and highlights 21 areas for improvement. These are set out in full in Section 6.

Leadership, accountability and partnerships

S4 Overall, we found many positive features in the way that the City of London police delivered its custody services. The force focused well on ensuring good care and treatment for detainees and had progressed many of the recommendations we made during the previous inspection. In the present inspection, we highlighted one cause of concern and a number of areas requiring improvement. The force was open to both our external scrutiny, and that of the independent custody visitors scheme, providing confidence that it would take action to make the improvements needed.

S5 There was a strong culture of care evident throughout the force's custody services. Custody staff were clearly focused on achieving good outcomes for detainees, and recognising and addressing the needs of vulnerable detainees.

S6 The force had made a number of changes in the previous year, having recognised that improvements were needed, such as better training and accreditation for staff working in custody. Comprehensive policies were in place, and good-quality guidance to help staff to perform their roles. There had been some investment in the custody suite to provide a better environment, although the facilities continued to fall below the standards expected.

S7 There was an appropriate governance structure for custody, but within this there was insufficient strategic oversight of some key areas. The experience and confidence levels of sergeants carrying out the custody role, and the way in which detainees were dealt with, varied, and the College of Policing *Authorised Professional Practice* (APP), along with the force's own policies, were not consistently followed. Although staffing issues were being addressed, the force was dependent on the use of trained officers from other service areas, and overtime to maintain minimum staffing levels in the custody suite and ensure safe detention.

S8 Our main area of concern was that children were sometimes processed (including taking their fingerprints, photograph and DNA) without an appropriate adult (AA) being present, and this was seen as accepted practice by some staff. This did not meet the requirements of paragraph 2.15 of the Police and Criminal Evidence Act 1984 (PACE) code D and needed to

be addressed as a matter of urgency. With a few other exceptions, the force mainly adhered to the PACE codes of practice.

S9 The performance management of custody services was limited, with some gaps in the range of data gathered and not enough analysis to assess different aspects of the service. The standard of detention logs was variable and the quality assurance of custody records was not yet sufficiently focused on assessing quality rather than whether processes had been completed.

S10 The force had an equality and diversity objective specific to custody, and collected a range of information in support of this. However, this was not comprehensive and had not yet been analysed to show whether all detainees were treated fairly, irrespective of their ethnicity or other protected characteristics.

S11 There was a good focus on the diversion of children and vulnerable people from custody. The force worked well with partners in relation to detainees with mental ill-health, successfully diverting many away from custody. The force worked with partners as part of the London-wide approach to providing alternative accommodation for children who had been charged and refused bail. Few children entered custody and only one child had been held after charge in these circumstances, but had not been provided with suitable alternative accommodation.

Pre-custody: first point of contact

S12 The arrangements for dealing with people at the first point of contact were good. Frontline officers were well trained and focused on assessing vulnerability. They were provided with accurate and timely information from the control room, which helped them to make informed decisions on whether to arrest and detain individuals or deal with them through alternatives to custody.

S13 This had resulted in vulnerable people and children being diverted away from custody, and a significant reduction in the number of people detained under section 136 of the Mental Health Act 1983.

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

S14 Detainees were treated with respect, empathy and consideration for their dignity and welfare while in custody. However, privacy at the booking-in area remained poor and unimproved since the previous inspection.

S15 Custody staff had received extensive training to help them to understand and manage the wide range of individual and diverse needs of those coming into custody. There was good support for female detainees and those observing a faith. We were confident that custody staff had a good understanding of, and would try their best to meet the diverse needs of, detainees, including those with disabilities, who were transgender or who had a limited understanding of English.

S16 The approach to identifying and managing detainee risk was mixed. The initial risk assessment was thorough and the frequency of checks was broadly adhered to. However, some care plans did not set observations at a level commensurate to the risk, intoxicated detainees were not always put on rousal checks and checks were not always well recorded.

S17 All custody staff carried anti-ligature knives, and anti-rip clothing was used sparingly. The content of handovers between shifts was properly focused on detainees' risks, case progression and welfare but they did not include all staff.

S18 Custody sergeants interacted positively with detainees when booking them into custody. The grounds and necessity for arrest were explained well and detention was appropriately authorised. Detainees' rights and entitlements were routinely explained but the written notice detailing these was not always provided, as required under PACE.

S19 Detainees generally had their cases dealt with promptly, which helped to minimise their time in custody. However, detainees arrested on behalf of other police forces sometimes remained in custody with little action taken by officers from those forces, unnecessarily extending their detention times.

S20 The overall approach to PACE reviews of detention was good. Inspectors' reviews of detention were carried out on time and mainly face to face, and were generally purposeful and conducted in the interests of detainees' welfare, lawful detention, and rights and entitlements. However, record keeping was variable and did not always reflect the good approach taken by inspectors. Some reviews, and other PACE requirements, were carried out by acting or temporary inspectors, and it was not clear that they had been authorised or trained to perform the role, which is required under section 107 of PACE.

S21 The management of bail and detainees released under investigation was good and helped to ensure that detainees had access to swift justice.

S22 There was good promotion of the complaints procedure in the custody suite, and staff had a good understanding of the procedure to be followed.

In the custody cell, safeguarding and health

S23 The custody estate was old and dated, and lacked basic standard facilities such as an exercise yard and in-cell wash basins. However, overall, conditions and cleanliness were good and there were no potential ligature points in the cells.

S24 Staff generally dealt well with challenging detainees, de-escalated situations and only used force as a last resort. The use of force incidents we reviewed against closed-circuit television (CCTV) did not raise any significant concerns.

S25 However, governance of the use of force was not sufficiently robust. Use of force information was collected but the accuracy of this information was undermined as not all incidents were recorded and officers did not always submit the required individual use of force forms. The force did not conduct its own qualitative monitoring of the use of force and could therefore not assure itself, the police committee and the wider public that all uses of force in custody were safe and proportionate to the risk posed.

S26 Detainees we spoke to confirmed that they had been well treated. They received a good standard of care while in custody, including regular offers of food and drinks, and replacement clothing, if required. Some detainees had access to washing/showering facilities and reading material, which was better than in many other forces we have inspected recently. However, the lack of an exercise yard was a serious weakness, particularly for those spending longer periods in custody.

S27 The importance of safeguarding vulnerable adults and children was well understood by all staff. In general, custody sergeants made good efforts to secure AAs for children as soon as

possible, and expected them to arrive early on in detention. This included during the night, regardless of whether it was a family member acting as AA or one from The Appropriate Adult Service (TAAS). In most cases we examined, we saw no undue delays in securing AAs for children. However, the arrangements for securing AAs for vulnerable adults did not work well. Custody sergeants did not always consider whether a vulnerable adult needed an AA. There was no overnight provision from TAAS, which meant that these detainees were sometimes held longer than necessary.

S28 There was some good care shown to children in custody, with good attention paid to meeting their particular needs. There was a strong focus on dealing with their cases quickly and minimising their time in custody.

S29 Improvements were being made to the health care arrangements for detainees, following staffing difficulties that had led to limited provision of the service. These were still bedding in at the time of the inspection but there were early signs that adequate health cover was in place and had become more accessible for detainees.

S30 The individual health care given to detainees was appropriate and most were seen promptly. Medicines management arrangements were safe and effective.

S31 Target drug testing and referral into treatment were well established. A dedicated substance misuse team offered face-to-face support and brief interventions to detainees with drug and alcohol problems, and delivered good ongoing support through effective joint working with other community services.

S32 Demand for support from the mental health liaison and diversion services was low. The current service met most needs and was valued by custody staff. Assessments for detention under the Mental Health Act (MHA) were generally undertaken in a timely fashion and access to beds and transfers was expedited promptly. It was positive that no detainees had been held in custody as a place of safety under section 136 of the MHA in, at least, the previous 12 months.

Release and transfer from custody

S33 Overall, there was a good focus on releasing detainees safely. Pre-release risk assessments were generally completed well but the recording of release arrangements on detention logs was not always clear and did not routinely demonstrate how detainees had returned home after release. Petty cash was available, but was not always offered, and the suite had no access to travel warrants. If required, vulnerable detainees and children were taken home by police officers after they were released.

S34 There were effective arrangements for ensuring that detainees could attend court promptly, so that they were not held in custody for longer than necessary.

Cause of concern and recommendation

S35 **Cause of concern:** Some children and vulnerable adults were fingerprinted, photographed and had DNA taken without having an AA present. This did not meet the requirements of paragraph 2.15 of PACE code D.

