Report on an unannounced inspection visit to police custody suites in

Nottinghamshire Police

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

1–12 October 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

We try to make our reports as clear as possible, but if you find terms that you do not know, please see the glossary in our 'Guide for writing inspection reports' on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

Any enquiries regarding this publication should be sent to HM Inspectorate of Prisons at 3rd floor, 10 South Colonnade, Canary Wharf, London E14 4PU, or hmiprisons.enquiries@hmiprisons.gsi.gov.uk, or HM Inspectorate of Constabulary and Fire & Rescue Services at 6th Floor, Globe House, 89 Eccleston Square, London SW1V 1PN, or contact@hmic.gsi.gov.uk

This publication is available for download at: http://www.justiceinspectorates.gov.uk/hmiprisons/ or http://www.justiceinspectorates.gov.uk/hmicfrs/

Printed and published by:
Her Majesty's Inspectorate of Prisons
Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services

Contents

Contents

Fact page[1]

Force
Nottinghamshire Police

Chief Constable
Craig Guildford

Police and Crime Commissioner
Paddy Tipping

Geographical area
Nottinghamshire

Date of last police custody inspection
12-16 March 2013

Custody suites	**Cell capacity**
Bridewell (Nottingham city centre)	71 cells
Mansfield	32 cells
Newark (contingency suite)	10 cells

Annual custody throughput
18,542

Custody staffing

Inspectors	7
Custody sergeants	40 plus one bail management sergeant
Detention officers	60

Health service provider
Mitie Care and Custody

[1] Data supplied by the force.

Executive summary

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

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

S3 We last inspected custody facilities in Nottinghamshire Police in 2013. This inspection found that of the 19 recommendations made during that previous inspection, nine had been achieved, one had been partially achieved and nine had not been achieved

S4 To aid improvement we have made five recommendations to the force (and the Police and Crime Commissioner) addressing key causes of concern, and have highlighted an additional 25 areas for improvement. These are set out in Section 6.

Leadership, accountability and partnerships

S5 Overall this inspection of facilities in Nottinghamshire found that many aspects of custody services were not being delivered to the standards expected or required. There had been too little progress since our last inspection in 2013, and we identified several causes of concern and areas requiring improvement.

S6 While part of a wider formal regional collaboration with three neighbouring forces, Nottinghamshire Police had a governance structure, with clear lines of accountability for the force's custody services. Despite this, we found a lack of day-to-day leadership and oversight in custody suites. Some policies were out of date and did not always reflect College of Policing Authorised Professional Practice. There was a particular issue with understanding around what constituted, and when to report, an adverse incident. The combination of these issues meant that staff often lacked clear direction. The initial and ongoing training for custody staff was adequate. There was an over-reliance on covering shortfalls in custody officer staffing with overtime. Staff were not always deployed in the most effective way, which sometimes impacted adversely on detainees.

S7 The force did not always meet the requirements of all aspects of the Police and Criminal Evidence Act (PACE) 1984 on the detention, treatment and questioning of detainees, or some of its codes of practice, which was a cause of concern. Examples where the force was not meeting the requirements of PACE are detailed throughout the report in paragraphs 1.7, 3.27, 3.32, 3.33, 3.34 and 3.41.

S8 The force was not managing the performance of custody services as well as possible. Although improving, performance information was not comprehensive, and some of the data were unreliable. The recording and reporting of adverse incidents in custody were not adequate.

S9 The culture of custody services was not effective in underpinning good detainee care. During our inspection, we found some concerning staff attitudes that were leading to punitive and unfair treatment of detainees.

S10 The quality of custody records was mixed and we found that important information was often not recorded. The quality assurance system was not sufficiently focused or robust enough to have identified or addressed the deficiencies we found.

S11 The force facilitated external scrutiny and was visited regularly by volunteers from an active Independent Custody Visitor (ICV) scheme.

S12 There was a focus on diverting vulnerable people away from custody. There were good partnership arrangements for the provision of support for detainees with mental ill health, and custody was now rarely used as a place of safety under section 136 of the Mental Health Act.[2] The position for children was, however, not so positive; too many who were charged and had bail refused were detained overnight when alternative local authority accommodation should have been provided.

Pre-custody: first point of contact

S13 Frontline officers had a good understanding of vulnerability and took this into account when deciding what action to take when dealing with an incident. We were told that the information they received from the control room was not always sufficient, but they were able to access the police national computer and other information on their mobile devices, which helped mitigate this.

S14 Frontline officers told us they were focused on diverting children and vulnerable people from custody and actively explored alternatives, and that in general they had good support for dealing with individuals experiencing mental ill health.

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

S15 The booking-in areas did not provide sufficient privacy for detainees to disclose personal or confidential information but this was mostly managed with sensitivity. In general, custody staff interacted with detainees courteously but this was not always the case when suites were busy. Custody staff identified and responded reasonably well to meet the individual and diverse needs of detainees, particularly women, transgender and older people. The arrangements to meet the needs of detainees who spoke little or no English were, however, sometimes poor.

S16 The approach to identifying risk was good but the response to managing it was inconsistent and not always robust. Most detainees experienced minimal waits to be booked into custody, and it was positive that children and other vulnerable detainees were prioritised. The initial assessments of risk were generally completed well but the observation levels set for some detainees, particularly those who presented as being under the influence of drugs and/or alcohol, did not always match the risks posed. By contrast, detainees presenting the highest risks received constant monitoring through CCTV or close proximity supervision. We found only limited use of anti-rip clothing, which was positive. Handovers between different staff shifts were poor; they were disparate, not undertaken collectively and the exchange of information did not always focus sufficiently on detainee welfare.

---

[2] Section 136 enables a police officer to remove someone from a public place, and take them to a place of safety – for example, a police station – to enable the person to be examined by a doctor and interviewed by an approved mental health practitioner, and to make of any necessary arrangements for their treatment or care.

S17 There was insufficient focus on ensuring that detainees always received information about their individual and legal rights. Detainees often experienced unnecessarily lengthy periods of detention, which was attributed to slow progress by investigating officers and delays in securing professional interpreters and appropriate adults (independent individuals who provide support to children and vulnerable adults in custody).

S18 The arrangements for reviewing detainees' detention were not adequate. Reviews were often not carried out in the best interests of the detainee. They were generally conducted poorly, with little or no understanding of the importance of the inspector's responsibilities for detainees' lawful detention, welfare, and rights and entitlements.

S19 The initial management of bail and processes to release under investigation (RUI) were effective. However, there was little emphasis on promoting detainees' rights to make complaints. Although the recorded number of complaints about custody was low, we found complaints that had been made but that were not recorded or dealt with before detainees left custody.

In the custody cell, safeguarding and health

S20 Nottinghamshire's custody estate was dated, and the conditions of the custody suites had deteriorated since the last inspection. Some cells were uncomfortably cold, and cleaning arrangements were not always good enough. We found potential ligature points in all three suites. At the end of the inspection we provided the force with a comprehensive illustrative report detailing the conditions and potential ligature points we had identified.

S21 The mechanisms to assure the force, the Police and Crime Commissioner and the public that the use of force in custody was always safe and proportionate were not sufficient. The recording and reporting of the use of force were not comprehensive, and staff did not always submit the required individual use of force forms to justify the need for force against detainees.

S22 Staff were generally patient when dealing with challenging detainees. Handcuffs were removed quickly from compliant detainees, and strip searching was justified and properly authorised. However, our examination of cases and CCTV footage identified a number of concerns. These included the lack of proportionality of the force used, poor techniques, and too little attention to maintaining detainees' dignity. We made a formal referral of one case we looked at for the force to review.

S23 The care provided by custody staff to detainees was inconsistent. Although most were given food and drinks at regular intervals, other aspects of care, such as access to exercise, showers and reading material, were not offered routinely. Some detainees were denied access to amenities and their requests were ignored by custody staff without adequate justification for this.

S24 Frontline and custody officers had a good understanding of safeguarding children and vulnerable adults. They tried to keep children in custody for as little time as possible but did not always achieve this, and there was no supervision at a senior level to ensure that cases involving children were dealt with as soon as possible. Children and vulnerable adults did not receive consistently early support from appropriate adults.

S25 The health provision was improving under new contract arrangements, with embedded practitioners delivering a more consistent service. Some aspects of clinical governance needed further enhancement to provide greater assurance on performance activity.

Individual care was mostly prompt and delivered by experienced and skilled health care practitioners. The governance of medicines management was effective.

S26 Opiate substitution treatment was provided, but nicotine replacement therapy was not available through the health provider, which caused unnecessary pressure for detainees who smoked. Substance misuse services were very good in the Nottingham Bridewell but there was no equivalent service for detainees held at Mansfield.

