Report on an announced inspection visit to

TACT custody suites in England and Wales

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

7 January–22 February 2019
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/
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Fact page

**TACT suite status**
There are five police custody suites in England and Wales identified to hold detainees arrested on suspicion of terrorism or terrorism-related offences.

**Assistant Commissioner Specialist Operations**
Neil Basu

**Senior National Coordinator for Counter Terrorism Policing**
Deputy Assistant Commissioner Dean Haydon

**Designated cell capacity**

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of TACT suites (England and Wales)</td>
<td>5</td>
</tr>
<tr>
<td>Total number of cells (all suites – England and Wales)</td>
<td>38</td>
</tr>
</tbody>
</table>

**Total TACT suite population (1 November 2017 to 31 October 2018)**

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>TACT detainees (England and Wales)</td>
<td>47</td>
</tr>
<tr>
<td>PACE detainees (England and Wales)</td>
<td>89</td>
</tr>
</tbody>
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**Health care providers**

Providers are commissioned in each host force.

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*1 Data supplied by Counter Terrorism Policing.*
Executive summary

S1 This report sets out the findings from an inspection of Terrorism Act (TACT) custody facilities in England and Wales in January and February 2019. This inspection, conducted by HM Inspectorate of Prisons (HMIP) and HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS), was the first one of custody facilities holding people detained for terrorism offences or terrorism-related offences.

S2 Individuals arrested for terrorism offences are detained at one of five TACT custody suites situated across the country. These detainees can be held in custody for up to 14 days, significantly longer than detainees held in mainstream custody. Because of this, there are different arrangements under the Police and Criminal Evidence Act 1984 (PACE) for the detention, treatment and questioning of detainees. We set out the legal background to TACT detention in the section on Context.

S3 Responsibility for the safe and respectful delivery of custody in the TACT suites rests with the chief constable of the force in which the TACT custody suite is situated. Counter Terrorism Policing oversee the provision of TACT custody and have a national strategic role in directing, coordinating and supporting TACT custody.

S4 This inspection assessed the effectiveness of custody services and outcomes for people detained on suspicion of terrorism offences or terrorism-related offences throughout the different stages of detention. It forms part of our wider work to inspect all police custody suites in England and Wales on a rolling programme. These inspections focus on the experience of the detainee in relation to custody and do not cover the criminal investigation or outcome of this. We examined the national framework for TACT detention suites provided through, and overseen, by Counter Terrorism Policing (CTP). There are five police forces that host a TACT custody suite, and the inspection also examined their approach to custody provision in relation to safe detention and the respectful treatment of detainees, with a particular focus on vulnerable people and children.

S5 To assist CTP and the police forces responsible for the custody provision to improve, we have identified several key causes of concern and areas for improvement. This report makes three recommendations and highlights 18 areas for improvement. These are set out in Section 6.

Leadership, accountability and partnerships

S6 Overall this was a good inspection with many positive features. Custody staff provided good care for detainees, meeting and, in some cases, exceeding required standards. The environments and conditions in which detainees were held were generally of a good standard. The main areas we identified for improvement related to governance, oversight and consistency of approaches and procedures. The network and individual forces were open to external scrutiny and, during the inspection, had already recognised and started to address some of our concerns. We were confident that the required improvements would be delivered.

S7 Leadership at both national and force level was not providing the necessary governance and oversight of TACT custody. In the individual forces that hosted the suites we inspected, the lines of accountability and responsibility for delivering TACT custody were unclear, and there was a lack of direction and support by Counter Terrorism Policing in providing a
national framework within which they could operate. This was compounded by a lack of integration between the network and the forces with regular custody provision, and some confusion between the roles and responsibilities of counter terrorism detention managers and custody officers. This resulted in little oversight or management of the suites by senior officers in the forces responsible for them, inconsistent practices to delivering TACT custody both within and between forces, and no clear view or accountability at either force or national level for the outcomes the service was achieving for detainees.

Forces ensured that there were sufficient custody-trained staff to deliver safe detention in TACT custody suites. However, there was little additional TACT-specific training or guidance at national or local level. Forces told us they followed College of Policing guidance for TACT custody but few of the custody staff we spoke with were aware of this and not all practices followed the guidance.

Performance management of TACT custody was poor. There was very little information gathered or monitored at either force or national level to show, for example, how long detainees waited to be booked into custody, with gaps in data for most aspects of custody provision. There was also a lack of accurate information on or monitoring of ethnicity to show that custody services treated all detainees fairly. This prevented forces and the network from being able to monitor performance effectively, identify trends and inform learning.

The quality of the custody records was not always good enough. They often lacked sufficient detail to show the actions taken or the rationale for decisions made. There was no quality assurance to ensure they met the required standards or that forces always met the requirements of the Police and Criminal Evidence Act 1984 (PACE). While there was good attention to meeting legislative timescales for detention, other aspects were not met consistently.

All five forces were open to external scrutiny and there was evidence that independent custody visitors (ICVs) attended the suites regularly. Forces welcomed and acted on feedback from ICVs.

There was some good work with partners. At a national level there was effective engagement to improve the arrangements for detainees required to attend court. There was also some joint working through the multiagency hubs, which aimed to divert and manage individuals away from custody and deal with safeguarding concerns. Although within forces it was not always clear where the responsibility for working with partners lay, there was a clear commitment to ensuring that children and vulnerable adults were supported before, during and after custody.

Pre-custody: first point of contact

Diversion of individuals away from custody was considered as part of the arrest strategy for dealing with suspects. Where detainees were taken into custody this was appropriate in all the cases we looked at. If arrests were not planned, custody officers decided whether detention in the TACT suite was suitable and diverted the detainee if necessary.

Custody staff were briefed about detainees before their arrival at the suite. This included any known vulnerabilities or particular needs of the detainee so that their risks could be properly managed, and any welfare needs met. There was no standardised approach across the forces to these briefings but most custody staff told us they felt reasonably well informed.
Executive summary

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

S15 Custody staff spoke to and treated detainees respectfully, and considered and maintained their dignity during their detention. Their interactions with detainees were professional and courteous throughout.

S16 The environment was not always private enough for detainees to have the confidence to provide sensitive information to custody officers without being overheard. Notices that CCTV was in use throughout the suite, including in cells, were not always clearly displayed, and detainees were not always advised about this or that cell toilets were obscured from view.

S17 There was generally good attention to meeting detainees’ individual and diverse needs. Females generally received good support and care, and custody staff were sensitive to detainees’ religious and cultural needs and took care to ensure these were met. Specific arrangements were often made to meet individual needs, with items sourced as needed. However, provision to meet the needs of detainees with disabilities was not always good enough. There was a lack of accessible facilities for detainees with mobility needs and insufficient provision for those with visual or hearing impairment. Religious artefacts that we expect to be readily available were not always at hand.

S18 Custody staff gave detainees information about their rights and entitlements in an appropriate language, and interpreting arrangements generally worked well. However, it was not always clear that foreign national detainees’ embassies had been notified, either at the request of the detainee or in line with agreed protocols, as required.

S19 The approach to the identification and management of risk was generally good. Risk assessments were completed routinely, and the observation levels set took account of presenting risks and were kept under review. Most checks on detainees were at the required frequency but there was sometimes an over-reliance on using CCTV, particularly at night, instead of visiting the cell, as recommended by College of Policing guidance.

S20 We expect detainees’ personal effects to be removed only following an individual risk assessment, but clothing with cords was generally taken from them routinely. Staff shift handovers varied in practice but mostly had a good focus on detainee welfare.

S21 Most detainees were made aware of and received their rights and entitlements promptly. Cases were progressed promptly with custody staff ensuring that detainees received sufficient rest periods to mitigate tiredness during the process. However, not all reviews to authorise TACT detention were as prompt as they should have been, detainees were not always given the correct written version of rights and entitlements, and, in a small number of cases, delays in the right to have someone informed of the arrest exceeded the maximum permitted time. Most reviews of detention were conducted well but the recording of some did not show that they met the requirements of TACT legislation, including whether they were completed on time or by an officer of sufficient rank.

S22 There were processes for the application, granting and monitoring of bail for PACE cases, although these were not always well recorded on custody records.

S23 Formal arrangements to deal with complaints from detainees were satisfactory, although few were received.
In the custody cell, safeguarding and health care

S24 Physical conditions in TACT custody suites were very good. Most cells were slightly larger than standard custody cells and had additional facilities to reflect the much longer periods that TACT detainees can be held. The cells were well ventilated and had good natural light. There were relatively few potential ligature points, and forces responded quickly to address or mitigate those we identified. However, the arrangements for testing fire evacuation procedures varied and were not sufficiently robust.

S25 The use of force in the TACT custody suites was infrequent and generally only involved low-level restraint techniques. The incidents we reviewed on CCTV were handled well and were proportionate to the threat posed. However, some custody officers routinely carried their full personal protection equipment, which did not follow College of Policing guidance. There was no monitoring of use of force, incidents were not always sufficiently recorded in detention logs and use of force forms were not completed as required.

S26 Detainees were very well cared for, with good consideration given to meeting their welfare needs. A range of food and drinks were provided. Some limited in-cell activities were offered to help occupy individuals during what could sometimes be lengthy periods in their cell. Detainees had relatively good access to showers and fresh air in the exercise yard, and were given clean clothing and bedding regularly. Some detainees, particularly children, benefited from visits from family members, and many were also allowed to make telephone calls. Senior officers made regular welfare visits. Detainees told us they were treated well.