Recommendation: The force must take immediate action to ensure that all children and vulnerable adults have an appropriate adult present when taking fingerprints, photographs and DNA.

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 the City of London Police, we analysed a sample of 35 records. The methodology for our inspection is set out in full at Appendix II.

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

Wendy Williams
HM Inspector of Constabulary

Peter Clarke CVO OBE QPM
HM Chief Inspector of Prisons

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

Section 1. Leadership, accountability and partnerships

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

Leadership

1.1 The force had recognised that significant improvements were needed to the delivery of custody services, and had made a number of changes in the previous year. We found many positive features about the service, although some of these changes were still bedding in and there were still some areas that required further improvement. The force was receptive to our inspection scrutiny and committed to improving its custody services. Some of the areas we identified were already starting to be addressed during the inspection, and the force's overall approach provided confidence that the service would further improve.

1.2 There was a strong culture of care throughout the force's custody services. Custody staff were clearly focused on achieving good outcomes for detainees, and recognising and addressing the needs of vulnerable detainees.

1.3 There were appropriate governance structures to oversee the delivery of custody services at a strategic level. The commander, as part of the senior management team, received regular verbal reports from the superintendent responsible for custody services. There were no strategic meetings focused specifically on custody, but custody matters were addressed at the force's various strategic panels where relevant. Although these governance arrangements provided an adequate structure to enable scrutiny of its custody delivery, there was a lack of strategic oversight of some key areas, such as staffing levels in the custody suite and ensuring that good outcomes were consistently achieved for detainees.

1.4 Operational management of custody was discussed at the two monthly custody management meetings. These were attended by representatives from across the force, alongside relevant partner agencies. This forum had driven some improvements in the service, including strengthening the approach to training and ongoing staff accreditation. However, not all key partners attended this forum and the meetings were not yet fully effective in providing sufficient oversight of operational matters and addressing any improvements needed.

1.5 Custody services were delivered as part of response policing. A chief inspector was responsible for the operational delivery of custody, supported by five inspectors and a number of custody-trained sergeants and police constable (PC) gaolers, the latter performing the detention officer role. There was a dedicated custody inspector with general responsibility for custody matters and there were 10 designated detention officers (DDOs) who were solely dedicated to custody duties, but the other officers working in custody, including PC gaolers and sergeants, had wider duties in response policing. All of these officers were trained and accredited to work in custody, although we found a variation in the experience and confidence levels of sergeants who carried out the custody role. There were also inconsistencies in the way that detainees were dealt with.

1.6 The force did not have its full complement of staffing for the custody suite. Across the five shifts of officers, there were only 12 trained sergeants available, when there should have

been 20. Four out of the five inspectors were sergeants covering the role temporarily. This had left the sergeant posts unfilled, and although additional sergeants had been recruited, they had not yet been trained. Delivering the service, even to the minimum staffing levels of one sergeant and one DDO, was dependent on using trained sergeants from other areas of the force, and overtime. The latter, on some occasions, was excessive, with some staff working consecutive double shifts, potentially putting detainees at risk, as well as showing insufficient focus on staff welfare. The arrangements were not sustainable and lacked managerial oversight in monitoring how minimum staffing levels were being maintained in the suite to ensure safe detention.

1.7 There had been some investment in the custody suite to improve the environment, and it was kept in good condition. However, the facilities continued to fall below the standards required, including meeting the needs of detainees with disabilities (see also paragraph 3.9). There were plans to replace the custody suite as part of the wider force estate strategy, but these were several years away from being implemented, and in the meantime detainees continued to be held in unsatisfactory facilities.

1.8 Negotiations with the British Transport Police, built on the existing arrangements to use each other's custody suites when required, were in advanced stages to enter into a formal S22 collaboration agreement (under the Police Act 1996) to share the delivery of custody services. This was intended to make more effective and efficient use of staff, and potentially mitigate some of the custody estate issues identified.

1.9 Training for custody staff was good and well monitored. All custody officers and DDOs completed a programme based on the College of Policing Detention and Custody Learning Programme. This involved a three-week induction course, 18 days of tutoring and a workplace assessment, followed by formal accreditation. Accreditation was awarded annually, dependent on completion of refresher training and spending at least one day performing the role every three months, to ensure that staff knowledge and experience within custody were maintained. Staff had also benefited from a range of other training, including, for example, legal changes to custody, and various aspects of vulnerability awareness.

1.10 The force followed the College of Policing *Authorised Professional Practice* (APP), supported by a range of clear and comprehensive local policies. These provided good guidance for staff. However, some aspects of APP, and the force's own policies, were not consistently followed by staff. For example, the reason for delays in booking a detainee into custody was not recorded on the detention log.

1.11 There was insufficient strategic oversight of the health care contract. Contract monitoring meetings took place at an operational level, but these did not address concerns effectively. It had taken a considerable time to begin to resolve ongoing concerns over the timely provision of health care to detainees.

1.12 The force had a strong focus on vulnerability at a strategic level. There was a vulnerability steering group, chaired at senior officer level, and a vulnerability working group, in which the chief inspector represented custody. There was a comprehensive policy framework, and some good training had been provided to staff, including topics such as mental health and child sexual exploitation. This focus on vulnerability had translated into some good operational working and knowledge.

Areas for improvement

1.13 The force should ensure that there is sufficient oversight of how minimum staffing levels are maintained in the custody suite, and the level of overtime in use to achieve these.

1.14 The force should address the unsatisfactory conditions that some detainees experience in the suite, especially those detained for long periods, and ensure that the facilities and arrangements for detainees with disabilities and those with limited mobility are suitable.

1.15 The force should ensure that all staff follow the College of Policing *Authorised Professional Practice* and its own policies and procedures to achieve consistent outcomes for detainees.

1.16 The force should manage the health care contract effectively, with escalation to a senior level when the service falls below the standard required.

Accountability

1.17 The performance management of custody services was limited. A report was considered monthly by the force's performance management group, and the custody manager received some information daily. However, there were gaps in the information collected; much of it was based on the number of activities or processes, with little analysis of how well the service had performed, how detainees were treated and where improvement was needed. The force was aware that it needed to improve its approach, but progress in developing better-quality reports had been hindered during the introduction of the NICHE police custody computer system because of problems in extracting the management information needed.

1.18 The force also gathered little information on the performance of services provided by partners or under contractual arrangements. It relied on information provided by the services themselves, rather than gathering any independently to enable more effective oversight. This meant that in some areas, such as the provision of appropriate adults (AAs) or substance misuse services, the force did not know what outcomes were being achieved for detainees.

1.19 The force took fingerprints, photographed and took DNA for some children and vulnerable adults without an AA present, which did not meet the requirements of paragraph 2.15 of the Police and Criminal Evidence Act 1984 (PACE) code D and was a cause of concern that needed to be addressed immediately (see also paragraph 4.31 and recommendation S35).

1.20 There were a few further areas where the force did not consistently meet the requirements of PACE code C for the detention, treatment and questioning of suspects, and these are detailed throughout our report (see paragraphs 3.28, 3.29, 3.32, 3.36 and 3.37, and areas for improvement 3.34 and 3.40). However, in general, the force adhered to the PACE codes of practice.

1.21 The force was not robust enough in monitoring the use of force and could not assure itself, the police committee or the wider public that all uses of force in custody were safe and proportionate to the risk posed. The number and type of incidents were reported to the performance management board and formed part of the data submission for the Home Office annual return, as recommended by the National Police Chiefs Council (NPCC).

However, not all incidents were recorded and not all use of force forms were completed, which undermined the accuracy of the information provided.

1.22 The use of force incidents which we viewed on closed-circuit television (CCTV) showed that the force used had been both appropriate and proportionate, and we did not formally refer any incidents back to the force for review. However, the force's own monitoring did not include cross-referencing incidents on CCTV, which limited its ability to assess the use of force qualitatively (see also paragraph 4.10 and area for improvement 4.16).

1.23 The standard and quality of custody records were inconsistent. In some, relevant information or details to explain why decisions had been made were not included or were unclear. The custody inspector dip-sampled about 10% of custody records each month for quality assurance, and this included limited cross-referencing to CCTV footage. However, there was little assessment in relation to the quality of record keeping, with the focus mainly on whether processes had been completed.

1.24 There was a clear definition of an adverse incident and a clear process for the reporting of these which was well understood by staff. When incidents occurred, they were publicised across the force to ensure that relevant learning was shared, along with that from any incidents reported nationally from other forces. There had been no deaths in custody since the previous inspection.