S27 Mental health liaison and diversion services were very good for the majority of detainees and included an impressive range of outreach and follow-up work post-release However, it was of concern that too many detainees who would have benefited from their support were not seen. For people brought into custody who subsequently required mental health assessments, they were generally timely. However, there were delays for some mentally ill detainees waiting for transfers to appropriate facilities due to a lack of inpatient beds and problems organising transportation.

Release and transfer from custody

S28 There was a lack of appropriate care and focus on the safe release of detainees, including the most vulnerable. Although the suites held travel warrants and petty cash, these were not always widely used to help detainees without adequate means get home safely. The recording of pre-release risk arrangements was often poor, and did not satisfy us that initial and ongoing risks had been adequately addressed or mitigated before release.

S29 The acceptance times at local magistrates' courts varied and were sometimes too early. This meant that some detainees were not presented before the first available court, leading to unnecessarily prolonged detention.

Causes of concern and recommendations

S30 **Cause of concern:** There were too many areas where the force was not meeting the requirements of legislation or guidance, notably codes C and G of the Police and Criminal Evidence Act codes of practice; this required immediate remedial action.

Recommendation: The force must with immediate effect ensure that all custody procedures fully comply with the requirements of legislation and guidance, and that officers consistently implement these. Quality assurance processes should test compliance with legislative requirements.

S31 **Cause of concern:** The culture of the custody service was not effective in focusing on the fair and equitable treatment of all detainees; some custody staff took punitive actions against detainees that were not justified and potentially unfair.

Recommendation: The force should ensure that staff treat all detainees fairly and with respect, and are accountable for their actions. This should be demonstrated in the culture of custody services, along with effective monitoring to show fair and equitable treatment.

S32 **Cause of concern:** The arrangements for and staff knowledge of the recording and reporting of adverse incidents in custody were not adequate in ensuring that all incidents were identified appropriately and dealt with in line with legislative requirements.

Recommendation: Nottinghamshire Police should ensure that staff understand their responsibilities in recording and reporting adverse incidents that occur in its custody suites. All incidents that fall within the definition of a death or serious injury matter under section 12 of the Police Reform Act 2002 must be referred to the Independent Office for Police Conduct (IOPC).

S33 **Cause of concern:** The governance and oversight of the use of force in custody were not adequate, data were unreliable and not all staff completed use of force forms. Some use of force was disproportionate to the risk or threat posed.

Recommendation: Governance and oversight of the use of force should provide assurance that all use of force is proportionate to the risk posed, and this should include comprehensive review of incidents against the records on CCTV.

S34 **Cause of concern:** There was a lack of appropriate care and focus on the safe release of detainees, including the most vulnerable; the pre-release arrangements were not adequate to ensure safe release.

Recommendation: There should be an improved focus on release arrangements for detainees: pre-release risk assessments should be carried out routinely with all detainees to ensure their safe release.

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 Nottinghamshire force we analysed a sample of 128 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 Nottinghamshire Police is part of a regional collaboration with three neighbouring forces (Leicestershire, Lincolnshire and Northamptonshire) under section 22 of the Police Act 1996. The East Midlands Criminal Justice Service is responsible for policy, training and resources for custody across the four forces, and some governance functions. The force's assistant chief constable provided local accountability, supported by a chief inspector who was responsible for the day-to-day custody function. Specialist staff were trained and accredited to deliver custody services. This structure provided clear accountability for the safe delivery of custody.

1.2 There were appropriate governance and performance meetings at both local and regional level. However, at the time of our inspection the focus of regional meetings was directed towards demand and resourcing in the suites, rather than the delivery of safe custody. This limited the oversight of detainee care and other aspects of custody services at a strategic level.

1.3 There was a lack of day-to-day operational leadership and direction in the suites. Staff were not always deployed in the most effective way, tasks and responsibilities were not clearly defined, and the suites, in particular the Bridewell in central Nottingham, were disorganised and at times chaotic. There were seven Police and Criminal Evidence Act (PACE) inspectors who should have been responsible for all aspects of management of the suites. However, they were not visible and told us that other custody demands often prevented them providing effective direction and oversight.

1.4 The significant shortfall in the number of custody officers was being addressed through overtime. The force was, however, recruiting to address this shortage. Although there was the required complement of detention officers, they were not always deployed effectively, and this sometimes affected detainee care, particularly at busy times. Our observations and case audits showed that cell call bells were not answered promptly (see paragraph 3.20), and not all staff were included in the shift handovers (see paragraph 3.23). The force needed to have sufficient staff on all shifts to ensure safe detention.

1.5 There was a good commitment to initial custody training, and staff were accredited and received ongoing professional development. Staff had a period of shadowing more experienced colleagues before undertaking their duties, and they completed a competency-based workbook.

1.6 The force followed *Authorised Professional Practice - Detention and Custody* (APP) as set by the College of Policing.[5] There were also additional local policies, including a regional custody procedures document and a joint mental health protocol, but these were out of date and some of the guidance was at odds with APP. Not all the practices we observed complied

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

with either APP or local policy. The force needed to ensure that staff had current and clear guidance to follow, and monitor their adherence to it.

1.7 Some practices did not always comply with some elements of codes C and G of the PACE code of practice for the detention treatment and questioning of suspects. (code C 2.1a, 3.4, 5.3c, 15.14, 15.7 and code G 4.3). These included arresting officers not giving the circumstances of the arrest to the custody officer with the detainee present, and detainees not told that there had been a review of their detention while they were sleeping. This required immediate remedial action (see cause of concern and recommendation S30).

1.8 The force had a new contract for the delivery of health care services in custody. This had only been in place since June 2018 and the governance arrangements were not yet embedded. It was too early to assess how well the new governance arrangements were working at the time of this inspection. However, there were early signs that health care practitioners saw most detainees within the agreed timescales (see paragraph 4.36).

1.9 During the inspection, we found that the culture of custody services did not always underpin good detainee care. In particular, we saw staff display some concerning attitudes that led to the punitive and potentially unfair treatment of detainees. This included a detainee who became difficult when released to police officers to be transported to court and who was then placed back in his cell and kept a further night with no justification for this decision recorded. We also observed staff denying amenities to detainees when, in our view, there was no justification for this, and staff were not held accountable when taking these actions. This led to inequitable treatment in the care of detainees, and did not ensure that all detainees were treated fairly and with respect. (See cause of concern and recommendation S31.)

Areas for improvement

1.10 Governance meetings should include sufficient oversight of detainee care to ensure that this always meets the standards expected for detainees.

1.11 There should be sufficient staff appropriately deployed to meet the demands of the service and ensure safe detention. PACE inspectors should have capacity to have robust oversight of the day-to-day management of the custody suites.

1.12 The force should ensure that clear and current policies and guidance are available to staff and monitor adherence to this.

Accountability

1.13 The collation and monitoring of performance data on custody were improving but were not comprehensive across all key areas of activity. Some gaps in data on custody performance prevented the force from assessing how well it was doing, and identifying trends and informing learning. For example, it was unable to provide data on the average time detainees were held before they were charged, or the number of people who were dealt with by voluntary attendance[6] rather than under arrest.

1.14 Performance was managed at a regional level. The regional arrangements focused on comparison between the four forces to share learning and drive improvement. However, the understanding of the performance information was limited in some areas. For example,

[6] Where suspects involved in minor offences attend a police station by appointment for interview, avoiding the need for arrest and subsequent detention.

Nottinghamshire Police was seen as an outlier because it carried out more CCTV level 3 (constant observation) and level 4 (close proximity) observations of detainees to manage the risks they posed than the other forces. Further investigation by the force showed that these levels of observations were set appropriately, and our inspection findings concurred with this. However, although there was no directive from the force, this approach from the region had created pressure on staff who told us they perceived they should be reducing their use of these levels of observation, and it had not led to the region considering whether the observation levels were being correctly set across the other forces. Without an understanding of the factors underpinning performance information, this approach to managing performance could potentially have unintended outcomes, with staff not clear about the performance they are expected to achieve.

1.15 The recording and reporting of adverse incidents in custody were not adequate and had not improved since our previous inspection. Despite the clear guidance available, staff we spoke to had insufficient knowledge of their responsibilities. We identified and referred a case that the force should have recorded as an adverse incident directly to the Independent Office for Police Conduct (IOPC), to comply with requirements set out in the Police Reform Act 2002. (See cause of concern and recommendation S32.)