S27 The approach to safeguarding detainees was generally well considered, including prior to detention where possible. Although custody staff did not necessarily know of any wider safeguarding arrangements in place, they had a good understanding of their safeguarding responsibilities in addressing any concerns.

S28 Detainees generally received early support from appropriate adults (AAs) from their arrival in custody and throughout their detention. However, there were some delays for vulnerable adults when the need for an AA had not been identified in advance. Forces had different arrangements for securing AAs. Although this did not affect the promptness of their arrival, because some AAs were trained in their particular role for TACT while others were not, there were potential inconsistencies in the support that detainees received.

S29 There was a good focus on caring for children in TACT custody. Very few children were detained but those who had been received good care. The welfare needs of children were considered from the outset, and arrangements made to best meet these.

S30 The commissioning and delivery of health services to detainees varied between the TACT custody suites but all the arrangements were responsive. Most health governance was good. Health care professionals generally saw detainees quickly and provided good individual care. Police and health care professionals were aware of the potential harmful effects of protracted custody and took steps to counter these. Systems for the prescription and administration of medicines were good. Nicotine replacement therapy was available to detainees if required. Although opiate-dependent detainees were rarely detained, some suites did not have access to opiate substitute therapy as indicated by national clinical guidance.

S31 No TACT suite had the embedded mental health professionals found in standard police custody suites. However, although required infrequently, we were told that referrals and assessments were completed promptly. In one case we looked at this had resulted in the quick transfer of a mentally unwell detainee to a secure mental health hospital.
Release and transfer from custody

S32  Detainee release plans were well considered and planned by the investigations teams, although not always conveyed to custody officers. The recording of release arrangements by custody officers was not always sufficiently detailed, but there was a proper focus on releasing detainees safely.

S33  There were good arrangements with Westminster Magistrates’ Court (the only court that deals with TACT detainees) for hearing cases, via video-link and in person.

Causes of concern and recommendations

S34  Cause of concern: There was no national framework or guidance within which forces could operate, resulting in inconsistent approaches to delivering TACT custody and different practices across the forces.

**Recommendation:** Counter Terrorism Policing should provide a clear framework for delivering TACT custody, supported by national policies and guidance, within which all forces can operate.

S35  Cause of concern: There was a lack of governance and oversight by senior officers in each of the forces, and the lines of accountability for TACT custody were unclear.

**Recommendation:** Each force should strengthen its governance arrangements with senior officers taking clear accountability for the delivery of TACT custody in their force.

S36  Cause of concern: Not enough information was collected or monitored at national or force level to show how well custody services were performing and whether the required standards for detainees were met.

**Recommendation:** Each force should gather and monitor comprehensive and accurate information on TACT custody to assess how well the services are performing. Counter Terrorism Policing should develop a performance framework to assess performance at a national level.
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 custody, and the outcomes achieved for detainees.

This was the first time we have inspected places of detention for individuals who are detained on suspicion of terrorism offences or terrorism-related offences.

Our assessments for this inspection are made against the criteria set out in the Expectations for detainees in TACT suites, developed in consultation with the wider police sector to reflect the particular standards for TACT custody provision. These standards are underpinned by international human rights standards.

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 inspection also assessed compliance with the Police and Criminal Evidence Act 1984 (PACE) codes of practice and the College of Policing guidance.

The methodology for carrying out the inspections was similar to other custody inspections but tailored to meet the specific differences for TACT custody. It was based on: a review of the forces’ strategies, policies and procedures; Counter Terrorism Policing’s policies and procedures; an analysis of forces’ data; interviews with staff; observations in suites and on CCTV; discussions with detainees; and an examination of case records. We also conducted a documentary analysis of custody records across all the suites for the period between 1 November 2017 and 31 December 2018. In total we analysed 45 TACT and 83 PACE (Police and Criminal Evidence Act) records. The methodology for our inspection is set out in full at Appendix I.

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. Inspections of TACT custody suites will now form part of our inspection programme.

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

Individuals arrested for terrorism offences are detained at one of five TACT custody suites. Those arrested under section 41 Terrorism Act 2000 (TACT) (suspected of being a terrorist) must be taken to a TACT suite where they will be held under the requirements of TACT and code H of the Police and Criminal Evidence Act 1984 (PACE). Those detained for terrorism offences under other sections of TACT (for example, if suspected of being involved in the funding of terrorism or the distribution of publications), or those arrested for other offences that are terrorism-related (such as murder), can be arrested under PACE and taken to a TACT suite or any other designated police custody suite, as determined appropriate by the senior investigating officer, where they will be held under the requirements of PACE and code C of PACE.

There are several differences in treatment for TACT detainees depending on whether they are arrested under TACT or PACE. Under TACT, detainees can be held for up to 14 days, subject to appropriate authorisations (warrant of further detention) by the magistrates’ court. Warrants of further detention are required to detain a person for longer than 48 hours. Individuals arrested under PACE can be routinely held for 24 hours, and a further 12 hours if extended and authorised by an officer of at least superintendent rank. They can be held in custody for up to a maximum of 96 hours, subject to the issue of a warrant of further detention by the magistrates’ court. Those held as PACE detainees initially can be further arrested under section 41 of TACT, at which point they must be transferred to a TACT custody suite, where they will be held under the requirements of TACT and code H of PACE.

Codes C and H of PACE set out the detailed requirements for the detention, treatment and questioning of detainees. Although the requirements are similar, there are a number of differences between them.

PACE code H takes account of the impact of longer detention and sets out additional requirements to assure the health and welfare of detainees who are held for extended periods. These cover, in particular, regular medical checks by a doctor or health care practitioner, regular reviews of detention and welfare visits, and an enhanced range of food and drinks provision. These additional requirements also reflect the importance of meeting international human rights for detainees held over longer periods.

In this report, the terms ‘TACT detention’ or ‘TACT custody’ refer to people held under the Terrorism Act 2000 or for terrorism-related offences under PACE. Counter Terrorism Policing may also be referred to as the ‘network’ throughout the report.
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 well-being of TACT detainees.

Leadership

1.1 Detainees entering the TACT custody suites can be arrested anywhere in the country, with the investigations carried out by regional counter terrorism teams. However, responsibility for the safe and respectful delivery of custody in the TACT suites rests with the chief constable of the force in which the TACT custody suite is situated. Counter Terrorism Policing oversees the provision of TACT custody, supported by working groups made up of officers from different forces. The network has a national strategic role in directing, coordinating and supporting TACT custody, but accountability for delivering custody remains with the chief constables.

1.2 Our inspection found that the lines of accountability, and the responsibility for delivering TACT custody services, were confusing and blurred. Although each force had leadership structures there was a lack of effective governance and oversight at a senior officer level for forces to show how their TACT custody service was performing, and the outcomes achieved for detainees. This was compounded by a lack of integration between TACT and mainstream custody provision, both at National Police Chiefs Council and local force level, where roles and responsibilities were unclear, and a lack of direction and support by the Counter Terrorism Policing in providing a national framework within which forces could operate. This resulted in little oversight or management of the suites by senior officers in the forces, and inconsistent approaches to delivering TACT custody with different practices across the forces. Examples of inconsistent approaches included: whether detainees were booked in at the main desk or in their cell, and the length of time CCTV footage was stored, which varied significantly. (See recommendations S34 and S35.)

1.3 Despite this, custody staff in all the suites were well focused on safe and respectful detention and were delivering good outcomes for detainees held in TACT facilities. Required standards were met and, in some cases, exceeded.

1.4 The network had recognised that governance required improvement at both national and individual force level and was taking steps to address this. It had set up a specific ‘capability strand’ for custody led by a chief superintendent. This had introduced quarterly governance meetings with representatives from each of the five forces, whose work fed into the network’s strategic meetings. Although it was early days, this had started to ensure that senior officers were aware of weaknesses and could agree the actions needed to improve.

1.5 Roles in delivering TACT custody were not always clear at an operational level. Each of the forces had a counter terrorism detention manager role (although these officers had a range of titles) responsible for the day-to-day operation of the suite and providing an important link between the counter terrorism investigation team and the custody staff. However, there was no specific role profile for these staff and, in practice, the activities they carried out differed between the forces. This led to some confusion between the counter terrorism detention manager and custody staff, including the PACE inspectors, about responsibilities.
1.6 This lack of clarity between the respective roles of counter terrorism detention managers and custody staff meant that some custody actions potentially did not meet the requirements of PACE. PACE and its codes of practice define some custody tasks as the responsibility of the custody officer and, although the task may be delegated, the responsibility for ensuring it is completed cannot be. For example, the custody officer is responsible for informing embassies that one of their citizens has been detained. However, we found that this action had often been passed to investigation teams without any follow up, or none recorded, to show that it had been completed and the custody officer had met their responsibilities.

1.7 There were no national policies or standard operating procedures for TACT custody to ensure a consistent approach across the forces; for example, CCTV retention periods varied from 30 days to one year, with none following the College of Policing guidance for TACT custody of seven years. (See recommendation S34.) Similarly, there were few force policies to provide guidance to staff on procedures that differed between TACT and standard custody. Although all five forces told us they followed the College of Policing guidance, not all staff were aware of this and not all practices and procedures we observed followed this guidance. (See recommendation S35.)