1.25 The force understood its obligations under the public sector equality duty (PSED), with an equality and inclusion board chaired at a senior level, and an equality and inclusion strategy and action plan. Training on meeting diverse needs had been provided and equality impact assessments had been carried out on custody policies.

1.26 There was an equality and inclusion objective specific to custody to 'assess arrest, custody and bail data to address areas of disproportionality'. A range of information was gathered – for example, the numbers of detainees entering custody and of strip-searches, completed by ethnicity, gender and age. The information was not comprehensive and had not been analysed to show whether all detainees were treated fairly, irrespective of their ethnicity or other protected characteristics, but work was progressing to achieve this and to show compliance with the PSED.

1.27 The force was open to external scrutiny from the independent custody visitor (ICV) scheme. ICVs reported a positive relationship with the force and generally a good response to the issues they raised. The scheme manager and chair of the scheme attended custody management meetings and were able to raise any concerns, in addition to liaising directly with custody sergeants or the custody inspector at the time of, or immediately following, their visits.

Areas for improvement

1.28 The force should improve its approach to performance management by collecting comprehensive information, and analysing this to show how well the service is performing and identify where improvements are needed.

1.29 Custody records should be completed to a consistently high standard. The recording of information on detention logs should be sufficiently detailed and include all relevant information. Quality assurance processes should ensure that the custody records meet the required standards.

1.30 The force should analyse data relating to diversity, to ensure that outcomes for all detainees are fair and demonstrate that custody services are meeting the public sector equality duty.

Partnerships

1.31 The force worked well with partners to improve outcomes for detainees with mental ill-health. This included developing a joint suicide prevention action plan with the City of London Corporation. The force had worked with mental health partners to provide a mental health triage scheme, in which police officers worked alongside mental health professionals during peak hours to respond to incidents. This was successfully diverting mentally unwell people away from custody, and reducing the number detained under section 136 of the Mental Health Act 1983. No section 136 detainees had been taken to custody as a place of safety in the year from 1 November 2017 to 31 October 2018 (see also paragraphs 2.4 and 4.55).

1.32 Only a small number of children had entered custody in the last three years, with few of these living in the force's area, but rather in other local authority and London borough areas. This made engaging with partners particularly challenging, and so the force primarily engaged with the City of London Corporation children's social services, which were expected to act as the gateway to other local authority services. Joint working for the provision of alternative accommodation for children who had been charged and refused bail was part of the London-wide approach. The force had detained only one child in these circumstances in the previous year, although no alternative accommodation had been provided in that instance (see also paragraph 4.35).

1.33 The force presented an annual update report ('The Custody of Vulnerable Persons') to the City of London Corporation's police committee. This included information on children and individuals with mental ill-health and other vulnerabilities, allowing issues around the effectiveness of joint working to be raised at a strategic level.

1.34 The force was working proactively with a range of partners to tackle rough sleeping and beggars, which was a particular concern within the force's area. This had resulted in a scheme to divert these vulnerable people away from custody and prevent further offending through facilitating access to a range of support services, such as for drug and alcohol addiction and housing.

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 recognising and responding to vulnerable people and the importance of safeguarding them. Those we spoke to had all received a range of training on vulnerability, and all recognised that children were vulnerable because of their age. Officers and staff applied their knowledge effectively when dealing with vulnerable people and children, seeking to divert them away from custody wherever possible and appropriate.

2.2 Officers attending incidents received accurate and up-to-date information from the control room on individuals and situations, which helped them to make informed decisions on what action to take, and whether an arrest was the best course of action. Many incidents attended involved people who lived in other police force areas, and we were told that control room staff contacted other forces to obtain and pass on information to officers to help inform their decision making in these circumstances. Officers were also able to access information directly through their handheld devices.

2.3 Officers generally felt well supported by mental health professionals when dealing with mentally unwell people. They had a clear understanding of the principles of the Mental Capacity Act and used this well to make effective risk assessments and decide what action to take.

2.4 Mental health triage nurses, based with an officer in a patrol car, were available seven days a week throughout the evening until 3am, and provided advice, or attended incidents, to assess vulnerable people who officers were dealing with. Officers considered this service to be an invaluable resource which reduced the number of people detained under section 136 of the Mental Health Act 1983 (MHA)[5] and diverted them away from custody. Officers also said that the scheme had improved their own knowledge and skills in relation to mental health. They never took people detained under section 136 to custody as a place of safety; in general, these individuals were transported to hospital by ambulance.

2.5 When mentally unwell people had committed an offence, officers were often able to contact their mental health carers directly, with a view to making alternative arrangements to arrest if the nature of the offence allowed this. If an arrest was required, any mental health needs were addressed in custody.

2.6 The number of children entering custody was low. Officers avoided arresting children by exploring all other possible options, and ensured that when an arrest was made, this could be robustly justified.

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

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

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

Respect

3.1 The detainees we observed were treated with respect, empathy and consideration for their dignity and welfare. This was consistent with the force's various custody policies and operating protocols, which all emphasised this as a priority. These standards were also maintained during some instances of challenging behaviour from detainees.

3.2 However, privacy at the booking-in area remained poor and unimproved since the previous inspection, with little physical screening or separation between the booking-in terminals, and no alternative facility available elsewhere in the suite. This meant that if more than one detainee was brought into custody and dealt with by custody officers simultaneously, conversations would be easily overheard. This was also the case if a detainee was being held in the holding area close to the desk. This could compromise their privacy and reduce the chance of them disclosing sensitive information, affecting their or others' welfare. From speaking to custody staff, there was little sense that they would consider this or try to mitigate against it, even though a laptop computer was available that could be taken to another office in the suite to facilitate this.

3.3 In some cases, too little consideration was given to detainees' dignity. We saw some detainees walking around the suite without shoes (see also paragraph 4.21) and having to ask for, instead of being offered, toilet paper (see also paragraph 4.22 and area for improvement 4.24).

Meeting diverse and individual needs

3.4 Detainees were routinely asked to self-define their ethnicity as part of the booking-in process, and this information was collated as part of the force's custody data set. However, the force had not yet maximised the value of this information by analysing, for example, trends in the arrest and treatment of individuals by ethnicity.

3.5 All detainees were asked whether they had care responsibilities when being booked into custody. This helped custody staff take any necessary actions to safeguard their collective welfare.

3.6 Custody staff were mindful and well prepared to deal with the wide range of complex needs, issues and diverse backgrounds presented by detainees. They had received a variety of formal training packages and occasional briefings to improve their knowledge and help them better to identify, understand and manage these issues. This had included coverage on topics such as mental health, vulnerability and human trafficking. They had also received guidance on the management and searching of transgender detainees, and staff we spoke to demonstrated a good understanding of how they would manage this in practice. They also had access to an

excellent range of supporting reference material via the force's internal website, which offered detailed advice and guidance on various diversity issues, such as managing detainees with autism (including 'best practice' tips on communications and behavioural interpretation) and the Ramadan worship needs of Muslim detainees.

3.7 The needs of female detainees were generally well served. A plentiful supply of suitable hygiene products was available and proactively offered to all women entering custody. There was also a consistent assignment of female officers to female detainees, to offer support through private conversation. When there were no female staff in custody to do this, female officers from elsewhere were called in to facilitate this and, when needed, conduct strip-searches. A helpful 'Females in Custody' information sheet, setting out these provisions, was available for women entering custody, although we were not confident that they always received this, and it was unavailable in languages other than English.

3.8 An excellent supply of respectfully stored religious observance materials was available, including a wide selection of common faith texts (including some in multiple copies) and other items such as rosary beads, prayer mats, ablution jugs and replacement hijabs. The compass to help Muslim worshippers to locate the direction of Mecca could not be found but staff said that they could use other means if necessary (such as mobile phone technology). Religious worship needs were well managed; for example, in one case we looked at, a child had been provided with suitable worship materials, halal food and the opportunity to wash before prayers. The range of available microwave meals and other foodstuff supplies met most religious needs, including various halal options, with useful guidance to direct staff on their suitability. Good alternative arrangements were available when this was not the case, such as an agreed protocol for the supply of kosher food to Jewish detainees.