1.16 The force did not have adequate mechanisms to assure itself, the Police and Crime Commissioner and the public that the use of force in detention and custody was always safe and proportionate. While there were data on incidents in custody suites, they were not reliable or collated clearly enough to enable effective scrutiny. There was insufficient governance and oversight to ensure force was used proportionately, and little cross-reference with CCTV records to assess how safely techniques were deployed. Not all staff completed individual use of force forms as required by the National Police Chiefs Council. (See cause of concern and recommendation S33.)

1.17 The quality of custody records needed to be improved. Although there was more narrative than we often see, our case audits and observations showed that some important information was not always recorded. This included justification for decisions made about detainees; in one case a mental health assessment was required but not conducted, with no reason for this recorded. There was a quality assurance process, in which inspectors sampled custody records. However, this was not sufficiently focused or robust enough to have identified or addressed the non-compliance with the codes of practice or the gaps in recording that we found.

1.18 The force had an understanding of the public sector equality duty and had provided staff with some training in dealing with diverse needs. However, there was little monitoring by ethnicity or other protected characteristics to demonstrate that all detainees were treated fairly and equitably while in custody.

1.19 The force was open to external scrutiny and responded positively to any concerns raised through the Independent Custody Visitors (ICVs). There were regular meetings where issues could be raised and discussed.

Areas for improvement

1.20 Nottinghamshire Police should use the regional performance information gathered for each force to understand the underlying factors for any variance so that staff can clearly identify and address any concerns.

1.21 The force should be able to demonstrate that it meets its public sector equality duty, and that outcomes for all detainees are fair and equitable.

1.22 Custody records should include all key information and clear justifications for any decisions made. Quality assurance of the records should ensure they meet the required standards.

Partnerships

1.23 The force had a strategic focus on diverting vulnerable people away from custody, and all staff had a good understanding of this. The number of children arrested and bought into custody was reducing. However, outcomes for children who were charged and refused bail remained poor, with too many detained in custody overnight when alternative accommodation should have been provided by the local authority.

1.24 There were good partnership arrangements for the provision of support for detainees with mental ill health. The force had held only three people in its custody suites as a place of safety under section 136 of the Mental Health Act (see footnote 2) in the previous 12 months (see also paragraph 2.4).

1.25 The force was monitoring the number of people arrested for an offence who subsequently required a mental health assessment while in custody. It also collected data to identify the average time taken to facilitate the assessment and transfer the detainee to a more appropriate health-based place of safety.

Section 2. Pre-custody: first point of contact

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

Assessment at first point of contact

2.1 Frontline officers had a good understanding of vulnerability and took this into account when deciding the action to take when dealing with an incident. They cited, for example, mental health and age as factors that influenced vulnerability, as well as the individual's particular circumstances. Officers had benefited from some training on different aspects of vulnerability but told us that they felt there was an over-reliance on e-learning and having to find out information themselves.

2.2 Officers told us the information they received from the control room was not always sufficient when considering whether to make an arrest. Although this was mitigated slightly because they could access the police national computer and other intelligence systems on their mobile devices, they said they did not always have time to research this before attending an incident.

2.3 Officers were focused on keeping children out of custody and explored alternatives, including voluntary attendance and restorative justice.[7] All children were regarded as vulnerable because of their age, and officers worked routinely with the youth offending team for a decision on the most appropriate outcome to prevent the child entering the criminal justice system.

2.4 Frontline officers did not routinely take people detained under section 136 of the Mental Health Act into custody as a place of safety (see footnote 2). There was reasonably good access to mental health beds across the force area. Where a bed could not be sourced, there were alternative provisions, including family rooms at local hospitals, where officers could take individuals. Although this was more positive for the individual than being taken into police detention, officers could spend a long time with them while they waited for an assessment.

2.5 Frontline officers dealing with individuals who had mental ill health had support from the mental health professionals working in custody and the triage car that provided advice and assistance. This allowed them to seek alternatives to custody for individuals with mental ill health. Where such individuals had committed a substantive offence, they were often arrested and then any mental health assessments arranged through custody.

[7] Under voluntary attendance, suspects involved in minor offences attend a police station by appointment for interview, avoiding the need for arrest and subsequent detention; in restorative justice programmes, offenders consider the consequences of their offending for all parties and can offer an apology or reparation.

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 Staff engagement with detainees was generally respectful during booking in, which was thorough, and custody staff were patient when speaking to detainees to complete this process. Staff responded well to some challenging behaviour exhibited by detainees who arrived intoxicated,

3.2 The custody suites did not provide detainees with enough privacy to disclose personal or confidential information during the booking-in process. Despite having six confidential booths for consultations we saw legal representatives discussing confidential matters in the booking-in area. There were no discrete booking-in rooms for sensitive cases, although staff tried to offset this at the two-storey Bridewell by using the booking-in area upstairs.

3.3 During busy periods staff did not always treat detainees with respect, and we observed some working practices that affected their dignity, such as the following. Although all cell toilets were suitably obscured on CCTV monitoring screens so that custody staff could not see them in use, detainees were not routinely informed of this, which could discourage them from using these facilities. We saw too many detainees walking barefoot around the suites, and even though alternative footwear was available this was not routinely offered. Some detainees had to request toilet paper via the cell call bell, even though there were adequate supplies. Staff did not routinely check that the needs of detainees had been met before locking them in a cell; this too often resulted in detainees shouting, banging on cell doors and repeatedly pressing cell call bells to make requests that could have been dealt with earlier. These requests were not always dealt with, and cell call bells were muted (see paragraph 3.20).

Area for improvement

3.4 Custody staff should protect detainees' privacy wherever possible, particularly at booking-in desks.

Meeting diverse and individual needs

3.5 Detainees with vulnerabilities, such as children or those with learning difficulties, were mostly identified promptly. The training to help staff recognise and meet the needs of protected groups was reasonable. Some staff had received relevant training, including classroom-based inputs on autism and dementia, and transgender detainees' needs in custody. Most custody staff had an awareness and understanding of how they would identify and manage the individual and diverse needs of those who came into custody.

3.6 Information for detainees was available in a range of formats, including rights and entitlement material printed in Braille and easy read, but not all staff could locate these when we requested them, and we did not see them used. Staff were unable to locate any hearing loops for detainees with hearing difficulties.

3.7 The needs of female detainees were mostly met. During the booking-in process, women were informed that a female officer had been allocated to care for them while in custody. Women were usually offered sanitary products when they were taken to their cell, and the range available was good. Although there were designated women's cells, it was not always possible to allocate these to women during busy periods.

3.8 Religious items were stored respectfully in the suites but the provision was not adequate. The Bridewell had no compass or prayer mat for Muslim worshippers in the store, and there was a limited range in the prayer room and no Qur'an. The direction of Mecca was not marked on cell ceilings to assist with daily Muslim prayers. We found guidance on religious dietary requirements in all suites, and staff understood the need to provide a diverse range of meals for detainees.

3.9 The suites had adapted toilets and showers for those with limited mobility, but not all staff were aware of these facilities. There were a range of high and low benches in the cells, and the Bridewell also had low call bells. Wheelchairs were available in the suites and detainees could take their own wheelchairs into cells if necessary. Although not all staff were aware of the adaptations in each suite, we observed them responding to the needs of detainees with limited mobility.

3.10 Custody and health care staff took the specific needs of older detainees into consideration. They were assessed individually for walking and mobility aids and, if required, sergeants would authorise their use in cells.

3.11 Staff had reasonable knowledge of the needs of transgender detainees, including how to carry out searches effectively and appropriately.

3.12 There were double-telephone handsets in all suites for staff to talk with detainees through professional interpreters, and staff said this system worked well. Interpreters also visited the suites to assist detainees in formal face-to-face interviews, but there were some delays in staff accessing this service.

3.13 Staff understood the process for foreign detainees who needed to contact their embassy or consulate, and could obtain the relevant contact details through the internet. Although foreign nationals were asked if they wanted to contact their embassy, high commission or consulate, we found that this practice was not always carried out, and that communicating with detainees with limited English was often poor.

Area for improvement

3.14 Staff should consistently meet the individual needs of detainees. In particular, all staff should be able to locate and use adaptations to assist detainees with disabilities, and there should be sufficient stocks of religious items to reflect the local population.

Risk assessments

3.15 Most detainees were booked in shortly after their arrival. They were not made to wait outside the police station in vehicles for long, which was positive. During busy periods, staff prioritised the booking in of detainees who were vulnerable, including children.

3.16 During booking in, custody staff focused appropriately on identifying risk. They interacted positively with detainees to complete the risk assessment template, responded patiently to individual need, and asked relevant supplementary and probing questions. They shared information with health care staff, and 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.