1.8 All forces used mainstream trained and accredited custody staff to perform duties in the TACT suites, and provided sufficient resources to ensure safe detention. There was no standard accredited course for TACT custody. Although all forces provided some additional training to cover the legislation and procedures, this varied from a minimum of awareness sessions to a comprehensive three-day course. There was little continuing professional development, and two forces did not provide any additional training for detention officers.

1.9 There was no national guidance setting out expectations in regard to the vetting of individuals entering TACT custody suites, and we found inconsistent approaches towards this for both staff and external partners. Independent custody visitors (ICVs) were subject to enhanced vetting, but this was not always the case for appropriate adults, healthcare professionals, and liaison and diversion staff, some of who had minimal vetting and a few only minimal checks by the Disclosure and Barring Service. This meant that individuals without sufficient security clearance could be privy to sensitive information.

Areas for improvement

1.10 The forces should improve integration between TACT and mainstream custody so that officers with the relevant training and expertise in managing custody have oversight of the TACT suites, and good practice and learning are shared. The National Police Chiefs Council lead officers for TACT custody should also improve integration with the national leads for mainstream custody.

1.11 Counter Terrorism Policing should provide guidance on the role of counter terrorism detention managers and TACT custody officers to clarify their respective responsibilities. Forces should provide clarity on supervisory responsibilities, quality assurance and the tasks that custody officers have responsibility for under PACE codes of practice.

1.12 Counter Terrorism Policing and forces should develop guidance and operational protocols for the vetting levels required for people entering TACT suites in an official capacity.
Accountability

1.13 There was no clear performance framework nationally or at force level. There were gaps in the information collected for most key aspects of custody provision, such as the time taken for detainees to be booked into custody, or for services provided by other agencies, such as health care practitioners, interpreters and appropriate adults. This meant that forces and the network were not able to monitor performance effectively, assess outcomes for detainees, identify trends and inform learning.

1.14 There was no monitoring or governance of the use of force in TACT custody. Although force was rarely used - and in the cases we looked at it was appropriate - the lack of systematic monitoring meant that forces were unable to demonstrate this. (See cause of concern and recommendation S36.)

1.15 The quality of custody records varied across and within forces and was often not good enough. TACT custody records, and some PACE ones, were handwritten on a nationally agreed form. Many records lacked sufficient detail to show the actions that had been taken and the rationale for decisions, and some important actions were not recorded at all. The records were often difficult to follow; loose-leaf sheets were used for some authorisations, not always held in chronological order, and not always recorded on the detention log. Handwriting was sometimes illegible. Some records were not always stored to be readily accessible. The standard of the records made it difficult to show that important information had been properly entered and that forces consistently met the requirements of the TACT and PACE codes of practice.

1.16 There was no quality assurance to assess the work of TACT custody officers. Records were not sampled to check that they were completed to the required standard, that the force met the requirements of the TACT and PACE codes of practice and that detainees received the required standard of care.

1.17 Custody staff were aware of how to report adverse incidents (where a detainee or other person in the suite was at risk of or experienced harm). The approach replicated standard custody arrangements with which staff were familiar.

1.18 There was good attention to meeting the legislative timescales for TACT detention, and this area was closely monitored by forces. All warrants of further detention were applied for within the prescribed 48 hours after arrest. However, the time these were granted and when they expired was not always recorded on detention logs, and some were not timed and dated by the court granting them, which was poor practice.

1.19 There were areas where forces were not meeting the requirements of the PACE codes of practice or following the College of Policing guidance for TACT custody (see also paragraphs 3.9, 3.13, 3.16, 3.19, 3.21, 3.23, 3.24, 3.29, 3.33–36, 3.39, 3.41–43, 4.14, 4.17 and 4.28). For example, when officers carried out observation checks on detainees there was sometimes an over-reliance on using CCTV, particularly at night, instead of visiting the cell, in line with College of Policing guidance. In addition, some reviews of TACT detention were carried out by officers not of the required rank but acting up ad hoc, and it was not clear that the formal arrangements for this accorded with section 107 of PACE. In some cases, inspectors carried out reviews that should have been conducted by superintendents, and there was some confusion between welfare reviews required under TACT and the more formal PACE reviews that decide on authority for further detention.

1.20 The recording and monitoring of data on protected characteristics were poor, particularly self-defined ethnicity, which was not accurately recorded on paper records. We saw the correct self-defined ethnicity codes used in only a handful of the cases we reviewed across all
five forces. This meant that the individual forces and the network could not demonstrate how they were meeting the public sector equality duty in TACT custody to show fair and equitable treatment and outcomes for detainees.

1.21 All five forces were open to external scrutiny and there was evidence of regular visits from ICVs (sometimes daily) to all the suites. Reports from visits had been routinely shared with the Independent Reviewer of Terrorism Legislation.\(^3\) Individual forces welcomed and acted on feedback from ICVs.

**Areas for improvement**

1.22 **Forces should ensure that custody records clearly and adequately record all information and the rationale for decisions, with robust quality assurance to confirm that the records are to the required standard.** Counter Terrorism Policing should review the current arrangements and forms used for recording on custody records, and identify and address any shortcomings.

1.23 **Forces should consistently meet the requirements of the PACE codes of practice and follow College of Policing guidance for TACT custody.**

1.24 **Counter Terrorism Policing and forces should work together to ensure that information on the protected characteristics of detainees is gathered accurately and monitored to show fair and equal treatment at force and national level.**

**Partnerships**

1.25 **There were some effective partnerships for TACT detention at national and regional levels.** For example, there were regular meetings with partners to improve the arrangements for detainees attending Westminster Magistrates’ Court (the only court that deals with TACT detainees), as well as arrangements for ‘virtual court’ appearances by video-link when there were requests for warrants to extend a detainee’s detention.

1.26 **There were also three counter terrorism multiagency hubs, which included police officers and mental health professionals.** Their main focus was to support the diversion of individuals away from terrorism activities, and to provide advice and support as part of the ongoing safeguarding and management of detainees. Although recently set up and still developing, several officers told us that these services were valuable. However, the role of the multiagency teams varied across the regions, and not all officers involved in TACT custody were aware of the support they offered.

1.27 **Forces worked with partners in their own areas, although on TACT it was not always clear who was responsible for this engagement.** There was, however, a clear commitment to ensuring that partnership working supported children and vulnerable adults before, during and following their detention in TACT suites.

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\(^3\) This position was vacant at the time of inspection.
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.

2.1 Relatively few detainees are held in TACT custody. Most of the detainees entering TACT custody suites were planned arrests, and the counter terrorism investigation teams had developed strategies to deal with them. We were told this included whether arrest or diversion from TACT custody was the most appropriate action, and that partner agencies were involved as needed. The TACT custody staff we spoke to said they would not know if such diversions had been considered (as these had been decided before detainees arrived into custody), but they did not report any examples – and there were none in the cases we reviewed – where it had been inappropriate for a detainee to enter the custody suite or have their detention authorised.

2.2 Where unplanned arrests took place, the severity and nature of the incident meant that diversion away from custody was generally not suitable. Custody officers told us they considered the person’s vulnerabilities when booking them into custody, including liaising with health professionals to determine whether custody was suitable for them. In one case we looked at where concerns became apparent, arrangements were made to divert the individual to a mental health facility to be assessed and receive the necessary care.

2.3 Before detainees arrived into custody, custody staff received a briefing providing information about them. This included any vulnerabilities or specific needs that would need to be catered for while in custody. However, there was no standard approach across the TACT custody suites about the content or method by which this information was relayed. Detainees’ custody records also did not record details of these staff briefings or any information relevant to the detainee’s ongoing care, which would have ensured a more comprehensive and systematic approach. The few briefings we observed were detailed in the issues and factors they considered for each individual, and most custody staff felt reasonably well informed.

2.4 Most detainees were transported to TACT custody in unmarked police vehicles. Travelling times were often lengthy because of the distances involved, which reflected the regional structure of TACT custody suites and that detainees could be held in suites far from their home area. However, there was little recording of the reasons for any delays from arrest to arrival at the custody suite, and there was little focus or oversight on ensuring that detainees had received the relevant care while in transit or when waiting in vehicles at the suites. In one case a detainee had spent a considerable time in transit dressed only in football shorts. He complained he was cold when he arrived at the custody suite, but there was no evidence to show how transporting officers had dealt with this during the journey.
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 In our observations in suites and of CCTV recordings, most custody staff spoke to detainees and treated them with dignity throughout their detention, including during strip searches. Custody staff interactions with detainees were respectful and courteous throughout.

3.2 Privacy for detainees to disclose sensitive information varied. Because of the differences in TACT detention procedures, detainees were booked into custody either in a cell or at the custody desk. When a cell was used for booking in, the detainee sat at eye-level close to the custody officer. In theory, this method offered greater discretion, improved interactions with custody staff and scope for detainees to disclose important sensitive information. However, regardless of whether a cell or other custody areas were used, we sometimes observed non-essential staff, including custody staff and investigating officers, situated or moving near to where the booking in took place. This lack of privacy could deter the detainee from disclosing sensitive information early on, which could be important for assessing risk and other care needs. In some cases that we reviewed, detainees did not disclose information that they later told health care practitioners during private medical assessments; this included one detainee who had a significant history of mental health treatment.

3.3 Although detainees were treated with dignity, they were not always made aware of how their privacy was affected in the custody suite or in their cell. Not all suites displayed notices that CCTV camera recording took place, and where they were displayed (such as front desk areas) they were often difficult to see. Although staff told us they would always inform detainees about this, and that cell toilets were obscured on CCTV monitors out of custody staff view, we saw one example on CCTV where a female detainee was clearly anxious about using the cell toilet; she wrapped a blanket around herself while she removed her lower clothing to use the toilet in an attempt to protect her privacy.