3.9 For detainees with poor mobility, the physical environment remained largely unchanged since the previous inspection, with limited facilities to help them (see also paragraph 1.7 and area for improvement 1.14). A wheelchair was not kept within the custody suite but was available from elsewhere in the building, and step-free access to the suite was possible by use of a wheelchair lift in the front office or via a staff entrance ramp. The suite had one cell with widened door access which was specially designated for such users but, despite our previous recommendation, its call bell remained too high and probably out of reach for any such detainees, rendering it unsuitable. There were two slightly thicker mattresses to offer extra physical support. The facilities failed to meet the needs of these detainees adequately but we were confident that staff would attempt to make them feel as comfortable as possible within the confines of the environment. For example, although there was no accessible toilet or shower, staff said that they would assess whether to take a detainee using a wheelchair to the adapted toilet located elsewhere in the police station, according to the circumstances of the particular case (see also paragraphs 1.7 and 1.14).

3.10 There were good support arrangements for detainees with sight and hearing impediments. Blue band markings on all cell walls helped to guide detainees visually and a hearing loop was also available and well promoted, and its use was understood by custody staff. A good supply of Braille reference materials (rights and entitlements, and complaints guidance) was also available, although not all staff knew this or where to access it. Force policy also allowed for assistance dogs to remain with blind detainees in cells.

3.11 For detainees who had no or limited English skills, professional telephone interpreting services were available, using interlocking handsets to facilitate private three-way conversations between detainees, custody staff and interpreters. Staff said that this worked effectively, with few reported concerns or delays in accessing interpreters either by telephone or in person. However, we identified some instances where the service should have been used but was not. For example, when two foreign nationals were arrested together, one of them received interpreting support but the other did not, even though it

was recorded that the latter detainee had difficulty with 'complex words' and was clearly having some difficulty in communicating with staff during his detention.

3.12 Custody staff were fully aware of their responsibility to inform foreign nationals' respective embassy/consulate when requested, and could do this with support from the force computer system. They were also aware of the need to check existing protocols which required some embassies/consulates to be notified regardless. Staff could also easily access and print up-to-date foreign language versions of the rights and entitlements leaflet to give to detainees. However, we found one example where this information had been explained to the detainee through an interpreter but not subsequently provided in written form, which was poor.

Area for improvement

3.13 Staff should routinely consider, and take any appropriate actions to preserve, detainees' privacy at the booking-in desk.

Risk assessments

3.14 Detainees were not always booked in promptly (see also paragraph 3.24) and some were made to wait in the holding room, in a cell or, on occasion, in a vehicle outside the custody suite. There was no triaging in these circumstances, to prioritise children or vulnerable detainees, or those who may present the greatest risks.

3.15 Custody staff focused appropriately on the welfare of detainees and identifying risks when booking individuals into custody. They interacted well with detainees to complete standardised risk assessments, responded to individual need and asked appropriate supplementary and probing questions. There was routine cross-referencing to police national computer warning markers and historical information held on the custody record system, to inform risk assessments further.

3.16 Initial care plans did not always reflect observations at a level that was commensurate with the presenting risk. In general, observation levels were reviewed regularly, with sufficient justification recorded on custody records for any changes. However, we found a few instances where the observation levels set for intoxicated detainees had not included rousal checks (level 2, according to APP guidance). We also found cases where these observations had been changed to a lower level too early when there was clear evidence of ongoing intoxication, which posed a risk to some detainees.

3.17 The frequency of checks conducted on detainees was mostly adhered to. However, these were not always carried out by the same member of staff, which meant that changes in a detainee's behaviour or condition might not always be readily identified. This posed significant risks, particularly to detainees who were intoxicated. When the need for rousing checks for intoxicated detainees was identified, staff conducted these checks in accordance with annex H of PACE code C, although checks were not always recorded.

3.18 Staff were generally confident and competent in managing the risk of suicide or self-harm. All custody staff carried anti-ligature knives. Officers conducting close proximity watches with detainees were well briefed by custody sergeants and were rotated regularly. We saw little use of anti-rip clothing during the inspection, and staff told us that it was used sparingly, which was positive. However, clothing with cords, footwear containing laces, and belts were routinely removed from all detainees, without an individual risk assessment, which was a disproportionate response to managing risk (see also paragraph 4.21).

3.19 The shift handovers did not include all staff. As we found at the previous inspection, sergeants and DDOs handed over separately to their incoming peers, with no involvement of health care practitioners (HCPs), even when they were available. This disparate approach to handovers potentially adversely affected the quality and accuracy of information shared between individual staff, particularly when some shifts were staggered, with a few individual handovers throughout the day. Despite this, the handovers we observed, particularly between sergeants, were well conducted and appropriately focused on risk, detainee welfare and case progression. However, not all custody sergeants visited the detainees after receiving their handover, and those who did, did not always engage or interact with them.

Area for improvement

3.20 The approach to managing some elements of risk should be improved. In particular:

- **Detainees who are intoxicated should be placed on observation levels that include rousals.**
- **Detainees' clothing and footwear should only be removed based on an individual risk assessment.**
- **All custody staff should be involved collectively in shift handovers.**

Individual legal rights

3.21 Interactions with detainees were positive during the booking-in process, and built a good rapport. Arresting officers ably explained the grounds and necessity for arrest in the presence of the detainee, and custody sergeants appropriately authorised the detention. There was generally good recording of this on the detention log. The approach showed good adherence to the relevant sections of PACE codes C and G, and enabled the detainee to understand why they were in police custody.

3.22 DDOs sometimes booked detainees into custody. When this occurred, it was adequately supervised by the custody sergeant, who, after considering the grounds and necessity for arrest, authorised the detention.

3.23 Officers actively used alternatives to police custody, especially for children and vulnerable adults. These included restorative justice options, penalty notices and voluntary attendance interviews. Information provided by the force showed that the frequency of the latter option had increased by 9% in the previous three years. However, there was only one room in the police station available for conducting a voluntary attendance interview, and when this was in use the voluntary attendee was brought into the custody suite to use a room there. Although, in the case we observed, a good explanation was given, and the person was reassured that they were not under arrest, this detracted from the aim of diverting people away from the custody environment.

3.24 As throughput was low, some detainees could be taken straight to the booking-in desk on arrival at the custody suite, and they usually did not wait long to be processed. However, if more than one detainee was brought to the custody suite at the same time, there could be a long wait to be booked in. Force information showed that the average waiting time for the period 1 November 2017 to 31 October 2018 had been 57 minutes for adults and 41 minutes for children, which was considerably longer than in other forces we have inspected.

3.25 Detainees were generally not kept in custody for longer than necessary. Cases were progressed quickly, with no undue delays in the attendance of solicitors, interpreters or AAs. Information provided by the force showed that, for detainees who were not held in custody after being charged, the average time they spent in detention before being released was just under 13 hours for adults and about eight hours for children.

3.26 Although detainees were dealt with promptly by City of London officers, this was not the case for detainees arrested on behalf of the Metropolitan Police Service and British Transport Police. These detainees often stayed in the custody suite for longer than necessary because of little or no investigative action taken by officers from those forces. This was poor for these detainees and did not ensure that all cases were dealt with promptly.

3.27 The number of immigration detainees entering custody had increased in the previous year. Force data showed that the time in custody from the service of the authority to detain notice to the detainee's onward transfer was an average of 15 hours and 28 minutes, which was not excessive.

3.28 Individual rights and entitlements (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) were routinely explained to detainees. However, detainees were not always given the rights and entitlements notice, as required under paragraph 3.2 of PACE code C. These notices were also out of date, as they did not include the latest changes to PACE and the codes of practice.

3.29 Inspectors correctly authorised and recorded the reasons for delaying a detainee's right to have someone told of their detention (when they were being held incommunicado). However, they did not always tell the detainee in simple language why that decision had been taken, and for some detainees this right was not restored to them as early as possible. We found three cases in which the time limit imposed for the delay had not been strictly adhered to, and detainees had waited longer than they should have for someone to be told of their arrest and to make a telephone call from the custody suite. This did not comply with annex B of PACE code C.

3.30 Copies of the most recent PACE code C booklets were available at the custody suite. These were made available to detainees if they requested one.

3.31 Multilingual posters informing detainees of their right to free legal advice were clearly displayed in all the custody suites. However, these were not complete, only displaying languages from A to P alphabetically.

3.32 Some, but not all, custody sergeants and staff knew how to access PACE code C annex M documents, enabling non-English-speaking detainees to be provided with a range of translated documents about their detention in their own language.

3.33 Custody sergeants and staff routinely told detainees of the force retention and disposal policy for DNA. Samples of DNA were regularly transported from the custody suite. However, the refrigerator containing the samples was not properly secured with a lock, potentially compromising the integrity of stored samples.