3.17 The management of risk was overly cautious and lacked an individualised approach. All belts, cords and laces from detainees' clothing and footwear were routinely removed without an individual risk assessment; this was a disproportionate approach to the management of potential risk, particularly for the many assessed as low risk and with no history of suicide or self-harm. In some cases, the removal of laces at the booking-in desk caused delays and unnecessary tension when some detainees became agitated and refused to remove them.

3.18 Initial care plans did not always set observations at a level matching the risks presented by the detainee. In our case audits and observations, we found evidence of intoxicated detainees who had not been set 30-minute checks with rousals (as in *Authorised Professional Practice*); this posed a risk to some vulnerable detainees. However, where detainees were identified as being under the influence of drugs and/or alcohol, staff conducted the required checks competently and documented them well. Posters on all cell doors promoted the practice and importance of rousing.

3.19 Level 3 (constant observation) and level 4 (close proximity) observations of detainees were managed appropriately. Positively, these were well used to manage self-harm risks rather than removing detainee clothes, as we have often found in other forces inspected. There were limited stores of anti-rip clothing in the suites, and evidence in our case audits and from custody records showed that it was used sparingly.

3.20 During busy periods, staff did not always respond to cell call bells promptly, and when they did answer, they did not identify or deal with the needs of some vulnerable detainees appropriately. In some cases, staff muted cell call bells when detainees made requests, without oversight from sergeants. When one child who was distressed because his detention had been extended after a court appearance used the cell call bell to request updates on his case, staff did not provide them and turned the call bell off without authorisation. This led to the detainee shouting and banging on his cell door, which could have been avoided if staff had provided regular updates and monitored his needs.

3.21 It was not always clear in custody records when observations levels had been reviewed. Although observation checks were allocated to a single detention officer, during busy periods this task was often rotated between different staff. This made it harder for detention officers to build rapport with detainees and potentially identify any behavioural changes that could affect their safety. This could pose risks, particularly to detainees who were under the influence of drugs and/or alcohol. However, staff mostly adhered to the set frequency of checks on detainees.

3.22 We observed that not all staff in the suites were carrying anti-ligature knives, which posed a risk to the safety of the most vulnerable detainees.

3.23 Staff shift handovers were not carried out with the whole team present, which is a safer and more efficient way to share risk information and discuss concerns about vulnerable detainees. Sergeants handed over to one another, and detention officers completed a separate handover. The recording of handovers was inconsistent; some shifts used the electronic whiteboard as a prompt, while others used a hard copy. Health care practitioners were not invited. There was an insufficient focus on the welfare of detainees and their risks during the handovers we observed, and not all were carried out in private. Although handovers were recorded on CCTV with audio, sergeants did not receive any feedback from their managers about their quality. Incoming custody officers visited all detainees in their cells at the beginning of their shifts, but this did not always involve meaningful interaction with detainees.

Area for improvement

3.24 The force should strengthen its approach to managing detainee risks by ensuring that:

- **all detainees who are intoxicated are placed on rousal checks**
- **staff answer cell bells promptly, only muting them with good rationale and proper authority, for the shortest time necessary, and subject to regular review**
- **there is a consistent approach to staff shift handovers, which should involve all custody staff and share comprehensive information about detainees, with incoming custody officers visiting detainees to check on their welfare.**

Individual legal rights

3.25 Custody officers generally authorised detention appropriately, considered individuals' vulnerability when making decisions about their detention, and explained to detainees why their detention was being authorised. Custody officers would refuse detention if it could not be justified.

3.26 Detention officers also often booked detainees into custody; in most cases that we observed, custody officers did not always properly supervise this process. Although custody officers authorised the detention as required, there was little oversight of the other areas of booking a detainee into custody.

3.27 Detainees were not always brought before the custody officer on arrival at the custody suite, which did not comply with section 2.1a of PACE (Police and Criminal Evidence Act) code C. On a number of occasions, we observed the arresting officer explaining the circumstances of arrest to the custody officer without the detainee being present. There was no apparent good reason to justify this. Although arresting officers had a good understanding of the criteria that determined whether an arrest was necessary (the necessity test), they did not always give this information to the custody officer - along with the circumstances and grounds for the arrest - in the presence and hearing of the detainee; this did not comply with section 4.3 of PACE code G. In addition, the grounds and necessity for arrest were not always accurately recorded on the custody record, as required by section 3.4a of PACE code C. This failure to meet the requirements of the PACE codes of practice is a cause of concern, which we expected the force to address as a matter of urgency. (See cause of concern and recommendation S30.)

3.28 The force made use of alternatives to custody in the form of restorative justice processes, fixed penalty notices, community resolutions[8] and voluntary attendance (see also footnote 7). However, the force was unable to provide data to show whether voluntary attendance was used well as an alternative to custody.

3.29 Some detainees stayed in custody for longer than necessary, with few actions taken or recorded to progress the case. We found that the interview with the detainee was often the only action recorded in custody records, and there was no reference to show that enquiries were made as quickly as possible. Custody officers did little chasing of the progress of investigations, and detention officers who made regular visits to detainees were unfamiliar with the state or progress of investigations. This left detainees uncertain of their situation while in custody.

3.30 Some delays were due to investigating officers not being assigned to the case, and waits for AAs or interpreters. PACE reviews conducted by inspectors did not actively address delays; some suggested that cases were progressing when the evidence in custody records indicated they were not being dealt with as quickly as possible.

3.31 There had been a 34% decrease in the number of immigration detainees brought into custody over the last three years. The force could not provide data on the average time between the service of an IS91 (authority to detain) warrant and the time of transfer to alternative accommodation, so it did not know how long immigration detainees remained in police custody before transfer to immigration detention facilities.

3.32 Custody officers routinely informed detainees of their 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) and gave them a comprehensive, printed copy of their rights when brought into custody. Custody staff could easily access copies in a broad range of languages, but this was not always done promptly when detainees with little or no English were first booked into custody. A professional interpreting service was generally used to explain detainees' rights when they were being booked into custody, but there was little evidence that the service was used subsequently during reviews of detention or for other aspects of custody. Posters in different languages about free legal advice were not prominently displayed as required in section 6.3 of PACE code C. (See cause of concern and recommendation S30.)

3.33 There were no up-to-date PACE codes of practice (July 2018) in the custody suites to give to detainees (contrary to section 1.2 of PACE code C). Once made aware, the force ordered the new version and we were told that these were due to be distributed. (See cause of concern and recommendation S30.)

3.34 Foreign nationals were often held in custody for longer than necessary due to delays in the arrival of interpreters. We met seven foreign nationals who had been in custody for many hours; custody staff had made assumptions about their capability to understand what was happening to them. The force could provide documents and records to be translated in 31 languages (PACE code C, annex M), but staff knowledge of this requirement was limited and had been used only once in these seven cases. This meant that these detainees were unaware of the police decisions being made about their detention. (See cause of concern and recommendation S30.)

3.35 We observed custody officers providing appropriate authorisation for DNA samples to be taken, but they did not always fully inform detainees of the force retention and disposal

[8] The resolution of a less serious offence or antisocial behaviour incident through informal agreement between the parties rather than progression through the criminal justice process.

policy. The system for collecting DNA and other samples generally worked well, but we found some samples that had not been collected promptly. Not all sample fridges were locked and secured, which might not protect the integrity of stored samples sufficiently.

Areas for improvement

3.36 Custody officers should provide adequate supervision where detainees are booked into custody by detention officers.

3.37 The force should minimise delays in progressing investigations so that detainees spend no longer than necessary in custody. In particular, the force should ensure that foreign nationals who have limited English receive early and ready access to interpreters.

PACE reviews

3.38 Inspector's PACE reviews of detention were poor, with little understanding of the importance of their responsibilities for detainees' lawful detention, welfare, and rights and entitlements. In the custody records we reviewed and during our observations, detainees were not always told the reasons for their continued detention. When they were, it was often in legal terminology or police jargon. Recording of reviews was generally poor.

3.39 Many PACE reviews were conducted early. PACE reviews are intended to ensure that the continued detention of a person is fully justified, and timescales are set to achieve this throughout a detainee's 24-hour detention period. Early reviews do not allow for all the factors influencing the decision on continued detention to be taken into account - for example, how long it will be before all the evidence is gathered. Our custody record analysis showed that 37 out of 80 first reviews of detention were conducted early and there was generally poor recording of the reasons for this. In one case, the detainee had their detention reviewed 22 minutes after detention was authorised, instead of after six hours; there was no apparent or recorded reason for the decision to review the detainee so early, other than for the convenience of the inspector conducting it.