3.4 Custody staff gave good consideration to the impact of the detainee’s detention on themselves and others. This took place regularly and at various stages of the person’s detention, including before their arrest (if planned), arrival into custody (when being booked in) and as part of ongoing welfare reviews. This meant that custody officers routinely established potential welfare or other personal issues to address, such as carer responsibilities. In one case we saw, custody staff made detailed arrangements with social services to accommodate safely the young children of a detainee arrested on their arrival back into the country. In the same force, we also saw a female detainee being released who, at her request, had her bail conditions varied for the first night to allow her to stay at her mother’s house where she could see her children.
Area for improvement

3.5 Detainees should be routinely advised (both verbally and in published notices) that they are being filmed on CCTV, but that cell toilets cannot be seen by staff.

Meeting individual and diverse needs

3.6 There was good attention to meeting detainees’ individual needs. This often relied on the making of specific arrangements rather than routine provision, but overall the outcomes for detainees were good.

3.7 All forces told us that female custody staff were routinely available or could be resourced where necessary (such as for planned arrests) to support female detainees and carry out gender-sensitive searches. This happened in the small number of cases that we reviewed and observed, with the female detainees receiving a high level of care and consideration. In one case, support aids were bought for a detainee who was breastfeeding, and in another staff purchased religious garments and provided other items, such as replacement underwear, a hairband and an additional mattress, to make the detainee feel more comfortable.

3.8 Not all the TACT custody facilities were suitable for detainees with mobility needs. Two suites had no step-free access or other support modifications, such as handrails or lowered call bells, and so could not accommodate such detainees. The forces had recognised these shortcomings, and one was making temporary improvements pending completion of a new custody facility. The lack of facilities emphasised the need for such issues to be identified in advance of reception into detention, but we were confident that suitable arrangements would be made to meet any needs.

3.9 Religious artefacts were insufficient across the suites. Provision for Muslim detainees was generally good and artefacts were respectfully stored, although there were not always prayer direction aids (qibla ceiling markings or compasses) to support worship. Provision for other faiths was limited across all suites, apart from Bibles and a few other religious texts. Although we were assured that religious items would be sourced where needed, we expect these items to be readily available.

3.10 Despite these shortcomings, custody staff across the suites were clearly sensitive to detainees’ religious and cultural needs and considered these regularly during their detention. We found examples where detainees were regularly reminded of prayer times, interviews and meals were scheduled around prayer times, and face-to-face meetings and telephone calls with faith leaders were facilitated.

Area for improvement

3.11 Forces should ensure that sufficient religious artefacts for the main faiths are readily available in accordance with PACE code H requirements.

Communication

3.12 Custody staff understood the importance of informing detainees about their custodial rights and entitlements in an appropriate language, and printed off information in the required language.
3.13 Foreign national detainees have the right to have their embassy or consulate informed of their detention if they so wish, regardless of any periods that they are held ‘incommunicado’. The evidence that this right was offered or facilitated was not always clearly recorded in the cases we looked at. Although custody staff were aware of these requirements, they did not always record that notification had happened in detention logs. Custody staff were also confused about who was responsible for notifying embassies/consulates as in some cases the task had been passed to investigative officers without oversight from a custody officer to ensure the responsibility was met. In one of the cases we looked at, custody staff had correctly informed the detainee’s embassy/consulate regardless of their wishes, which was in accordance with the relevant international convention. However, in cases where foreign nationals were detained in custody for longer than 24 hours, there was no evidence of daily contact with the relevant embassy beyond the initial notification, although this is set out in the College of Policing’s guidance for counter terrorism.

3.14 Interpreters for detainees generally arrived promptly, and they were often arranged in advance for planned arrests. While interpreters for TACT detainees were sourced through centralised national TACT procedures and those for PACE detainees through standard local custody provisions, officers told us that in practice both arrangements generally worked well, with few delays in the arrival of interpreters. However, there was limited recording of arrival times or other aspects of interpreting services on custody records, and no effective monitoring to assess whether interpreters arrived quickly enough. In the case of one detainee held under PACE powers, there was a delay of several hours in obtaining an interpreter for interview, even though the matter had been escalated to duty managers. In addition, although PACE code H makes provision for the use of live-link video in suites to enable interpreters to assist in interviews, we were not aware that this provision had been used.

3.15 Interpreting facilities such as speakerphones, dual-telephone handsets and portable telephones varied across the suites but custody staff told us they all worked well in enabling effective interpreting. The ‘closed’ nature of the TACT custodial environment reduced the potential for detainees’ privacy to be compromised while using speaker or public area telephones, although the presence of non-essential officers and staff could affect this (see paragraph 3.2).

3.16 There was little provision for detainees with sight or hearing impairment with few, if any, hearing loops, Braille or audio materials to convey legal rights and entitlements in any of the suites. There were also no up-to-date versions of ‘easy-read’ legal rights and entitlements to help those with reading or learning difficulties. Although staff told us, and custody records showed, that specific arrangements were likely be made for individual cases, the lack of core provisions to communicate with individual detainees with sight or hearing impairment did not meet their needs from their point of entry into custody.

Risk assessments

3.17 Individuals detained for terrorism or terrorism-related offences pose a potentially high risk to themselves because of the seriousness of their offence and often because it is their first time in custody. Unlike PACE custody, those detained under TACT can be held for longer periods, which could raise their levels of stress and affect their health and well-being. Officers need to take account of these factors when assessing and reviewing detainee risks to keep them safe.

3.18 The records we reviewed indicated that most arrests were planned, and custody staff told us they were properly briefed by counter terrorism officers in advance of detainees arriving at the custody suites (see paragraph 3.3). Pre-detention risk assessments were comprehensive,
Section 3. In the custody suite: booking in, individual needs and legal rights

and most were shared with custody officers. We saw thorough and informative briefings by counter terrorism officers before the arrival of detainees subject to a planned arrest. They shared the risk factors and vulnerabilities that were known in advance of the arrest, including additional up-to-date information received from arresting officers while en route to the custody suites.

3.19 Detainees were not always booked in promptly (see paragraph 3.28), and a few waited in vehicles outside the custody suites, sometimes in handcuffs, for lengthy periods (see paragraph 4.16). Custody staff told us that acting on information received from counter terrorism officers, they triaged detainees to identify children or vulnerable detainees to prioritise them for booking in. However, some delays were lengthy and the reasons for them were not always explained on the custody record (see paragraph 1.15).

3.20 Custody officers focused on the welfare of detainees and identifying risks, but the quality of the recording of risk assessments on detention logs was variable. We observed cases where custody officers interacted well with detainees to complete standardised risk assessments, responded to individual need and asked necessary supplementary and probing questions. Counter terrorism officers told us that they routinely completed checks of intelligence systems and the police national computer for warning markers. However, it was not always evident that custody officers were aware that these checks had been completed or recorded this information in the detention log (see paragraph 1.15).

3.21 Most initial care plans set observations of detainees at a level that met presenting risks. Although not in line with College of Policing guidance that two officers should conduct any movements of detainees, we were assured that when only one officer carried out observation checks and supervised movements around the custody suite this was appropriate and based on an individual assessment of risk. In general, custody officers reviewed changes in demeanour and other risk factors, and responded to manage these. The set frequency of checks on detainees was mostly adhered to and was generally well documented in detention logs. However, we found several cases in two forces that recorded checks, particularly at night, as having been conducted solely by CCTV. We were told this was to avoid disturbing detainees’ sleep, but this practice was potentially unsafe as it could not always identify changes in a detainee’s condition; it also did not follow the College of Policing guidance.

3.22 Custody staff were focused on keeping detainees safe and were alert to managing the risk associated with suicide and self-harm. However, they routinely removed detainees’ clothing with cords, belts and footwear, rather than assessing whether the risks posed by the detainee merited this; this was a disproportionate response to managing risks, particularly in a well-supervised and controlled environment. All custody staff carried anti-ligature knives, and we were told that anti-rip clothing was not used in any suite.

3.23 Custody staff told us that if a detainee’s risk to themselves was high they would use close proximity supervision, with staff - briefed by the custody officer - sitting outside the cell with the door open. We reviewed CCTV footage of a close proximity watch where we saw the officer conducting the watch using their mobile telephone instead of monitoring the detainee, which was potentially unsafe.

3.24 The staff shift handovers that we observed, particularly between custody officers, were well conducted and focused on risk and the welfare of the detainee. However, practice varied and handovers did not always include all staff, were not always recorded on CCTV, and the records in detention logs were often poor (see area for improvement 1.22). We were told that counter terrorism officers would attend staff shift handovers where possible to provide an update on the detainee’s welfare needs and case progression, and we saw some good input from counter terrorism officers.
Area for improvement

3.25 Some elements of detainee risk should be better managed. In particular:
- checks of detainees should take place in the detainee’s cell
- detainees’ clothing and footwear should only be removed on the basis of an individual risk assessment
- all custody staff should be involved collectively in shift handovers.