Area for improvement

3.34 The force must consistently meet the requirements of PACE code C for the detention, treatment and questioning of suspects. In particular by:

- **consistently issuing an up-to-date rights and entitlement notice to all detainees, translated into the detainee's own language when required (paragraph 3.2 of PACE code C)**
- **clearly explaining to detainees who are held 'incommunicado' the reasons for this, and ensuring that it is lifted promptly when the reasons for invoking it have expired (annex B of PACE code C)**
- **ensuring that all custody sergeants and staff provide translated documents to non-English-speaking detainees about their detention in their own language (PACE code C Annex M documents).**

PACE reviews

3.35 Inspectors' PACE reviews of detention were generally purposeful and conducted in the interests of detainees' welfare, lawful detention, and rights and entitlements.

3.36 PACE reviews were carried out on time and conducted face to face with detainees. When reviews were carried out when the detainee was sleeping, these were only during recognised periods of rest. However, detainees were not always told on waking that a review had taken place, and reminded of their rights and entitlements, as required by paragraph 15.7 of PACE code C.

3.37 Acting or temporary inspectors often carried out PACE reviews and other PACE requirements. Although the content of these reviews was generally good, it was not clear that they had been authorised by a senior officer, as required under section 107 of PACE. None of the records we reviewed identified whether the acting or temporary inspector had had the approval of a senior officer or had completed training for the role. Some sergeants were acting into the role in an ad hoc arrangement, for a day at a time, when no other inspectors were available. This diminished the importance that should have been attached to this role and is not the intention underpinning section 107 of PACE, which sets out who can perform the role of a reviewing officer in relation to detention, along with other requirements, such as authorising intimate searches and the searching of premises.

3.38 We were concerned that, when detainees were held in the custody suite on behalf of other forces (see paragraph 3.26), reviewing inspectors did not adequately satisfy themselves that out-of-force investigations were being conducted diligently and expeditiously before they authorised continued detention on behalf of that force. These reviews were not always conducted with the same rigour as for the force's own detainees.

3.39 The recording of reviews was inconsistent and often lacked detail. Although we observed good engagement with detainees, comprehensive explanations by inspectors and a focus on detainee welfare, as well as their rights and entitlements, the records did not always reflect the good work done. There was too much use of 'copy and paste' excerpts placed on some detention logs, some of which were inaccurate, and the entries for the reviews we saw did not properly represent what we had seen taking place.

Area for improvement

3.40 The force should strengthen its approach to conducting PACE reviews of detention by:

- **ensuring that it meets the requirements of section 107 of PACE, so that all acting inspectors are appropriately authorised to perform the role and that this is clearly recorded on the custody record**
- **conducting rigorous reviews for detainees held in the custody suite on behalf of others forces, so that investigations are carried out promptly and that these detainees spend no longer than necessary in custody**
- **providing accurate and detailed entries on the custody detention log, reflecting the content of the review carried out and ensuring that all detainees are told the outcome of any review conducted while they were sleeping, as required by paragraph 15.7 of PACE code C.**

Access to swift justice

3.41 The force had recently introduced the systematic review of 'released under investigation' (RUI) cases, as well as the management of bail cases. An experienced custody sergeant was dedicated to scrutinising investigations and setting lists of actions and timescales to ensure that RUI and bail cases were dealt with promptly and effectively in the interests of victims, witnesses and suspects.

3.42 The decision to bail suspects with conditions was considered, and the rationale for 'necessity and proportionality' was accurately recorded both by investigating and authorising officers.

3.43 Applicable bail periods were carefully chosen to meet the requirements of the investigation, and were not excessive. Bail was only extended to allow officers to complete enquiries, strictly within the time allowed.

Complaints

3.44 At the time of leaving the custody suite, most detainees were asked how they had been treated while in custody and if they wanted to make a complaint. Detailed notices were clearly visible in the custody suite which explained how a detainee, or someone acting on their behalf, could complain about their treatment. This was reinforced in the individual's rights and entitlements notice. There was also a 'making a complaint' booklet in Braille.

3.45 Generally, custody staff were aware of the procedure for recording a complaint while a detainee was in custody, and referred these to the duty inspector. Inspectors told us that they would deal with any complaint as soon as the detainee was released from custody, but before they left the building, when this was possible. Few complaints were received but the nature of some we looked at suggested that they could have been dealt with during the detainee's time in custody, rather than relying on the more formal procedure on release.

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 The custody suite was old and dated but, overall, conditions and cleanliness were good, with little evidence of in-cell graffiti. A few cells lacked natural light, and the temperature in the suite was variable. Staff were unable to control the temperature but were alert to this and managed the situation by moving detainees to alternative cells when necessary. When cells had biological hazards that required a deep clean, these were removed promptly and efficiently by an external contractor.

4.2 The custody suite lacked some of the facilities that we would expect to be present, with no in-cell sinks, exercise yard, secure van dock (see also paragraph 5.8), accessible toilet/showers or privacy screening at the booking-in desks (see also paragraph 3.2 and areas for improvement 1.14 and 3.13).

4.3 There was CCTV coverage in all cells but the positioning of the monitors above head height at the booking-in desks made it possible for these to be seen by detainees and visitors to the suite, which compromised the dignity and privacy of the detainees on view. The positioning of these was also not ideal for staff carrying out constant monitoring via CCTV (level 3, according to APP) as they could easily have been distracted when the suite was busy.

4.4 The cell call bells we tested were functioning, and during the inspection were responded to promptly.

4.5 Daily checks of the physical environment, including cells and communal areas, were routinely conducted both by custody sergeants and DDOs, but there was no pre-determined checklist to ensure a consistent approach, and we found variances in the way they were carried out. These checks were not recorded to show that they had been completed. Any damage or faults were recorded locally and reported online to a central department. Minor faults were, in most cases, responded to promptly but staff told us that some repairs took considerably longer to be addressed. Positively, we identified no potential ligature points in the cells.

4.6 Custody staff had a reasonable awareness of the fire evacuation procedures and were aware of how and where to evacuate detainees in an emergency. However, most told us that they had not been involved in a fire drill in the previous 12 months, which contravened legal requirements. There were sufficient sets of handcuffs in the custody suite to evacuate the cells safely if required. Weekly fire alarms checks had lapsed for some months following the installation of a new system.

4.7 Custody staff received first-aid training which was appropriate to the demands and risks of custody. All staff we spoke to were confident in providing basic life support to detainees if required. The emergency bag was stored in the medical room. The contents were

appropriate and routinely checked by health staff. Custody staff could access and use this equipment, which included an automated external defibrillator, in the absence of an HCP.

Areas for improvement

4.8 Staff should conduct and record standardised daily cell checks.

4.9 The force should ensure that all custody staff take part in an annual fire drill.

Safety: use of force

4.10 Although the force collected data on the use of force in custody, its governance and oversight were not good enough (see also paragraph 1.21). Not all staff involved in such incidents completed the required use of force forms. In the incidents for which we requested documentation, we received none in some cases, and too few in the remaining cases. The recording of information in detention logs did not always make it clear that force had been used, and when it did, the entries often lacked sufficient detail to justify the use. Not all uses of force were recorded in custody records.

4.11 Data provided by the force showed that most of the custody staff were up to date with their personal safety training or were due to attend refresher training in the next few weeks.

4.12 Custody staff generally dealt patiently and reassuringly with some challenging and vulnerable detainees. They told us, and we observed, that they would only use force as a last resort and following appropriate negotiations with detainees.

4.13 We carried out an in-depth review of 14 recent cases involving the use of force, including cross-referencing against CCTV footage. Most incidents had been managed well overall and reflected sensitive treatment of the detainee. We made no formal referrals to the force. However, in three cases there were some learning points surrounding the use of poor restraint techniques, including one case of potentially dangerous prolonged prone restraint, which we shared informally with the force so that they could review them. The force did not review CCTV footage to assure itself that the force used had been proportionate to the risks posed or to identify any learning points.

4.14 Detainees did not routinely arrive in custody wearing handcuffs. When handcuffs were applied to compliant detainees for transportation, in most cases these were removed quickly on arrival at the custody suite.

4.15 In the previous 12 months, 219 detainees (12%) had been subject to a strip-search in custody, which was higher than we normally see. These searches took place in cells but not all staff were aware that CCTV monitors should be switched off during the searches, to maintain privacy. The records we examined showed that strip-searching was appropriately authorised and recorded on custody records, but this was not always the case when clothing was removed by force.