3.40 Over half of reviews also took place while detainees were asleep. In some of these cases there was evidence that the detainee was awake, which meant the review could have taken place with them in person. We saw two reviews taking place when the detainee was thought to be sleeping, but they had been visited by custody staff 10 minutes earlier and found to be awake. There was rarely any record of detainees being told that a review had taken place at the earliest opportunity and its outcome, which did not comply with section 15.7 of PACE code C. (See cause of concern and recommendation S30.)

3.41 When custody inspectors carried out reviews by telephone instead of in person, they did not routinely record their location or why they did not attend the custody suite where the detainee was held. This did not comply with section 15.14 of PACE code C. (See cause of concern and recommendation S30.)

3.42 There was no consideration of the particular needs of children or vulnerable detainees when conducting reviews, and for whom not carrying these out in person was particularly poor practice. Inspectors also often reviewed detention of foreign nationals with limited English without an interpreter, which meant detainees were unable to understand the process.

3.43 Superintendents' reviews were timely, considered and the rationale recorded, including an explanation of the requirements of the investigation. Rights and entitlements were discussed and the information offered to detainees, and extended periods of detention were limited to the time needed by investigators to complete enquiries.

Area for improvement

3.44 The force should ensure that reviews of detention are carried out at the appropriate time, provide adequate information to the detainee in a language they can understand (particularly for foreign nationals with limited English) and that the review is fully recorded on the custody record.

Access to swift justice

3.45 When there was insufficient evidence to charge detainees, custody sergeants' decisions to release under investigation (RUI) or seek authorisation from senior officers to bail detainees with conditions were generally well made. However, in cases we observed, many detainees released under investigation were not told that they would commit criminal offences, such as witness intimidation, if they attempted to compromise investigations. While they were provided with the appropriate written notice, the consequences of failing to comply with requirements were rarely explained to them.

3.46 The recording by investigating officers and inspectors of the 'necessity and proportionality' rationale on bail application forms was inconsistent and did not always adhere to the College of Policing guidelines. Superintendents were better at recording their considered rationale for applicable bail periods of up to three months; they chose the time limit necessary for the completion of enquires.

3.47 Bail was reasonably well managed, with a dedicated bail sergeant acting as bail manager for the force. Cases were dealt with appropriately; for example, we saw one detainee answer bail that had been authorised by a superintendent for seven weeks who was released under investigation after the risk to the victim and witness was offset by other safeguarding actions. However, the scheduling of detainees to return to answer bail was not always aligned to staff availability to deal with cases, and there was no process to notify custody sergeants or the bail manager if detainees failed to turn up at the appointed time.

Area for improvement

3.48 The notice explaining release under investigation (RUI) should be given to all detainees, and custody officers should explain what RUI means for detainees and the consequences should they interfere with the course of justice.

Complaints

3.49 Information for detainees on making a complaint about their treatment was not well promoted. Although there was information in the rights and entitlements documentation, there were no posters or leaflets prominently displayed in the suites telling detainees how they could make a complaint.

3.50 Custody staff informed us that they would speak with the detainee and deal with minor complaints there and then - for example, if they had not been offered a drink. Most staff said

they would pass more serious complaints on to an inspector and record the complaint on the custody record.

3.51 The number of complaints were low but we saw two cases where detainees made complaints that were not recorded. This suggested that the force's recording of complaints was inaccurate.

Area for improvement

3.52 All custody suites should promote the complaints procedures to detainees adequately. Complaints should be dealt with consistently and, where possible, while the detainee is in custody

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

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

Physical environment is safe

4.1 The condition of the custody suites had deteriorated overall since the previous inspection. We found potential ligature points in all three suites, in particular in many of the Bridewell cells and legal consultation booths. We provided the force with a comprehensive illustrative report detailing these at the end of the inspection.

4.2 Detention officers made cell checks consistently and these were generally effective but had not identified the potential ligature points that we found. Other day-to-day checks - particularly relating to 'slips, trips and falls' - were less effective and could lead to injury or ill health. For example, ongoing problems with the hand washbasins meant that water regularly poured on to cell floors, which made them slippery and potentially dangerous. The cell call bells we tested were in working order, as was the CCTV in all suites.

4.3 Fire evacuation procedures and plans were prominently displayed in all suites, but statutory health and safety checks and fire drill tests were irregular, and recordkeeping of these was poor.

4.4 The Bridewell was not cleaned effectively, even though cleaners were present every day. We found food residue in washbasins and longstanding stains over large areas of cell walls where drinks had been thrown by detainees. In contrast, Mansfield custody suite was cleaned effectively but only during weekdays; at weekends, there was a build-up of rubbish and uncleaned areas, which could lead to health risks. Newark custody suite was clean.

4.5 Most cells in Mansfield and Newark had some natural light with good ventilation and suitable temperature. However, many Bridewell cells were uncomfortably cold and many detainees complained about this, even though they had been given blankets.

4.6 All the clinical rooms had a standard emergency bag containing all essential equipment and medication, which was checked regularly. Automated external defibrillators were clearly located in the general custody areas and checked daily. All custody staff we spoke to had received appropriate first aid training and expressed confidence in their ability to provide basic life support to detainees if needed.

Area for improvement

4.7 The force should improve the safety and environments of the custody suites by:
- **identifying and dealing promptly with ligature points**
- **addressing maintenance issues that constitute health and safety risks**
- **ensuring there is an annual fire drill in all custody suites**
- **keeping all the suites clean and free from debris**
- **ensuring that cells are adequately heated.**

Safety: use of force

4.8 Data on the use of force were collated and disaggregated for custody, but the governance and oversight of the use of force were inadequate. We found that data on the use of force were inaccurate, the recording of information in custody records did not always make clear that force had been used and, when it did, the entries did not always justify the use. Individual use of force forms were not always submitted or completed by all the officers directly involved in incidents, and the forms lacked any qualitative information about the incidents (see cause of concern and recommendation S33).

4.9 Data provided to us showed that most custody staff were in date with officer safety/protection training, and this was confirmed by all the custody staff we spoke with; they were either in date or due for retraining.

4.10 Custody staff were generally patient and reassuring when dealing with some challenging detainees. Most routinely carried personal safety equipment, including handcuffs, leg restraints and batons (custody sergeants only), which we do not normally see in controlled custody environments.

4.11 Through our case audits, custody record analysis and conversations with staff, we identified 15 recent cases involving the use of force that we reviewed in depth, including cross-referencing against CCTV footage. Half of the incidents were managed well overall, but we found a range of learning points in seven of them. Our concerns that arose from the CCTV footage we viewed included that force used was not always proportionate to the risk posed, and that there was sometimes little attention to maintaining detainees' dignity - in one case a female detainee had her clothing forcibly removed while she was restrained by two male officers with no attempt made to protect her dignity. We shared these cases with the force, and also formally referred a further case for full review due to the use of non-approved and poor techniques (see cause for concern and recommendation S33).

4.12 The force did not cross-reference use of force reports to CCTV footage. This did not offer assurance to senior managers that the force used in custody had been proportionate to the risks or threat posed, or to identify any learning points and improve practice.

4.13 Handcuffs were applied routinely for the transport of detainees to the suites. Where they were applied to compliant detainees, they were removed quickly on arrival at the custody suites.

4.14 In the previous 12 months, 836 detainees (5%) had been subject to a strip search, which was relatively low. Few strip searches were authorised during the inspection, and we were assured that all were for appropriate reasons. The searches were conducted in cells and, where relevant, staff ensured that CCTV monitors were switched off to maintain privacy. Removal of clothing for other reasons (such as to prevent self-harm), with or without force, were not always justified or properly recorded on custody records (see also paragraph 3.17).

Detainee care

4.15 Although most of the detainees we spoke to did not complain about their treatment while in custody, the care provided by custody staff was inconsistent. Items that they should have been offered routinely - such as replacement footwear, blankets, reading materials, exercise and showers - were available in too many cases by request only.

4.16 The provision of food and drinks to detainees was good. During their booking in, they were asked if they had any dietary requirements. The wide range of microwave meals available included vegan, vegetarian and halal options. Adequate portions of food were served at designated meal times and on request from detainees. Hot drinks, fruit squash and drinking water were offered to detainees regularly. However, the kitchens were not clean enough and the microwaves and food probes used to monitor food temperatures were dirty.

4.17 All suites had showers, but most were not sufficiently private and some had ligature points. Showers were not offered routinely to detainees held in custody overnight and attending court the following morning. There was only one working shower at the Bridewell, which was insufficient for a large custody suite. In our case audits, only 1% of detainees, and none of those who had who had been in custody overnight, were offered a shower.

4.18 Exercise yards were a decent size and had natural light; detainees using them were monitored on CCTV but we did not see them used often. In our case audits, very few detainees were offered exercise. Our custody record analysis showed that only 6% of detainees had been offered exercise outside, and only 9% of those held over 24 hours.