Individual and legal rights and reviews

3.26 Under both TACT and PACE, custody officers are responsible for completing custody records and informing detainees of their rights once they arrive at a custody suite. However, arrests under TACT (section 41 and schedule 7 Terrorism Act 2000) differ from those under PACE. A main difference is that TACT detainees can be held in custody for up to 48 hours without charge from the time of their arrest (or when their examination began, if detained under schedule 7). Under PACE, however, a detainee can only be held in custody for up to 24 hours without charge from the time they arrive at a police station, or 24 hours after the time of their arrest, whichever is the earlier. In each case, these timings are known as the ‘relevant time’. Detention can be extended, if appropriately authorised under a warrant of further detention issued by a court, for up to 14 days from the relevant time for TACT detainees and up to four days from the relevant time for PACE detainees (a superintendent can extend a PACE detention for up to 36 hours before a court intervention).

3.27 Under PACE code G, when a detainee is brought to a police station the custody officer must make sure they are fully informed about the circumstances of the offence for which they have been arrested, and the reasons and necessity for their arrest and detention. Under PACE section 37, it is the custody officer who can authorise the continued detention of someone arrested and held at the police station, if they believe there are reasonable grounds to do so. Under TACT, the custody officer must make sure that the detainee is informed on their arrival why they have been arrested and detained on suspicion of being involved in the commission, preparation or instigation of acts of terrorism. However, due to the sensitive and secure nature of terrorism investigations, the custody officer may not always disclose the full grounds for the arrest. In TACT cases, detention is not authorised by the custody officer but is authorised at a first review conducted by an officer of at least the rank of inspector, which must be carried out as soon as reasonably practicable after the detainee arrives at the police station. The review officer must be independent of the TACT investigation but they will be fully briefed by the counter terrorism investigation team so that they can make their decision on whether there are reasonable grounds to authorise continued detention.

3.28 In our TACT custody record analysis, detainees were sometimes delayed in arriving at the custody suites when they travelled from a neighbouring police force. The longest time between arrest and arrival was four hours 59 minutes and the mean time was one hour 53 minutes. Detainees were generally booked in promptly once they had arrived at the custody suites, but in a few cases there were further delays while they were held in vehicles outside. In some suites we were told that if many detainees arrived together only one would be booked in at a time. We saw this happen in one case, and we were aware that some delays were because the suite was being prepared for use. These delays were not always explained and justified in the custody records. (See area for improvement 1.23.)

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4 Code of practice for the statutory power of arrest by police officers.
Section 3. In the custody suite: booking in, individual needs and legal rights

3.29 The necessity for arrest criteria in the PACE cases that we examined was not always recorded (see area for improvement 1.23). In some cases, arresting or escorting officers did not always advise the custody officer of, or were not asked in the presence of detainees for, the necessity criteria for their individual arrests; this did not meet the requirements of PACE code G.

3.30 Initial reviews to authorise detention under TACT were conducted by officers of an appropriate rank, but they were not always prompt. In our TACT custody record analysis, nearly half of first reviews took place over 90 minutes after a detainee arrived at the custody suite. In two cases the initial review took over four hours to be completed, with the longest taking four hours 41 minutes; this was not acceptable, particularly when most of these arrests were planned.

3.31 In the records we reviewed and our observations, custody staff gave full consideration to ensure that detainees’ rest periods were adhered to, and that cases were progressed promptly to minimise detention periods. In our custody record analysis, 27 TACT detainees were charged and remanded for court but 18 were released with no further action. The shortest detention period was 22 hours 27 minutes and the longest was 13 days 17 hours 52 minutes. The average length of detention was five days 20 hours 53 minutes. Warrants of further detention to extend TACT detention beyond 48 hours were applied for promptly (see also paragraphs 1.18 and 6.5).

3.32 PACE code C covers the detention, treatment and questioning of persons by police officers under PACE, while code H covers the detention, treatment and questioning of persons in police detention under section 41 of and schedule 8 to the Terrorism Act 2000. Under both codes, custody officers must ensure that detainees are informed of their continuing rights and are issued with a written notice that sets out their rights and entitlements under the respective legislation.

3.33 Our case audits, review of CCTV footage and observations in suites showed that detainees had their rights and entitlements explained to them in a timely manner. They signed to indicate they had received their rights, but it was not always clear which written version of the rights and entitlements material was issued. Not all forces had both code C and code H versions, some were out of date and one force only issued an abbreviated easy-read version.

3.34 Under PACE the right for a named person to be informed of a detainee’s detention can be delayed by an inspector for up to 36 hours from the ‘relevant time’. Under TACT, such delays can only be authorised by a superintendent for up to 48 hours. Such delays, known as ‘incommunicado’, can only be authorised if there is a belief, for example, that if a person is informed of someone’s detention it may lead to the interference with or physical harm to other people or evidence. When this right was withheld, it was not routine and was authorised by an officer of the appropriate rank. However, in some cases we looked at it was not possible to establish when some detainees had their rights withheld, how long this had been authorised for and when this restriction was finally lifted. In two TACT cases, these restrictions extended slightly beyond 48 hours from the relevant times, but pertinent notifications to named people were subsequently completed.

3.35 In a few cases we examined, staff were not always clear on the identification of ‘relevant times’, particularly when this related to an examination under TACT schedule 7 and the

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5 The right 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.

6 A superintendent’s authority is required for delay in notifying a legal representative.
Section 3. In the custody suite: booking in, individual needs and legal rights

The custody suite did not display posters advertising the right to legal advice, as required under PACE codes C and H. All detainees were offered free legal representation, and if they declined they were told they could change their mind at any time and accept this offer. There were sufficient consultation and interview rooms in all the suites. Legal advisers could read their client’s custody record on request, which we observed taking place.

Under both PACE and TACT, detainees have the right to read a copy of PACE code C or H if they wish to do so but, other than in one suite, there were no up-to-date copies of either available. However, there was evidence in the case audits that these were sometimes issued, and we also saw them proactively offered without being requested.

There was an effective system for collecting DNA samples taken in custody, which were handled by specialist staff.

None of the custody officers we spoke with were aware that a range of documents – such as reviews of detention and TACT application for warrant of further detention – should have been available for non-English speaking detainees in their own language. One of the forces gave us the relevant documentation that should be translated but told us this had never been used.

All detainees in police custody should have their detention regularly reviewed by a senior police officer (inspector or above) to determine whether it remains lawful and justified to continue. Under PACE section 40, detention should be reviewed at six hours after it was authorised and then every nine hours until the 24 hours expires, unless an extension is authorised or the detainee is charged or released from police custody. Under the Terrorism Act, reviews of TACT detention should take place no longer than every 12 hours from the first review up to 48 hours from arrest, unless a warrant of further detention is granted by the court. Reviews within 24 hours of arrest can be conducted by an officer of at least the rank of inspector, but any reviews thereafter must be done by an officer of at least the rank of superintendent. TACT reviews should be conducted in person, as, unlike PACE, the legislation does not allow for telephone or video conferencing reviews or reviews while the detainee is asleep.

Reviews of detention were generally conducted well; they were done in person and were well recorded. However, we found too many that were conducted early or late with no rationale or justification for this recorded. For example, in our PACE custody record analysis 39 of 78 first reviews (50%), and in our TACT custody record analysis 25 of 42 second reviews (60%), took place early. In two of the forces TACT reviews had taken place when a detainee was asleep, and in one case when they were in interview, when this should have been postponed until after interview.

Some forces were also using sergeants and chief inspectors to perform ‘acting’ duties above their substantive rank to carry out both PACE and TACT reviews. In these cases, the forces must ensure their processes to authorise these staff are in accordance with PACE section 107, but it was not clear that this was the case. In two TACT cases, we found that inspectors had conducted reviews after the initial 24-hour period when these should have been done by

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7 PACE code C annex M and PACE code H annex K detail the documents considered essential for the creation and provision of translations.
a superintendent, apparently due to confusion over the applicable ‘relevant time’. (See also paragraph 1.19.)

3.43 In all forces we found cases where inspectors conducted a third review with TACT detainees just before expiry of the 24-hour period, when the third review should have been carried out by a superintendent after the 24-hour period had expired. In our TACT custody record analysis, the shortest time between a second and third review was six hours 35 minutes, when these should have been 12 hours apart. The reasons why these reviews were early were unclear as there was no rationale or justification recorded in the detention logs (see area for improvement 1.22).

Areas for improvement

3.44 Officers should carry out PACE and TACT reviews of detainees in accordance with relevant legislation and the requirements of PACE codes C and H.

3.45 Custody officers and reviewing officers should have a clear understanding of the ‘relevant times’ for both PACE and TACT detainees.

Access to swift justice

3.46 Under PACE code H, there is no provision for TACT detainees to be bailed before or after charge. Bail was applicable in PACE cases and we found this was managed effectively by the respective counter terrorism units. When detainees were released without charge, bail was used in accordance with the applicable bail periods set out in legislation. These bail periods were strictly adhered to and were proportionate for the complexity of investigations. Although there were processes to monitor and supervise bail cases, the application and granting of bail were often poorly recorded in detention logs (see area for improvement 1.22). In our PACE custody record analysis, 38 detainees (46%) were released on bail.

3.47 ‘Release under investigation’ (RUI) was used less often, and applied to only 20 detainees (24%) in our PACE custody record analysis. All forces had electronic or written notices to notify RUI detainees about their status. These explained what RUI meant and the consequences if they attempted to interfere with the course of justice. These cases were managed effectively by the respective counter terrorism units, but again the details were often poorly recorded in detention logs (see area for improvement 1.22).