Area for improvement

4.16 The governance of the use of force in custody should be improved and provide assurance that when force is used it is safe and proportionate to the risk posed. In particular:

- **The force should collate accurate data concerning the use of force and ensure that all incidents are adequately recorded on custody records.**
- **All staff involved in incidents in which force is used should complete individual use of force forms.**
- **Incidents involving the use of force should be quality assured, including cross-referencing with closed-circuit television.**

Detainee care

4.17 Our observations and case reviews showed that detainees were generally treated with care and consideration. The detainees we spoke to confirmed they had been treated well in custody.

4.18 Food and drink were regularly offered throughout the day, including outside of recognised mealtimes, with staff willing to provide multiple meals when requested and appropriate. An adequate range of in-date microwave meals was available, including vegetarian and halal options, alongside recently introduced cereals and fresh milk for breakfast. Staff said that if a detainee had money and wished to buy other preferred foods, they would try to facilitate this, depending on operational demands at the time. Although food could not be brought in for a detainee by friends or family (following previous security breaches), there were satisfactory arrangements for buying alternative food, such as vegan or allergy-suitable items, from a nearby supermarket if required. Tea, coffee, hot chocolate and water were also available from the kitchen, but there was no drinking water available in cells. Although force policy required used food and drink detritus to be removed from cells as quickly as possible, this did not always happen.

4.19 All cells contained a toilet but none had hand-washing facilities. A sufficient supply and range of toiletry items were available, and detainees held for longer periods were regularly offered the opportunity to wash or shower. Of the limited number of detainees that we observed going to court after being held overnight, all had been given this option, as had all four detainees in our custody record analysis (CRA) who had been held for over 24 hours. Overall, we found that in 34% of the cases analysed, showers or washes had been offered, which compared favourably to other forces we have inspected since March 2016.

4.20 A large quantity of reading materials was available, including a small number in foreign languages (Lithuanian, Spanish), although there was nothing aimed at children. These were not offered routinely, but we saw some evidence of detainees being given these to help pass the time, although it was not clear whether this had been at the detainee's request. Visits from friends or family were not facilitated, even for those held over longer periods, such as weekends. A bespoke visits room in the custody suite was available but used for other purposes (including storage). Although some staff said that visits might be possible, none could recall any examples where this had been arranged.

4.21 Detainees were permitted to keep their own clothing, although cords, belts and laced shoes were removed routinely (see also paragraph 3.18 and area for improvement 3.20). When such items were confiscated, alternative tracksuit clothing items of suitable quality were

available, in all sizes, along with replacement underwear (male and female). Replacement footwear (plimsolls) was also available. However, we saw some detainees walking around the suite in socks or bare feet, which, as well as compromising their dignity, was a health and safety risk. Staff told us that detainees were allowed to have clothing brought in by friends or family.

4.22 Detainees were not provided with toilet paper unless they specifically requested it, and staff confirmed that this was standard practice. This contravened both force policy and the College of Policing's APP directive that toilet paper should be issued, subject to any individual risk assessment concerns identified.

4.23 There was no exercise facility available at the suite, which meant that detainees could be held in custody for long periods without having access to time outside; this was poor and contrary to College of Policing's APP. Staff said that, if directed by an HCP, a detainee could be escorted to stand near an open doorway for a short time but this would have to be carefully risk assessed and managed, given the lack of a secure airlocked area around the building. However, while offering some access to fresh air, this arrangement would still not allow for any physical exercise. Staff were aware of the problem and said that they would try to help detainees held for long periods feel more comfortable and content in other ways, such as by facilitating additional telephone calls to friends or family. One example they gave was of two foreign nationals waiting for transfer to an immigration detention centre whom staff allowed to sit and eat together outside their cell.

Area for improvement

4.24 Detainee care should be improved. In particular, detainees should: be able to access fresh air and exercise in a suitable facility; be routinely provided with toilet paper; and be provided with replacement footwear when theirs is removed.

Safeguarding

4.25 Safeguarding children and vulnerable adults was well understood and the officers we spoke to saw it as everyone's responsibility. This was emphasised in force policies and written guidance, and by training on vulnerability. A number of custody staff had benefited from training topics to help to identify safeguarding concerns – for example, on child sexual exploitation and people trafficking.

4.26 Arresting or investigating officers were mainly responsible for submitting safeguarding referrals for children and vulnerable adults. However, custody sergeants were expected to ensure that these were made and, when needed, to make referrals directly themselves.

4.27 In general, custody sergeants made good efforts to secure AAs for children as early as possible into their detention. When family members or friends could not attend within a reasonable time, custody sergeants requested an AA from The Appropriate Adult Service (TAAS), commissioned through the City of London Corporation. Although AAs from this service sometimes arrived only shortly before the interview, they attended during the night if required. In the cases we looked at, other than one exception, there had been no undue delays for children waiting to be supported by an AA.

4.28 The arrangements for securing AAs for vulnerable adults did not work well. Custody sergeants did not always consider whether an AA was needed for a vulnerable adult, despite force policy clearly stating the circumstances in which an AA should be called. In several

cases we looked at, information on the custody record suggested that consideration should have been given to securing an AA, but this had not taken place. When family members or friends were not available, custody sergeants relied on TAAS but there was no overnight provision, and we were told that AAs would normally only attend for the time of the interview. This meant that these vulnerable detainees were held in custody without support from an AA until arrangements could be made the following day.

4.29 The force did not monitor how long detainees waited before receiving support from an AA, whether this was a family member or from TAAS. This made it difficult for them to assess how well detainee needs were being met and identify where improvements were needed.

4.30 Guidance for AAs who were not familiar with the role was available in the suite, and we were told that it would be given out when needed, although this did not happen in a case we observed while in the suite.

4.31 Some children and vulnerable adults had their fingerprints, photographs and DNA taken without an AA present. Some custody staff told us that they thought this was an acceptable practice, and the force's policy also reflected this. However, this did not meet the requirements of paragraph 2.15 of PACE code D and was a cause of concern which we expected the force to address as a matter of urgency (see recommendation S35).

4.32 Good care was shown for children while in custody. Custody sergeants recognised the importance of keeping children away from adult detainees when booking them into custody, and of placing them in cells near to the booking-in area. We observed only one child in custody during the inspection, and they were cared for well.

4.33 The custody records of detained children also indicated good levels of care. This included family members being allowed to stay with children in their cells or in other areas of the custody suite; girls being assigned a female officer to care for their needs, in line with the Children and Young Person's Act 1933; all children being routinely seen by the health care professional and referred to the liaison and diversion scheme for support; the provision of easy-read rights and entitlements information and a specific guide to custody for children; and ensuring that all children were released home safely in the care of a responsible adult.

4.34 In addition, the duty superintendent was advised of any child entering custody, to check that the detention was justified and the case progressed as quickly as possible. Where possible, they, or a chief inspector, visited the child to ensure their welfare, check that they understood what was happening and provide reassurance.

4.35 Custody sergeants were well focused on minimising the time that children spent in custody. Cases were generally progressed quickly, including during the night, and in some of the cases we looked at this had resulted in children being released home and avoiding overnight detention. Only one child had been charged and refused bail in the previous 12 months. A request had been made to children's social services for alternative secure accommodation, but as there is no secure accommodation provision across the London area, this had not been provided. This had resulted in the child remaining in custody for 33 hours. The force was working with partners across London to develop arrangements to address the lack of alternative accommodation.

Area for improvement

4.36 The force should ensure that it consistently identifies when an appropriate adult is needed for a vulnerable adult, and that one is subsequently secured without undue delay.

Governance of health care

4.37 G4S Health Services (UK) Limited ran physical health care provision in the suite, and East London NHS Foundation Trust provided the criminal justice liaison and diversion services. There were good operational relationships between health care providers and the police. Clinical governance processes were in place but needed strengthening to drive improvement and to improve quality assurance, and a plan was being implemented to ensure that such steps were taken. Performance reports were produced and considered at a regular joint police and provider meeting, but the analysis and testing of the data supplied by the provider were not sufficiently robust.

4.38 A full clinical policy set was in place. Processes to report and review incidents were used appropriately, and an independent complaints process was advertised, although rarely used by detainees. In August 2018, there had been significant staffing problems, which had led to failures to meet some core elements of the contract and resulted in detainees not always receiving adequate support. The appointment of a new clinical lead had invigorated provision, and revised core and contingency staffing had seen a more sustainable embedded service introduced. Although not a contractual requirement, the presence of embedded HCPs was appreciated by custody staff and had led to improvements in detainee care. Electronic clinical records were not in use, which was a potential weakness, in terms of information management and governance. Staff supervision and support to front-line HCPs were also inadequate.