4.19 All the suites had sufficient replacement clothing, including jogging bottoms, sweatshirts, T-shirts, underwear and socks, for detainees whose clothes had been seized for evidence or were soiled. Replacements were also issued to detainees who had cords in their own clothes, which were routinely removed. Shoes were removed from all detainees; although all suites had good stocks of plimsolls, they were not routinely offered, and we saw some detainees walking around the suite without any shoes.

4.20 Toiletries and sanitary items were available to detainees in all suites. Toilet paper was not routinely provided, contrary to *Authorised Professional Practice*, and some detainees had to ask for it. Not all cells had handwashing facilities.

4.21 Most suites had a reasonable range of reading materials for detainees, including magazines and books suitable for children and a limited range in foreign languages. Our sample of records in case audit showed that only five detainees (4%) had been offered reading materials, and only three (13%) of those held for longer than 24 hours. Most detainees were only given reading materials on request.

Area for improvement

4.22 Detainees, particularly those held for longer periods, should be routinely offered exercise, showers and reading materials to improve their care and welfare while in custody, and those whose footwear has been removed should be provided with replacement footwear.

Safeguarding

4.23 Frontline and custody sergeants had a good understanding of the safeguarding of children and vulnerable adults. However, the role of custody in safeguarding was restricted to detainee

care and their safe release, relying on frontline or investigating officers to make referrals and address any safeguarding concerns. Safeguarding concerns had not always been adequately addressed in some custody records we looked at; for example, in one case self-harm issues had not been appropriately identified and dealt with. Although we were satisfied that children were released safely into the care of a responsible adult, custody records did not always reflect this.

4.24 Children and vulnerable adults often waited too long before receiving any support from appropriate adults (AAs), independent individuals who provide support to children and vulnerable adults in custody. When family members or friends were not available there were arrangements through a contracted AA service (The Appropriate Adult Service -TAAS), but this was not available overnight. Delays were mainly due to requests for AAs not being made until the investigating officer was ready for interview, regardless of whether family members or TAAS were used. Our custody record analysis showed that detainees waited an average of seven hours before an AA arrived, but some waited much longer - in one case, 19 hours.

4.25 Recordkeeping was poor, with limited recording of when AAs were requested and when they arrived. Although custody sergeants told us that AAs from TAAS arrived promptly after being called, there was no overall monitoring to assess the effectiveness of securing AAs, or how long detainees waited.

4.26 Custody sergeants determined whether an AA was needed for vulnerable adult detainees. However, in some of the cases we looked at involving vulnerable adults, there was evidence that an AA might have been necessary but that this had not been considered.

4.27 The suites had written guidance for AAs explaining the role, but this was not always handed out.

4.28 Care for children in custody was mostly good. Easy-read rights and entitlements material was available from the force intranet, and we saw this printed and provided to children. Most children were placed in detention rooms rather than cells, and girls were routinely assigned a female officer in line with the Children and Young Persons Act 1933. However, children were not kept separate from adults in the holding or booking-in areas, and although we were told they would see a member from the criminal justice liaison and diversion team (CJLDT), this was not always documented on the detention log.

4.29 Response officers told us that there was an emphasis to keep children out of custody, and custody sergeants said they tried to ensure children spent the minimum time possible in custody. While some children were dealt with and released quickly, others remained in custody with little activity to progress the case. Where children were held overnight, there was no evidence that the custody inspector considered their case to ensure prompt action to progress the case. This meant that some children remained a long time in custody pre-charge pending investigations.

4.30 Children charged and denied bail continued to remain in custody rather than be transferred to alternative accommodation, which should have been arranged by the local authority. Although we saw cases where the custody officer had made enquiries with the local authority emergency duty team when accommodation was not provided, they did not escalate this problem to an inspector, and juvenile detention certificates were not always completed as required. The force monitored performance information with partner agencies that focused on improving this position. However, this had not delivered an improved service for children. Force data showed that of the 68 requests for accommodation made in the year to 30 September 2018, just one child was transferred out of custody. This was a poor outcome for children held overnight.

Areas for improvement

4.31 The force should ensure that children and vulnerable adults consistently receive early support from appropriate adults.

4.32 The force should strengthen its work with local authority partners to ensure that there is provision for children to be moved from custody into alternative accommodation.

Governance of health care

4.33 There was close collaboration and effective partnership working between health care providers and the police. Mitie Care and Custody had run physical health care services since June 2018. Nottinghamshire Healthcare NHS Foundation Trust provided the criminal justice liaison and diversion team (CJLDT), which was directly commissioned by NHS England.

4.34 There was a governance structure to support the new Mitie contract but these arrangements were still embedding. There was a plan to monitor the implementation of the new contract that was regularly reviewed. There were policies to report and manage incidents, and we saw the independent health complaints process being advertised and used effectively. Clinical processes and procedures were appropriate, and detainee care had improved due to increased staffing availability and enhanced response times. There were still some gaps, particularly in ensuring sustained clinical leadership and consistent use of the electronic clinical record, as well as in delivering staff training and support.

4.35 A health care professional (HCP) was embedded in both operational suites, with a second HCP providing additional support to the Bridewell over the weekend. HCPs offered all clinical and forensic services, and a forensic medical examiner (FME) was available for consultation and telephone advice to all HCPs covering suites. The rota did not always provide for the second HCP at the weekend, but staff shortfalls were generally covered through the use of regular bank staff and overtime, which offset the impact on service delivery.

4.36 Standard response times set in the new contract of between 60 and 120 minutes were linked appropriately to clinical and forensic priorities. In our custody records analysis, response times were a mean of 107 minutes, with the shortest at zero minutes and the longest 14 hours and 54 minutes. Performance had been improving in the previous three months, with 96.1% of cases referred in August 2018 seen within the agreed timescales. As practitioners were embedded in the suites, custody staff could also raise concerns through face-to-face discussion.

4.37 There were systems to monitor clinical competencies and opportunities for staff to undertake mandatory and professional training, but some training elements had not been delivered to all staff. Lessons learned and new developments were shared with staff through email. However, local leadership was not yet sufficient, both in number and because they were also providing shift cover, to provide consistent supervision and appraisal.

4.38 The clinical rooms were clean and uncluttered. Although there were some minor infection prevention issues, these areas were generally in good condition. HCPs wiped down all areas before forensic sampling, but the Mansfield room had no countertop to enable the effective collection and labelling of samples. HCPs told us some equipment was not sufficiently robust given the throughput of detainees, but we found that clinical rooms contained appropriate clinical equipment and in-date stock.

Areas for improvement

4.39 Clinical governance arrangements should be developed to cover key aspects of performance, such as staffing, use of clinical records and managerial oversight, as well as staff training and support.

4.40 The Mansfield suite should have an appropriate work surface to facilitate efficient forensic testing.

Patient care

4.41 Custody staff understood the role of Mitie and made appropriate referrals to HCPs based on identified need, or at the request of the detainee. There were good working relationships, and custody staff we spoke to described the contribution of the health care team as much improved.

4.42 The interventions and care provided to detainees were good and delivered sensitively by experienced and competent practitioners. Although reported response times were generally within the contract specification (see paragraph 4.36), some detainees waited too long to be seen. The care provided to individual detainees with recognisable health needs lacked continuity as custody staff had to trigger new referrals for each intervention for them, rather than operating from an agreed plan of care formulated following an initial assessment.

4.43 Professional interpreting services were available for HCP contact with non-English speaking detainees, although dual-telephone handsets were not provided in clinical rooms. Treatment rooms were routinely left open during consultations without assessment of risk, which was inappropriate. Detainee consent was appropriately sought and recorded. A single electronic recording system had been introduced; this was positive but not all staff could access the system, which was a potential risk. However, they made written handover notes, and significant risk issues, including medication requirements, were added to the custody record.

4.44 The medicines management we observed was good; governance of this area was still developing. An appropriate range of patient group directions (PGDs, authorising appropriate health care professionals to supply and administer prescription-only medicine) facilitated effective detainee care. Drug cupboards were secure and accessible only to health care staff. The range of stock medicines, including controlled drugs, was proportionate, safely stored and fully accounted for. The senior HCPs oversaw date and stock checks, and reconciliation arrangements were effective. Officers could obtain current prescribed medicines for detainees, which were checked by HCPs. Individual personal prescriptions were held appropriately in detainees' personal property, although there was an accumulation of medicines left behind by detainees; their disposal needed to be aligned to Mitie's reconciliation processes.