Complaints

3.48 None of the custody suites displayed information on the complaints process. However, it was contained in most of the rights and entitlements notices issued to detainees, and detainees were asked during their reviews of detention if they wished to make any representations. The number of complaints received was low, and they were looked into and responded to appropriately. Custody officers told us that if a detainee wished to make a complaint in the first instance they would try to resolve the issue but, if unsuccessful, they would facilitate the complaint and request the custody/duty inspector to attend. In addition, our observations and CCTV footage showed that TACT detainees were asked on release if they had been satisfied with their treatment during their time in custody, and we saw several positive comments recorded on detention logs.
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.

Physical conditions

4.1 The physical conditions in TACT custody suites were very good overall. All the suites, apart from one, were used solely for detaining those who had been arrested for terrorism or terrorism-related offences. One custody suite was a dual-purpose facility that was closed to standard PACE detainees when required for TACT detentions.

4.2 Cells in TACT-specific facilities had additional security measures, and each suite had cells that could be forensically sealed. Cells were generally well maintained, clean and offered good ventilation, natural light and were free from graffiti. There were adequate arrangements for both daily and specialist cleaning when required. All communal areas in the suites were also clean and tidy.

4.3 With the exception of one suite, all cells were larger than and had further features not found in standard custody facilities. The cells in the one suite that were the same as those in standard custody facilities offered reduced space and functions, but custody staff took steps to offset this for those held for longer periods; these included moving detainees (both adults and children) to larger rooms to facilitate welfare and education provision.

4.4 All cell call systems were in good working order and there were satisfactory arrangements for officers to answer calls promptly.

4.5 There were adequate washing facilities within the cells or elsewhere in the custody suite, and communal showers were mostly accessible and clean. One suite had two cells with showers.

4.6 All suites had CCTV cameras inside cells and communal areas, and custody staff monitored footage. However, notices informing detainees about this were not always well displayed (see paragraph 3.3 and area for improvement 3.5).

4.7 All suites had good arrangements for checking cells and the physical conditions of suites, and had routine maintenance regimes. We found evidence of recent repairs after such routine cell inspections, including one instance where a reported fault was fixed within 24 hours. Some forces also had arrangements to monitor the condition of suites when they were out of use for any extended period. When arrests and detentions were planned, custody staff inspected cells that day to ensure they were in a safe and suitable condition.

4.8 Despite these measures, we found a few potential ligature points in cells in four suites, and communal areas in two suites. We raised these concerns with each force during the inspection, and they responded promptly to outline the remedial steps taken or planned to address them.

4.9 Only two suites could demonstrate that there had been fire evacuation procedures within the previous 12 months. The other suites had no structured testing regime, relying on
custody staff taking individual responsibility to update and test their knowledge; this was unsatisfactory and not safe in the event of a fire.

4.10 All TACT suites had first aid and resuscitation equipment, but not all kit was in date or complete. Some first aid supplies were out of date in two suites, but were withdrawn immediately this was pointed out. Two suites did not have equipment to clear the mouth of obstruction, and one of these had no oxygen for use in an emergency. Resuscitation kit in three suites was complete, although one had out-of-date automated external defibrillator chest pads, compromising effectiveness. (See area for improvement 4.55.) Unusually, one suite provided Yankauer’s airway suction catheters, an effective, and least injurious, means to clear a patient’s airway during emergency resuscitation.

Area for improvement

4.11 Forces should ensure that all TACT custody facilities are subject to regular fire evacuation testing.

Good practice

4.12 The availability of Yankauer’s suction catheters in one suite provided health care professionals with an effective means to clear a patient’s airway during emergency resuscitation, which was least injurious to the patient.

Safety: use of force

4.13 There were few incidents involving the use of force in TACT custody. When force was used it was generally only low level. However, there was limited oversight and governance and no collation or monitoring of the use of force data. (See cause of concern and recommendation S35 and S36.)

4.14 Custody staff told us they were in date with their officer safety/protection training and this was a requirement for them to be allowed to work in the TACT suites. In three custody suites, custody staff carried personal safety equipment, including handcuffs, batons and incapacitant spray, which we do not routinely see in controlled custody environments and which does not follow the College of Policing guidance.

4.15 Due to the varying CCTV footage retention periods, we could view only a few interactions with TACT detainees (see paragraph 1.14). In our review of footage of four incidents where force was used, the application and techniques used to apply restraints were safe and proportionate. Although we were told that individual use of force forms were completed, these were not submitted for any of the incidents that we identified. Detention logs did not always record that force had been used and, when it was, there was not always a justification or rationale for why this was necessary (see area for improvement 1.22).

4.16 Most detainees arrived wearing handcuffs. While these were generally removed quickly, in some cases compliant detainees were held in handcuffs in the suite or in vehicles outside for too long (see paragraph 3.19) - one compliant detainee remained in handcuffs for two hours 40 minutes, which was disproportionate to the threat posed in the controlled custody environment. Custody officers did not always ask escorting officers if handcuffs had been used, and their use was not always recorded in detention logs. When there were delays in the removal of handcuffs, the justification or rationale for why the continued restraint had been necessary was not always recorded (see area for improvement 1.22).
4.17 In our TACT custody record analysis, seven detainees (16%) had been subject to a strip search in custody, which is slightly higher than we normally see in standard police custody. In our PACE custody record analysis, only six detainees (7%) were strip searched, which was broadly comparable with what we usually find. The strip searches recorded in the cases we reviewed were warranted and, in the main, properly justified and authorised. However, in one case the record was incorrect as it related to a removal of clothing for forensic purposes rather than a strip search. In another case, no justification or rationale for the strip search was recorded (see area for improvement 1.22).

Areas for improvement

4.18 All staff involved in the use of force against a detainee should submit an individual use of force form.

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

Detainee care

4.20 TACT detainees can spend up to 14 days in detention and we would expect, in line with the requirements of code H of PACE, higher levels of detainee care. TACT detainees were very well cared for, with greater focus on their personal welfare needs. Because of the higher ratio of staff to detainees (reflecting the nature of offences), more staff were usually available to facilitate access to welfare provision. There was evidence that staff actively offered detainees showers and outside exercise, and responded to their requests.

4.21 Provision of food and drink was generally very good. Refreshments were provided regularly and at the detainee’s preference, rather than adhering to fixed meal times. Most forces arranged for detainees to have access to fresh food from their arrival into custody. This was more than is set out in the College of Policing guidance (which allows standard custody provisions to be used for the first 48 hours of detention) and demonstrated a high level of care. Detainees in some suites had ready access to drinking water in their cells or by request elsewhere. Custody staff endeavoured to identify detainees’ dietary needs (such as halal or vegan requirements) and to source required items. Staff also monitored detainees’ diets (in conjunction with daily health care professionals’ assessments), and we found evidence that some detainees were encouraged to eat fresh fruit and vegetables to ensure a suitably balanced diet.

4.22 There were small outside areas for exercise or fresh air at all suites; they were generally well maintained and offered suitable privacy. However, the areas in two suites had no sheltered areas for use during bad weather. In some suites, detainees also had access to some sports equipment (such as footballs) to occupy them. In general, we found evidence that detainees were allowed to use these facilities, particularly those held for longer under TACT detention powers.

4.23 As soon as a court grants a warrant of further detention to extend detention beyond the initial 48-hour period, the detainee’s welfare should be assessed daily (every 24 hours) by officers of the appropriate rank (inspector or above), in line with College of Policing guidance for TACT custody. The custody records we reviewed showed these welfare reviews happened routinely, and in most forces occurred more frequently (every 12 hours), which was positive. There was a generally good focus on the individual’s welfare needs during welfare reviews, including enquiries about their comfort, religious or cultural needs, or desire for telephone calls with family members. Welfare reviews were also informed and
supplemented by daily assessments by health care professionals. In one suite, a template helped guide reviewing officers on the issues to consider, but this was not used across all the forces. The recording of welfare reviews was generally good, but some were poor with a greater focus on re-stating the detainee’s legal rights and entitlements.

4.24 Our observations in suites and reviews of custody records indicated that custody staff at all suites were mindful of the impact of detention on a person’s well-being and would address any issues identified wherever possible. For example, in one suite a particularly anxious detainee was allowed and encouraged to spend frequent periods outside, including taking their meals there. During observation checks of the detainee the cell door was left open to reduce their feeling of discomfort, and an additional staff member was used to manage the additional risks from doing this. Some cases also demonstrated other welfare checks and enquiries, such as monitoring a detainee’s weight or frequency of eating, with staff clearly understanding and performing their role in safely managing detainees’ welfare.

4.25 In all suites, independent custody visitors (ICVs) regularly visited detainees (including some on their first day of detention); they noted few concerns, and some positive feedback from detainees about their treatment. The detainees we spoke to during the inspection also said they had been treated well.

4.26 Reading material for detainees at most sites was minimal and insufficient to occupy them over an extended period. Clothing and toiletry supplies, although generally sufficient, were basic. However, custody staff made relevant purchases (within reason) where shortfalls in provision were identified on site, such as buying magazines, books and puzzles, appropriate sized or alternative clothing and toiletries.

4.27 Bedding in cells was of sufficient condition, with all suites using extra thick mattresses to offer additional support and comfort to detainees being held for potentially long periods. We were told that where detainees were held beyond 24 hours they were offered regular changes of clothing, and we saw some evidence of this in our review of detention records. We were also informed that there were efforts to clean detainees’ cells every day, such as at times when they left their cell for interview or outside exercise, or they would be moved to another clean cell if one was available.