4.39 HCPs provided all clinical and forensic services appropriately, and a forensic medical examiner was available to provide advice and guidance over the telephone. According to our CRA, case audits and the performance data provided by the police, most detainees were generally seen in a timely fashion and in line with the contract expectations. Response times were appropriately linked to clinical and forensic priorities. In our CRA, the mean response time was 30 minutes, with the shortest being four minutes and the longest three hours and 25 minutes. A small number of detainees had waited too long to be seen, and the staffing shortages in August 2018 had resulted in the performance for the most urgent grade 1 referrals only achieving an 82.29% level of compliance with the contract timescales.

4.40 Mandatory training requirements were met but professional development opportunities, including input to group training and reflective practice, were more limited. The monitoring and assessment of the ongoing clinical competencies of HCPs, including a robust appraisal system, were underdeveloped.

4.41 The clinical room was shared with the mental health team. It was clean, well maintained and complied with infection prevention standards. Clinical equipment and general stock were good. There was a CCTV camera in the room which recorded activity digitally. Although the treatment couch area was pixelated and the images were not directly monitored, the presence of CCTV was inappropriate and could be off-putting to detainees.

Area for improvement

4.42 Joint performance monitoring meetings should routinely analyse evidence about all aspects of staffing (vacancies, contingencies, training and supervision) and focus performance data to obtain assurance about detainee outcomes rather than simply considering health care practitioner activity.

Patient care

4.43 Custody staff valued the embedded G4S HCPs and could approach them directly to discuss concerns. Appropriate referrals were made, based on identified need or at the request of the detainee.

4.44 During the inspection, few detainees were booked in and there was limited opportunity to observe the work of HCPs or talk to detainees about their experiences of the service. However, we reviewed clinical records, considered information from our case audits and spoke to some HCPs about their background and competencies. We found HCPs to be experienced and knowledgeable, with the skills to deliver effective support to detainees. The records we reviewed varied in quality but mostly provided an appropriate care and treatment plan that kept detainees safe.

4.45 Professional telephone interpreting services were available. Consent was appropriately sought and recorded. The introduction of a single electronic recording system was being considered, which was positive, and all significant risk and medication issues were appropriately captured in the custody record.

4.46 Medicines management arrangements were good. Drug cupboards were secure and accessible only to health care staff. On the few occasions when embedded HCPs were not present at the suite, custody staff had access to a small range of simple over-the-counter medications, which they could administer after receiving telephone approval from a forensic medical examiner. They also had access to, and were trained to administer, naloxone (used in the event of an opiate overdose). There was an appropriate range of patient group directions (which enable nurses to supply and administer prescription-only medicine), although most of these needed to be reviewed. A suitable range of stock medicines, including controlled drugs, was available, safely stored and fully accounted for, with sound medicine reconciliation arrangements in place. Detainees could access prescribed medicines, provided that these were checked by HCPs, and these were then held appropriately within secure personal lockers.

4.47 Detainees could be provided with symptomatic relief for drug and alcohol withdrawal, including those attending court. Prescribed opiate substitution treatment could be continued for detainees in custody when deemed clinically appropriate. Nicotine replacement therapy was also available.

Substance misuse

4.48 Detainees were subject to drug testing based on their arrest profile, and this triggered referral to specialist community services when appropriate. The Westminster Drug Project provided face-to-face support and brief interventions to detainees with substance misuse or alcohol problems, through a dedicated team working from Monday to Friday, based at Bishopsgate. The team was part of a range of local community services facilitated by the Corporation of London which enabled detainees to be appropriately diverted away from custody, and they provided good support and effective follow-up. Practitioners undertook twice-daily 'cell sweeps' to offer help to all detainees. When the team was off-site, custody and other health staff could make appointments directly into the team's diary, and practitioners had access to the custody records to record their contacts.

4.49 On leaving custody, detainees who needed it were given information on a range of relevant community-based services. Health promotion advice was offered directly to detainees signposted to harm minimisation community services; these services could provide access to naloxone and sterile injecting equipment.

Mental health

4.50 East London NHS Foundation Trust's (ELFT) criminal justice liaison and diversion team was based in Bethnal Green but supported detainees at Bishopsgate with mental health needs. Demand was low, with 14 referrals received between May and September 2018. The service provided an all-age and vulnerability model but few children needed this provision. A dedicated mobile phone hotline enabled custody staff to make direct contact for urgent support, and referrals were confirmed through a generic email account that was routinely monitored.

4.51 The service operated Monday to Friday, 8am to 9pm, and attended the suite when required. We found that most initial contacts and support were provided in a timely fashion and that the service offered was generally good. However, referrals made towards the end of a shift were unlikely to be seen that day, which potentially incurred risks. G4S provided out-of-hours cover, but were not able to offer the same level of service, although they could access the emergency duty team if a formal MHA assessment was required. We were told that there were imminent plans to introduce a comprehensive suite-based service, operating seven days a week.

4.52 Custody staff had a good knowledge of mental health issues, and regular training was provided to sergeants and DDOs, with additional bespoke sessions also provided by ELFT. Custody staff appropriately referred detainees based on reported risk and presentation, and were generally positive about the support provided by ELFT practitioners. The team routinely accessed their own organisation's health records to ascertain if detainees were known to services, and also liaised with other providers to gain further information and share the input provided when necessary.

4.53 Between May and September 2018, two MHA assessments had been carried out, with one detainee being admitted to hospital. Data provided indicated that waiting times for an MHA assessment were between one hour 45 minutes and six hours, and we were told that admissions to mental health beds in the East London area were usually accessible within a reasonably timely manner.

4.54 There were good joint working arrangements between the police and mental health services. Strategic oversight and partnership were coordinated by the service commissioner, which ensured that the needs of the detainee had an appropriate focus and had led to the plans for an enhanced provision.

4.55 An effective street triage scheme, jointly run by police and ELFT mental health practitioners, was in operation seven days a week, between 5pm and 3am. This provision was rightly regarded as a major factor in diverting vulnerable people away from custody, and was seen by custody staff as an invaluable resource. No detainees had been held in custody as a place of safety under section 136 of the MHA in, at least, the previous 12 months, and there was good access to the designated local hospital section 136 suite.

Area for improvement

4.56 The provision of the planned embedded seven-day pilot scheme should be introduced as soon as practically possible.

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 Overall, there was a good focus on ensuring that detainees were released safely. Our examination of cases and our observations assured us that detainees underwent a pre-release risk assessment. Although details were limited, these mostly reflected that previously identified risks had been addressed or mitigated before release. However, we were often unable to determine from the records how detainees had returned home after release.

5.2 The practice we observed was much better than the records indicated. All the pre-release risk assessments we observed showed good attention to securing a safe release for detainees. Initial risk assessments and care plans were checked, to ensure that all identified risks had been addressed or managed before release. All detainees were asked if they had the means to get home, but although custody staff had access to petty cash, this was not always routinely offered or issued to facilitate journeys home by public transport, and there were no travel warrants available. Custody staff said, and our case audits showed, that vulnerable detainees and children were taken home by police officers if they had no other means of transport available to them.

5.3 A support leaflet with useful telephone numbers was available but this was not routinely given to all detainees on their release.

5.4 The quality of information in the person escort records (PERs) we examined was generally good. However, many PERs also included additional loose-leaf documents, such as risk assessments and confidential medical notes, which was unnecessary.

Areas for improvement

5.5 The recording of release arrangements, to ensure that detainees are released safely, should be more detailed.

5.6 Unnecessary documentation should not be added to person escort records, and any medical examination notes that need to accompany the detainee should be placed in a sealed envelope marked 'confidential'.

Courts

5.7 Custody staff told us that the local remand courts would normally accept detainees until approximately 3pm on weekdays, which was reasonable. However, the 9am acceptance deadline imposed by the courts on Saturdays was too early. We were told that there was generally some flexibility each day, depending on how busy the courts were. We found no evidence that court acceptance times resulted in detainees being held in custody for longer than necessary.

5.8 We were told that, due to the absence of a secure van dock (see also paragraph 4.2), detainees were sometimes handcuffed and walked from the police custody suite, up a side road, to board the escort vehicle outside the main police station entrance, in view of passing motorists and pedestrians, which failed to protect their dignity and privacy.

Area for improvement

5.9 Detainees should be moved to escort vehicles in a way which protects their dignity and privacy.

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

Cause of concern and recommendation

6.1 **Cause of concern:** Some children and vulnerable adults were fingerprinted, photographed and had DNA taken without having an AA present. This did not meet the requirements of paragraph 2.15 of PACE code D.