4.45 Symptomatic relief for drug and alcohol withdrawal was administered appropriately in police custody. HCPs aimed to administer such medicines in the morning before detainees left for court, but medicines providing symptomatic relief did not accompany the detainee; this could create some clinical risks. We saw opiate substitution treatment being continued for detainees in custody when prescribed and deemed clinically appropriate, which was positive, although nicotine replacement therapy was not available through health practitioners, which could affect detainees who smoked.

Areas for improvement

4.46 Detainees with recognisable health needs should be seen promptly and provided with an agreed plan of care following initial assessment, and all anticipated interventions or milestones should be noted on their custody record.

4.47 Nicotine replacement support should be available to detainees who smoke.

Substance misuse

4.48 At the Bridewell suite, Framework Clean Slate provided face-to-face support to detainees with substance misuse problems through a dedicated practitioner working Monday to Friday. This was an extension of local community services, which enabled good support and effective follow up. Practitioners at the Bridewell saw all detainees referred by custody and health staff, and worked closely with the CJLDT. Contacts with substance misuse practitioners were recorded in the custody record. There was no parallel provision in the Mansfield suite, and although custody staff and other health professionals could refer detainees to local community services, the service was inequitable with only limited immediate support for detainees.

4.49 Detainees were targeted for drug testing based on their offence and other risk factors, which triggered referral into community treatment. Detainees leaving custody were given information that included details of community substance misuse services, but there was no immediate access to harm minimisation advice, naloxone (to manage substance misuse overdose) or sterile injecting equipment.

Area for improvement

4.50 There should be comprehensive and appropriate services for drug and alcohol misusers across the force area.

Mental health

4.51 Nottinghamshire Healthcare NHS Foundation Trust's CJLDT offered a range of services at both operational suites. An 'all-age and vulnerability' model was embedded and operated daily from 8am to 8pm, based on the national commissioning strategy. Out-of-hours mental health support was coordinated by Mitie Care and Custody practitioners. Custody staff we spoke to had a good knowledge of mental health issues and the impact of such factors on detainees. The mental health team provided regular training sessions for staff, although not all we spoke to had benefited from these.

4.52 Custody staff referred detainees based on reported risk and presentation in custody. Detainees were triaged and seen on a needs-led basis with several clear pathways identified. Demand was high and practitioners at both suites provided an extensive outreach service into the community, offering support to vulnerable individuals awaiting trial or on bail. This was an impressive and positive contribution to detainee welfare. However, at the Bridewell suite around 30% of the referrals were not seen by the team and left custody with only written information about how to access services. Despite the triage arrangements, and generally very good support on offer, we found some referrals that eventually triggered transfer to hospital who had not been seen; this was a concern. This was partially due to the potential masking of a detainee's condition because of illicit substance or alcohol misuse,

which created delays in making a comprehensive assessment. More CJLDT staff would enable all potentially vulnerable detainees who were referred to be seen.

4.53 Custody staff were positive about the support provided by the CJLDT, and partnership working was good at all suites. Advice about detainees with complex needs was routinely supplied, and all contacts noted on the custody record. CJLDT practitioners had comprehensive access to their organisation's own health records to ascertain if detainees were known to services and what support was provided.

4.54 There were no readily available data on the timescales for detainee requiring assessment and transfer to hospital under the Mental Health Act, but we found most assessments were generally undertaken in good time. However, input was not consistent, particularly out of hours, and there were some lengthy delays due to the unavailability of inpatient beds and appropriate transport.

4.55 There were well-established and effective joint working arrangements between the police and mental health services, with strategic partnership and oversight coordinated by the service commissioner, ensuring an effective focus on detainee outcomes.

4.56 A street triage scheme jointly delivered by police and mental health practitioners was regarded as a significant asset in diverting vulnerable people away from custody. It was reported that in the previous 12 months there had been only three cases of individuals detained in the suites as a place of safety under section 136 of the Mental Health Act (see footnote 2). Health professionals indicated that these had been appropriate, and custody sergeants were clear on their responsibilities to refuse detention or redirect detainees to an appropriate place of safety where needed. The designated hospital section 136 suites were too frequently used to provide hospital beds for people not in contact with mental health services through the police, which could limit their accessibility.

Area for improvement

4.57 Nottinghamshire Police should work with the criminal justice liaison and diversion team to ensure that access to its services meets demand, and enables the assessment of all those referred to it.

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 Staff did not check the safety and welfare of detainees with any rigour before their release. Custody officers did not routinely ask detainees how they planned to travel home or check if they had the means to travel after their release. During the inspection, we saw detainees who were vulnerable leaving the custody suite, during the night, in pyjamas, and others released without shoes, yet staff did not notice this. Risk assessments in the custody record were not routinely cross-checked to determine if any safeguarding issues had been identified or if actions were required to release detainees safely. (See cause of concern and recommendation S34.)

5.2 Detainee release arrangements were not systematically recorded with sufficient detail in detention logs. The pre-release risk assessment was not routinely completed with detainees before they left custody. In some cases, we observed the template completed after detainees had left the custody suite, which meant that sergeants were not assessing any potential risk to detainees before their release. In too many cases it was not clear how detainees had travelled home or if they had been released safely.

5.3 Detainees without the means to travel home following release could be given travel warrants; these were easily accessible to staff in both suites and used regularly. Petty cash was also available for bus journeys, but this was not used often and there was very little cash stored in Mansfield when we inspected. Despite these arrangements for safe release, staff told us that they expected adult detainees to find their own way home, although they would facilitate telephone calls to assist their arrangements. Custody staff said, and our case audits and observations found, that police officers often provided transport to take children or vulnerable adults home safely, although there could be lengthy waits to arrange this.

5.4 Staff routinely issued detainees being released with an up-to-date information leaflet with contact details of local support agencies, and explained this to them. Detainees attending court were also given the leaflet, which was positive.

5.5 In the sample of person escort records we examined, over half did not include risk information that was dated. Too many had confidential medical records attached to them without an envelope, which was a breach of confidentiality.

Courts

5.6 We were told that most detainees arrested on warrant at Mansfield were able to appear in court on the same day as their arrest, as the court acceptance times were flexible. However, at Nottingham Magistrates' Court the acceptance times changed daily and were sometimes too early, resulting in some detainees held in custody for longer than necessary. At the Bridewell, however, we saw the prisoner escort contractor transferring some detainees to

the magistrates' court after the initial morning court run had taken place, thus minimising the time they spent in detention. There were no secure court video-link facilities in the suites.

Area for improvement

5.7 Nottinghamshire Police should engage with HM Courts & Tribunals Service to ensure that early court acceptance times do not result in detainees staying in police custody for unnecessarily long periods.

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

Causes of concern and recommendations

6.1 Cause of concern: There were too many areas where the force was not meeting the requirements of legislation or guidance, notably codes C and G of the Police and Criminal Evidence Act codes of practice; this required immediate remedial action.

Recommendation: The force must with immediate effect ensure that all custody procedures fully meet the requirements of legislation and guidance, and that officers consistently implement these. Quality assurance processes should test compliance with legislative requirements. (S30)

6.2 Cause of concern: The culture of the custody service was not effective in focusing on the fair and equitable treatment of all detainees; some custody staff took punitive actions against detainees that were not justified and potentially unfair.

Recommendation: The force should ensure that staff treat all detainees fairly and with respect, and are accountable for their actions. This should be demonstrated in the culture of custody services, along with effective monitoring to show fair and equitable treatment. (S31)

6.3 Cause of concern: The arrangements for and staff knowledge of the recording and reporting of adverse incidents in custody were not adequate in ensuring that all incidents were identified appropriately and dealt with in line with legislative requirements.

Recommendation: Nottinghamshire Police should ensure that staff understand their responsibilities in recording and reporting adverse incidents that occur in its custody suites. All incidents that fall within the definition of a death or serious injury matter under section 12 of the Police Reform Act 2002 must be referred to the Independent Office for Police Conduct (IOPC). (S32)

6.4 Cause of concern: The governance and oversight of the use of force in custody were not adequate, data were unreliable and not all staff completed use of force forms. Some use of force was disproportionate to the risk or threat posed.

Recommendation: Governance and oversight of the use of force should provide assurance that all use of force is proportionate to the risk posed, and this should include comprehensive review of incidents against the records on CCTV. (S33)

6.5 Cause of concern: There was a lack of appropriate care and focus on the safe release of detainees, including the most vulnerable; the pre-release arrangements were not adequate to ensure safe release.