4.28 Although detainee care was generally to a high standard with a strong focus by custody staff on meeting their welfare needs, this was not always well recorded on custody records. While food and drink details were usually documented this was not the case for other aspects of detainee care, such as changes of clothes and bedding, or when reading materials, showers or exercise were offered, as prescribed in the College of Policing guidance. Custody staff in all forces assured us that such care happened routinely and regularly, but it was not always possible for us to confirm this through detainees’ written detention records. (See area for improvement 1.22.)

4.29 Detainees held for terrorism offences are allowed to receive visits from friends and family (provided this would not have any potentially adverse impact on the investigation). There were facilities for visits at each suite, and some examples of visits taking place in the cases we looked at. In some suites, faith representatives were allowed to meet detainees, and in one case a child in custody was allowed to spend time with his parents in the suite for several hours each day. Personal telephone calls to family members were also regularly facilitated.

4.30 Arrangements for detainees who smoked were inconsistent. In some suites they were allowed to smoke outside routinely, whereas elsewhere nicotine replacements were generally used instead.
Safeguarding

4.31 The custody staff we spoke with had a good understanding of vulnerability and identifying safeguarding concerns. However, there was very little specific guidance or training on safeguarding in the TACT environment, with reliance on standard custody practice. There was additional training in some forces, for example on the national ‘Prevent’ programme (aimed at diverting individuals away from terrorism) or grooming for terrorism, but none specifically related to custody.

4.32 Safeguarding assessments were part of the pre-arrest planning process, and any measures considered necessary were taken at this stage. Most custody staff told us that they were reasonably well briefed about detainees due to enter TACT suites, but it was not clear in the custody records we looked at whether or how safeguarding considerations had informed the management of detainees while in custody.

4.33 Custody staff in the TACT suites saw their safeguarding role as focused on meeting the detainee’s care needs in custody and ensuring their safe release. Any concerns identified during custody were referred through the counter terrorism detention managers to the counter terrorism investigation teams to take the necessary action and engage with partner agencies as needed. This was to ensure that information relating to TACT detainees was only shared with other officers and partner agencies as required. However, some custody staff we spoke to were confused about how they might engage directly with other agencies for TACT detainees known to them, with no formal framework or guidance for sharing sensitive information in these circumstances.

4.34 Detainees received support from appropriate adults (AAs) from very early on in their detention. AAs were normally arranged as part of the pre-arrest strategy and, in the cases we looked at, they were present at the time of, or shortly after, the detainee’s arrival. AAs were available for the reading of the detainee’s rights and entitlements during booking in, and they returned regularly and promptly to support detainees through the different stages of custody processing. We were told that most AAs were available throughout the night if needed.

4.35 There were some delays in securing AAs for vulnerable adults when this had not been identified at the arrest planning stage and the need had only become evident after the detainee had entered custody. Custody officers told us that they were confident in assessing whether an AA was needed and took decisions in liaison with the health care practitioners – although in one case we looked at, this had not been considered even though there was evidence that the detainee might have required AA support.

4.36 There was insufficient information recorded, and no monitoring, to demonstrate how well the timeliness of AAs provision was meeting the needs of detainees. There was little recording on custody records to show when AAs were called, their arrival into custody, whether they were present for different aspects of custody processes or their relationship to the detainee. (See area for improvement 1.22.)

4.37 The arrangements for securing AAs were different for each TACT suite. Some forces preferred to seek family members in the first instance, whereas others who had easy access to independent AAs felt these were better suited to support detainees in the TACT environment. Some forces used AAs from their local authority through a paid-for scheme,

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which ensured that detainees were supported quickly. Others relied on their standard custody arrangements for AAs, and if family or other professionals the detainee was known to were not available, they requested an AA from the local authority (youth offending team, YOT, or social services). We were told that local authorities prioritised AAs in these circumstances to avoid delays in support for the detainee.

4.38 These different arrangements meant that not all AAs were trained to perform the role. Those from paid-for schemes and some local authority staff were trained, but this was not the case for AAs sourced from elsewhere. Similarly, not all AAs were vetted to the necessary security clearance level to enter a TACT custody suite and could potentially be privy to sensitive information. While AAs from paid-for schemes (and, we were told, some local authority staff) were suitably vetted, family members and other professionals in the role were unlikely to have been. There was no guidance or national framework for securing AAs in TACT suites. The inconsistent arrangements, as well as the varying training and experience of AAs who attended, meant that children and vulnerable adults might not have received consistent support.

4.39 Few children entered TACT custody. Between 1 November 2017 and 31 December 2018, only five children were held in TACT custody suites and dealt with under PACE (TACT) code H, and 10 children for terrorism offences dealt with under PACE code C.

4.40 Children were well cared for in TACT custody. Their welfare needs were identified and considered before their arrest and kept under review, and arrangements made to best meet these. For example, in one case we looked at a child was arrested under PACE so that officers could use bail powers (unavailable for offences dealt with under TACT) to allow him to return home to his parents’ care each evening while the investigation was ongoing. In another case, arrangements were made for a child to receive school education materials while in the custody suite.

4.41 Children were offered a choice of food and drink, with attention to ensuring a healthy and balanced diet. Where parents or family were available they could see their children regularly, if appropriate. One force had designated a cell specifically for children, which displayed artwork and provided a bean bag to make it a less intimidating environment.

4.42 Custody staff we spoke to were aware that girls should be assigned a female officer to look after their welfare needs, as required by the Children and Young Person’s Act 1933. There were only two girls in the cases we looked at, but it was not clear whether this provision had been made as it was not recorded on the custody record.

4.43 In the cases where children were released from custody, arrangements were made for them to return home safely in the care of a responsible adult. For children who were charged and taken to court, all of the forces followed a recent protocol to ensure that a YOT worker was always available to accompany them while at Westminster Magistrates’ Court.

4.44 Few children entering custody were charged and refused bail. Forces followed the requirements of the Home Office concordat on children in custody and requested alternative accommodation from local authorities. However, there was some variation in how forces did this. One force said they made this decision on a case-by-case basis, as the level of risk could make any type of alternative accommodation inappropriate. Others said they would always make a request for alternative accommodation to the local authority, which has a statutory duty to provide accommodation in such circumstances. The lack of secure accommodation nationally meant that there was little expectation that such requests would be met. However, we found one child detainee who was transferred to alternative accommodation, although in this case this might not have been in their best interests. The transfer occurred late in the evening, with an early start needed the next morning to travel to court, and, we were told, the child did not want to move. While in this case the force
followed the relevant protocols (based on standard custody arrangements to divert children away from police custody wherever possible), it did not take account of wider considerations affecting TACT detainees - the child had already spent several nights in custody, had access to a much higher standard of custody facilities and welfare provision than standard custody, and had asked not to be moved. This example indicates potential merit in reviewing the approach at a national level and, if necessary, develop a more tailored arrangement for children detained in TACT custody.

Areas for improvement

4.45 Counter Terrorism Policing should provide guidance and a clear framework for custody officers to engage with partner agencies where there are safeguarding concerns about detainees to ensure that sensitive information is shared appropriately. Forces should set up arrangements to achieve this.

4.46 Counter Terrorism Policing should provide guidance on the provision of appropriate adult services to children and vulnerable adults that clarifies training and vetting requirements. It should work with forces to ensure that all detainees needing an appropriate adult receive a consistent level of support.

Governance of health care

4.47 There was no dedicated health needs assessment of TACT detainees. However, in most forces the health needs of TACT detainees were factored into those identified for existing contractual arrangements, which was pragmatic.

4.48 Competent health care practitioners (HCPs) including doctors and forensic medical examiners (FMEs), nurses and paramedics were available to TACT detainees. Contractual arrangements varied and included a consortium of local FMEs and existing health contracts. HCPs we spoke with were highly experienced. We spoke with one detainee who said they had received careful attention to their privacy and dignity in their health care. Partnership working between the forces and their respective health providers was very good.

4.49 Some forces had written agreements with local health and ambulance partners about the care and security of TACT patients during non-emergency admissions to hospital, as in the national guidance. An exemplary protocol agreed in one force, with a shared commitment between police and health partners to addressing health needs and maintaining safety and confidentiality, enabled non-emergency prompt and effective responses to detainees with dental, mental health and physical needs.

4.50 Clinical governance assurances were satisfactory in four forces, and were incorporated into existing contractual monitoring arrangements. In one force, the lead FME told us he undertook NHS-compatible governance checks, which were available to the force if requested, but that no request had been made. The force was therefore unaware of the credentials of the FMEs.

4.51 Four of the health providers had confidential health complaints processes. The fifth used the police complaints process, which did not maintain medical confidentiality. None of the suites publicised the availability of an independent health complaints system.

4.52 The standard of clinical facilities varied widely. Access to natural light was good in all but one suite, which was adequate for TACT detainee consultations. While all the rooms were clean not all met infection-control standards. There was no examination couch paper roll in one
suite, a non-wipeable chair in another, and no handwashing advice displayed at several suites, although the forces were taking action to achieve compliance. Some clinical sterile supplies were out of date in two suites; these were removed immediately this was pointed out.

4.53 In two suites, medicines for use in a medical emergency were not stored with the resuscitation equipment, which could lengthen response times in an emergency.

4.54 The doctors/FMEs and HCPs we spoke with were aware of the procedures for safeguarding adults and children, and when to use them.

Area for improvement

4.55 Police forces that commission health services for detainees held in TACT suites should ensure that there is robust clinical governance, suitable provision of emergency medical equipment and integrity of clinical supplies.