Recommendation: The force must take immediate action to ensure that all children and vulnerable adults have an appropriate adult present when taking fingerprints, photographs and DNA. (S35)

Areas for improvement

Leadership, accountability and partnerships

6.2 The force should ensure that there is sufficient oversight of how minimum staffing levels are maintained in the custody suite, and the level of overtime in use to achieve these. (1.13)

6.3 The force should address the unsatisfactory conditions that some detainees experience in the suite, especially those detained for long periods, and ensure that the facilities and arrangements for detainees with disabilities and those with limited mobility are suitable. (1.14)

6.4 The force should ensure that all staff follow the College of Policing *Authorised Professional Practice* and its own policies and procedures to achieve consistent outcomes for detainees. (1.15)

6.5 The force should manage the health care contract effectively, with escalation to a senior level when the service falls below the standard required. (1.16)

6.6 The force should improve its approach to performance management by collecting comprehensive information, and analysing this to show how well the service is performing and identify where improvements are needed. (1.28)

6.7 Custody records should be completed to a consistently high standard. The recording of information on detention logs should be sufficiently detailed and include all relevant information. Quality assurance processes should ensure that the custody records meet the required standards. (1.29)

6.8 The force should analyse data relating to diversity, to ensure that outcomes for all detainees are fair and demonstrate that custody services are meeting the public sector equality duty. (1.30)

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

6.9 Staff should routinely consider, and take any appropriate actions to preserve, detainees' privacy at the booking-in desk. (3.13)

6.10 The approach to managing some elements of risk should be improved. In particular:

- Detainees who are intoxicated should be placed on observation levels that include rousals.
- Detainees' clothing and footwear should only be removed based on an individual risk assessment.
- All custody staff should be involved collectively in shift handovers. (3.20)

6.11 The force must consistently meet the requirements of PACE code C for the detention, treatment and questioning of suspects. In particular by:

- consistently issuing an up-to-date rights and entitlement notice to all detainees, translated into the detainee's own language when required (paragraph 3.2 of PACE code C)
- clearly explaining to detainees who are held 'incommunicado' the reasons for this, and ensuring that it is lifted promptly when the reasons for invoking it have expired (annex B of PACE code C)
- ensuring that all custody sergeants and staff provide translated documents to non-English-speaking detainees about their detention in their own language (PACE code C Annex M documents). (3.34)

6.12 The force should strengthen its approach to conducting PACE reviews of detention by:

- ensuring that it meets the requirements of section 107 of PACE, so that all acting inspectors are appropriately authorised to perform the role and that this is clearly recorded on the custody record
- conducting rigorous reviews for detainees held in the custody suite on behalf of other forces, so that investigations are carried out promptly and that these detainees spend no longer than necessary in custody
- providing accurate and detailed entries on the custody detention log, reflecting the content of the review carried out and ensuring that all detainees are told the outcome of any review conducted while they were sleeping, as required by paragraph 15.7 of PACE code C. (3.40)

In the custody cell, safeguarding and health care

6.13 Staff should conduct and record standardised daily cell checks. (4.8)

6.14 The force should ensure that all custody staff take part in an annual fire drill. (4.9)

6.15 The governance of the use of force in custody should be improved and provide assurance that when force is used it is safe and proportionate to the risk posed. In particular:

- The force should collate accurate data concerning the use of force and ensure that all incidents are adequately recorded on custody records.
- All staff involved in incidents in which force is used should complete individual use of force forms.
- Incidents involving the use of force should be quality assured, including cross-referencing with closed-circuit television. (4.16)

6.16 Detainee care should be improved. In particular, detainees should: be able to access fresh air and exercise in a suitable facility; be routinely provided with toilet paper; and be provided with replacement footwear when theirs is removed. (4.24)

6.17 The force should ensure that it consistently identifies when an appropriate adult is needed for a vulnerable adult, and that one is subsequently secured without undue delay. (4.36)

6.18 Joint performance monitoring meetings should routinely analyse evidence about all aspects of staffing (vacancies, contingencies, training and supervision) and focus performance data to obtain assurance about detainee outcomes rather than simply considering health care practitioner activity. (4.42)

6.19 The provision of the planned embedded seven-day pilot scheme should be introduced as soon as practically possible. (4.56)

Release and transfer from custody

6.20 The recording of release arrangements, to ensure that detainees are released safely, should be more detailed. (5.5)

6.21 Unnecessary documentation should not be added to person escort records, and any medical examination notes that need to accompany the detainee should be placed in a sealed envelope marked 'confidential'. (5.6)

6.22 Detainees should be moved to escort vehicles in a way which protects their dignity and privacy. (5.9)

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

There should be systematic and clearly recorded quality assurance of custody records, linked to evidence from closed-circuit television, person escort records and staff handovers. (2.17)	**Partially achieved**

National issues

Appropriate adults should be available to support without undue delay juveniles aged 17 in custody, including out of hours. (2.18)	**Achieved**

Strategy

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

Recommendations

G4S Forensic Medical Services should be part of the custody user group. (3.9)	**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

Arrangements in booking-in areas should allow for private communication between detainees and staff. (4.9)	**Not achieved**
There should be designated adapted cells that have a lowered call bell. (4.10)	**Not achieved**
There should be a range of items at both suites to facilitate religious observance. (4.11)	**Achieved**
All custody staff should be involved in the same shift handover; where possible this should take place away from the booking-in area and be recorded. (4.19)	**Partially achieved**
Bus fares should be provided to bailed or released detainees who have no legitimate means of getting home. (4.20)	**Partially achieved**

The City of London Police should collect and analyse data about use of force and strip searching in accordance with the Association of Chief Police Officer's policy and National Policing Improvement Agency guidance. (4.25)	**Partially achieved**
All cells should be clean and free of graffiti. (4.32)	**Achieved**
Custody staff should ensure that non-custodial staff do not visit detainees in cells unsupervised. (4.33)	**Achieved**
Regular fire evacuation drills should be carried out and recorded, with sufficient handcuffs available. (4.34)	**Partially achieved**
All detainees held overnight, or who require one, should be offered a shower. (4.44)	**Achieved**
Adequate stocks of replacement clothing should be held at both suites. (4.45)	**Achieved**
Suitable facilities should be provided for detainees to have exercise in the open air. (4.46)	**Not achieved**
A range of reading materials should be offered, including books and magazines suitable for young people and non-English speakers. (4.47)	**Partially achieved**
Visits should be facilitated for vulnerable young people or detainees held for long periods. (4.48)	**Not achieved**

Individual rights

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

Recommendations

Information about detainees' rights and entitlements should always be available in formats that meet the needs of detainees whose literacy is limited. (5.8)	**Partially achieved**
The City of London Police should engage with the local authority to ensure the provision of safe beds for juveniles who have been charged but cannot be bailed to appear in court. (5.9)	**Partially achieved**
Detainees should be routinely informed about how they can make a complaint about their care and treatment, and be able to do this before they leave custody. (5.18)	**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

All clinical rooms should be fit for purpose and meet infection control guidelines. (6.6)	**Achieved**
All medications should be stored safely and securely at all times. (6.13)	**Achieved**
Secondary dispensing should not be routine. (6.14)	**Achieved**
There should be a mental health liaison and/or diversion scheme to enable detainees with mental health problems to be identified and diverted in to appropriate mental health services as required. (6.22)	**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.

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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.

The audits examine a range of issues to assess how well detainees are treated and cared for in custody. For example, the quality of the risk assessments, whether observation levels are met, the quality and timeliness of Police and Criminal Evidence Act (PACE) reviews, if children and vulnerable adults receive timely support from appropriate adults, and whether detainees are released safely. Where force is used against a detainee, we assess whether it is properly recorded and if it is proportionate and justified.

Observations in custody suites

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

Interviews with key staff

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

Focus groups

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

Feedback to force

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

Appendix III: Inspection team

Kellie Reeve	HMI Prisons team leader
Lee Bruckshaw	HMI Prisons inspector
Fiona Shearlaw	HMI Prisons inspector
Patricia Nixon	HMI Constabulary and Fire & Rescue Services inspection lead
Anthony Davies	HMI Constabulary and Fire & Rescue Services inspection officer
Adrian Gough	HMI Constabulary and Fire & Rescue Services inspection officer
Steve Eley	HMI Prisons health services inspector
Matthew Tedstone	Care Quality Commission inspector
Joe Simmonds	HMI Prisons researcher
Patricia Taflan	HMI Prisons researcher