Recommendation: There should be an improved focus on release arrangements for detainees: pre-release risk assessments should be carried out routinely with all detainees to ensure their safe release. (S34)

Areas for improvement

Leadership, accountability and partnerships

6.6 Governance meetings should include sufficient oversight of detainee care to ensure that this always meets the standards expected for detainees. (1.10)

6.7 There should be sufficient staff appropriately deployed to meet the demands of the service and ensure safe detention. PACE inspectors should have capacity to have robust oversight of the day-to-day management of the custody suites. (1.11)

6.8 The force should ensure that clear and current policies and guidance are available to staff and monitor adherence to this. (1.12)

6.9 Nottinghamshire Police should use the regional performance information gathered for each force to understand the underlying factors for any variance so that staff can clearly identify and address any concerns. (1.20)

6.10 The force should be able to demonstrate that it meets its public sector equality duty, and that outcomes for all detainees are fair and equitable. (1.21)

6.11 Custody records should include all key information and clear justifications for any decisions made. Quality assurance of the records should ensure they meet the required standards. (1.22)

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

6.12 Custody staff should protect detainees' privacy wherever possible, particularly at booking-in desks. (3.4)

6.13 Staff should consistently meet the individual needs of detainees. In particular, all staff should be able to locate and use adaptations to assist detainees with disabilities, and there should be sufficient stocks of religious items to reflect the local population. (3.14)

6.14 The force should strengthen its approach to managing detainee risks by ensuring that:
- all detainees who are under the influence of drugs and/or alcohol are placed on rousal checks
- staff answer cell bells promptly, only muting them with good rationale and proper authority, for the shortest time necessary, and subject to regular review
- there is a consistent approach to staff shift handovers, which should involve all custody staff and share comprehensive information about detainees, with incoming custody officers visiting detainees to check on their welfare. (3.24)

6.15 Custody officers should provide adequate supervision where detainees are booked into custody by detention officers. (3.36)

6.16 The force should minimise delays in progressing investigations so that detainees spend no longer than necessary in custody. In particular, the force should ensure that foreign nationals who have limited English receive early and ready access to interpreters. (3.37)

6.17 The force should ensure that reviews of detention are carried out at the appropriate time, provide adequate information to the detainee in a language they can understand (particularly for foreign nationals with limited English) and that the review is fully recorded on the custody record. (3.44)

6.18 The notice explaining release under investigation (RUI) should be given to all detainees, and custody officers should explain what RUI means for detainees and the consequences should they interfere with the course of justice. (3.48)

6.19 All custody suites should promote the complaints procedures to detainees adequately Complaints should be dealt with consistently and, where possible, while the detainee is in custody. (3.52)

In the custody cell, safeguarding and health care

6.20 The force should improve the safety and environments of the custody suites by:
- identifying and dealing promptly with ligature points
- addressing maintenance issues that constitute health and safety risks
- ensuring there is an annual fire drill in all custody suites - keeping all the suites clean and free from debris
- ensuring that cells are adequately heated. (4.7)

6.21 Detainees, particularly those held for longer periods, should be routinely offered exercise, showers and reading materials to improve their care and welfare while in custody, and those whose footwear has been removed should be provided with replacement footwear. (4.22)

6.22 The force should ensure that children and vulnerable adults consistently receive early support from appropriate adults. (4.31)

6.23 The force should strengthen its work with local authority partners to ensure that there is provision for children to be moved from custody into alternative accommodation. (4.32)

6.24 Clinical governance arrangements should be developed to cover key aspects of performance, such as staffing, use of clinical records and managerial oversight, as well as staff training and support. (4.39)

6.25 The Mansfield suite should have an appropriate work surface to facilitate efficient forensic testing. (4.40)

6.26 Detainees with recognisable health needs should be seen promptly and provided with an agreed plan of care following initial assessment, and all anticipated interventions or milestones should be noted on their custody record. (4.46)

6.27 Nicotine replacement support should be available to detainees who smoke. (4.47)

6.28 There should be comprehensive and appropriate services for drug and alcohol misusers across the force area. (4.50)

6.29 Nottinghamshire Police should work with the criminal justice liaison and diversion team to ensure that access to its services meets demand, and enables the assessment of all those referred to it. (4.57)

Release and transfer from custody

6.30 Nottinghamshire Police should engage with HM Courts & Tribunals Service to ensure that early court acceptance times do not result in detainees staying in police custody for unnecessarily long periods. (5.7)

Section 7. Appendices

Appendix I: Progress on recommendations from the last report

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

Strategy

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

Main recommendation

The Police and Crime Commissioner or Chief Officer should engage with health care partners at a strategic level to reduce the number of detainees held in police custody under section 136 of the Mental Health Act 1983. (2.27)	**Achieved**

Recommendations

The force should fill custody sergeant vacancies, as identified by its risk management processes, to ensure more effective custody provision for detainees. (3.10)	**Partially achieved**
Information on adverse incidents should be clearly communicated to frontline staff. (3.20)	**Not achieved**

Treatment and conditions

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

Main recommendation

The force should review its policy or guidance on cell observations. Detainees who have had their clothes removed for their own safety should, as far as possible, be observed by staff of the same gender. Rip-proof clothing should be provided to detainees whose clothes have been removed. (2.25)	**Achieved**

Recommendations

Booking-in areas should provide sufficient privacy to facilitate effective communication between staff. (4.14)	**Not achieved**
The booking-in process in the Bridewell custody suite should be more efficient and use all available capacity on available floors to reduce queues on the ground floor. (4.15)	**Achieved**
Frequency of observations of detainees should be strictly adhered to so that risk can be managed adequately. (4.30)	**Achieved**
Handovers should be comprehensive and attended by detention officers and police custody staff, with the area in which the handover takes place cleared of other staff and detainees. (4.31, repeated recommendation 4.16)	**Not achieved**
The recording of pre-release risk assessment should be improved and cover the advice or support offered to detainees before their release, including means of getting home. (4.32)	**Not achieved**
Nottinghamshire police should collate the use of force in accordance with Association of Chief Police Officers' policy, and custody staff should be given training or advice on when to submit a use of force form. (4.37)	**Not achieved**
All detainees held overnight, or who require one, should be offered a shower, which they should be able to take in private. (4.55, repeated recommendation 4.36)	**Not achieved**

Individual rights

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

Recommendation

Appropriate adults should be available at all times without undue delay to support detained children and young people aged 17, provided that informed consent has been given. (5.10)	**Not achieved**

Health care

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

Main recommendation

Nurses should be trained to use the full range of resuscitation equipment. (2.26, repeated recommendation 6.11)	**Achieved**

Recommendations

Clinical meetings should be reinstated, clinical supervision should be available for all clinical staff and a programme of clinical audit should be established to monitor the quality of patient care. (6.6, repeated recommendation 6.9)	**Not achieved**
Action should be taken to refurbish the environment and reduce infection control risks. Cleaning services in health care should meet professional	**Achieved**

standards of cleanliness and infection control. (6.7, repeated recommendation 6.10)	
All clinical records should include consent from the detainee to share information with relevant personnel, and should be stored in accordance with Caldicott guidelines on the use and confidentiality of personal health information. (6.15)	**Achieved**
All medications should be stored safely and securely, and any discrepancies in stock should be thoroughly investigated. (6.16)	**Achieved**
There should be comprehensive and appropriate services for drug and alcohol users across the force area. (6.20)	**Not achieved**
The comprehensive service for detainees with mental health issues should be available across the force area as soon as practicable. (6.27)	**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*.[9]

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.[10] 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.[11]

Case audits

We carry out in-depth audits of approximately 40 case records (the number may increase depending on the size and throughput of the force inspected) to assess how well the force manages vulnerable detainees and specific elements of the custody process. These include looking at records for children, vulnerable people, individuals with mental ill health, and where force has been used on a detainee. The audits examine a range of issues to assess how well detainees are treated and cared for in custody. For example, the quality of the risk assessments, whether observation levels are met, the

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

[10] 95% confidence interval with a sampling error of 7%.

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

quality and timeliness of Police and Criminal Evidence Act (PACE) reviews, if children and vulnerable adults receive timely support from appropriate adults, and whether detainees are released safely. Where force is used against a detainee, we assess whether it is properly recorded and if it is proportionate and justified.

Observations in custody suites

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

Interviews with key staff

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

Focus groups

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

Feedback to force

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

Appendix III: Inspection team

Kellie Reeve	HMI Prisons team leader
Fionnuala Gordon	HMI Prisons inspector
Fiona Shearlaw	HMI Prisons inspector
Norma Collicott	HMI Constabulary and Fire & Rescue Services inspection lead
Adrian Gough	HMI Constabulary and Fire & Rescue Services inspection officer
Andrew Reed	HMI Constabulary and Fire & Rescue Services inspection officer
Steve Eley	HMI Prisons health services inspector
Matthew Tedstone	Care Quality Commission inspector
Helen Ranns	HMI Prisons researcher
Patricia Taflan	HMI Prisons researcher