Good practice

4.56 An agreement between the police and health partners in one force, with a shared commitment to addressing health needs and maintaining safety and confidentiality, enabled non-emergency prompt and effective responses to detainees with dental, mental health and physical needs.

Patient care

4.57 Detainees received a first medical assessment and subsequent medical consultations in line with national TACT guidance. With one exception, all forces had more frequent local visiting arrangements by HCPs than specified in national TACT guidance, irrespective of clinical need. Most TACT health assessments were pre-booked and took place within an average 68 minutes of the detainee’s arrival in custody, which was equitable to detainees in standard police custody suites with no embedded health staff. PACE detainees in TACT suites received the same service.

4.58 Our sample of clinical records indicated attention to gaining patients’ consent and respecting their choice. Detainees could see an HCP of a gender of their choice, and all suites had suitable chaperone arrangements if required. HCPs confirmed that professional interpreting and translation services were available but were rarely used. Medical assessments were completed in extensive detail, with very precise use of body maps to record injuries, etc.

4.59 Medical treatments were not generally required as about three-quarters of TACT detainees were aged 29 years or less. In two suites, all patients had a care plan with a named doctor/FME (with the HCPs providing care) who was responsible for the patient until release, providing medical continuity.

4.60 In some TACT suites, HCPs involved in the care of TACT detainees were aware of the potential effects of prolonged detention on mental health and well-being. In four suites, the HCP saw TACT detainees twice a day, which enabled them to build up a working relationship that aided a more informed assessment of the detainee’s well-being. Some HCPs told us that they had observed that TACT detainees could become sullen after three or four days in custody, which they attributed to post-stress malaise following initial arrest and detention. However, no HCP had noticed clinically significant mental distress because of prolonged detention. Detainees staying for more than a few days in a TACT suite had access...
Section 4. In the custody cell, safeguarding and health care

4.61 Individual patient care was very good and usually well documented using national TACT guidance medical templates, although one suite used more extensive pro formas. Some handwritten medical notes were difficult to read at every suite. One suite was planning to introduce electronic clinical records. Storage of medical records was generally satisfactory. Custody staff confirmed they were satisfied with their verbal and written communications with HCPs.

4.62 HCPs told us that they liaised with relevant health services, such as GPs, to ensure continuity of care during detention and on release. In our case audits, we saw very few completed pre-release health templates, as set out in national TACT guidance.

4.63 Systems for ordering, storage, prescription and administration of medicines were good at all suites, including clear records of administration and the correct mechanisms for the disposal of medicines. In one suite there was no stock of medicines, as the FMEs supplied them, and at another a new medicines storage cabinet was being installed as we visited. All suites except one had medicines fridges, although none held medicines. The fridges were not monitored daily to ensure compliance with recommended temperatures. Patient group directions enabled non-medical HCPs to prescribe and administer common medications. When HCPs were not on site, there were suitable arrangements for custody staff to assist detainees to take their medicines at the prescribed times.

4.64 Nicotine replacement therapy was available to TACT detainees at all suites. Opiate substitution therapy, such as methadone, could be continued subject to suitable checks, although none of the HCPs we spoke with could recall prescribing it. We were informed in two suites that opiate substitution therapy was only available to longer-term TACT detainees, which was not consistent with national clinical guidelines.

Area for improvement

4.65 Detainees in TACT custody should receive health care and treatment in accordance with national clinical guidelines, with any deviation from these only on the basis of an individual clinical assessment.

Mental health

4.66 No TACT suite had embedded mental health or substance misuse practitioners to offer rapid assessments, as in busier police custody suites. However, HCPs in three forces said that liaison and diversion practitioners at other police custody suites were responsive to calls for advice from TACT HCPs, even though they were not contracted to assist.

4.67 HCPs called for specialist mental health assessments, as necessary, via local authority emergency duty teams. While this was rare, there had been a recent prompt Mental Health Act assessment of a detainee in one suite, who was transferred to a hospital within six hours of being assessed; this was quicker than we commonly see in police custody.

4.68 Custody staff in all suites felt that detainees with mental health issues were arriving into TACT custody more frequently than previously. Custody officers received suitable training to enable them to alert an HCP where a mental health problem was suspected.
Section 4. In the custody cell, safeguarding and health care
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 well-being on release. Detainees appear promptly at court in person or by video.

Pre-release risk assessment

5.1 We found a good focus on ensuring that, where relevant, detainees were released safely. The practice we observed was better than what was actually recorded in the custody records.

5.2 With terrorism-related detainees, counter terrorism senior investigating officers, rather than custody officers, took the lead in considering and planning their safe release. This was generally due to the sensitive nature of these cases and their in-depth knowledge of each individual. But this often meant that custody officers, who have a responsibility to satisfy themselves that all identified risks are taken into account before release, were not always made fully aware of release plans, and infrequently noted in the custody record what the plans were. Few pre-release risk assessments were completed in the cases we audited, and in a few instances the custody records had been closed and it was unclear what had happened to the detainee. We saw some examples of detainees being released with travel and welfare arrangements arranged by counter terrorism officers, but the detail recorded in the corresponding custody record entries was variable. (See area for improvement 1.22.)

5.3 Some suites had generic support leaflets with useful telephone numbers for different agencies but these were not routinely issued to detainees. Custody officers said this was because some detainees did not reside in their force area and so the details could have little relevance for them.

Courts

5.4 TACT detainees can be held in police custody for up to 48 hours from arrest.9 If an extension to detention is required, this must be applied for by a Crown prosecutor or a police officer of at least the rank of superintendent. All applications for a warrant of further detention are dealt with by Westminster Magistrates’ Court, and these take place via video-links, installed in all the custody suites, which means the detainee does not need to travel to the court. In three suites, these video-links were installed in recognised courtrooms; in the other two suites the rooms were multi-functional, but cleared of all non-essential staff and secured when used for court purposes. Warrants of further detention can be issued initially up to seven days from the time of arrest, but also for a shorter period if applied for or if the judicial authority deems this necessary. Subsequent applications can also be made for a warrant of further detention, taking the maximum detention period up to 14 days.

5.5 Counter terrorism officers told us that all suites had arrangements for advising Westminster Magistrates’ Court when a TACT detainee was held in custody should a warrant of further detention be required.

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9 Up to 54 hours from arrest (with a six-hour grace period) in exceptional circumstances.
detention subsequently be required, depending on the nature and scale of the TACT investigation. Custody officers were not involved in the court arrangements or the service of relevant papers on TACT detainees, which was carried out by counter terrorism officers. Although we were satisfied that warrants of further detention were granted within required timescales, in the cases we audited the court had not always timed and dated them, and the force rarely recorded detail of when they were granted. (See area for improvement 1.22.)

5.6 All detainees who are subsequently charged under TACT must appear at Westminster Magistrates’ Court, regardless of where in the country their investigation has taken place. Counter terrorism officers were responsible for liaising directly with the court to arrange the first hearing, and staff reported generally good relationships with the court. Detainees appeared in court in a timely manner, with consideration given to the need to arrange the transport and staffing involved in the transfer to London, as this role falls to the police to complete.

5.7 The only involvement of custody officers in the court process was to complete a person escort record (PER) detailing all risks relevant to the detainee. Copies of PERs were not always included in the case files, and those that were, were sometimes illegible. (See area for improvement 1.22.)
Section 6. Summary of causes of concern, recommendations and areas for improvement

Causes of concern and recommendations

6.1 Cause of concern: There was no national framework or guidance for forces to operate in, resulting in inconsistent approaches to delivering TACT custody and different practices across the forces.

Recommendation: Counter Terrorism Policing should provide a clear framework for delivering TACT custody, supported by national policies and guidance, within which all forces can operate. (S34)

6.2 Cause of concern: There was a lack of governance and oversight by senior officers in each of the forces, and the lines of accountability for TACT custody were unclear.

Recommendation: Each force should strengthen its governance arrangements with senior officers taking clear accountability for the delivery of TACT custody in their force. (S35)

6.3 Cause of concern: Not enough information was collected or monitored at national or force level to show how well custody services were performing and whether the required standards for detainees were met.

Recommendation: Each force should gather and monitor comprehensive and accurate information on TACT custody to assess how well the services are performing. Counter Terrorism Policing should develop a performance framework to assess performance at a national level. (S36)

Areas for improvement

Leadership, accountability and partnerships

6.4 The forces should improve integration between TACT and mainstream custody so that officers with the relevant training and expertise in managing custody have oversight of the TACT suites, and good practice and learning are shared. The National Police Chiefs Council lead officers for TACT custody should also improve integration with the national leads for mainstream custody. (1.10)

6.5 Counter Terrorism Policing should provide guidance on the role of counter terrorism detention managers and TACT custody officers to clarify their respective responsibilities. Forces should provide clarity on supervisory responsibilities, quality assurance and the tasks that custody officers have responsibility for under PACE codes of practice. (1.11)

6.6 Counter Terrorism Policing and forces should develop guidance and operational protocols for the vetting levels required for people entering TACT suites in an official capacity. (1.12)
Section 6. Summary of causes of concern, recommendations and areas for improvement

6.7 Forces should ensure that custody records clearly and adequately record all information and the rationale for decisions, with robust quality assurance to confirm that the records are to the required standard. Counter Terrorism Policing should review the current arrangements and forms used for recording on custody records, and identify and address any shortcomings. (1.22)

6.8 Forces should consistently meet the requirements of the PACE codes of practice and follow College of Policing guidance for TACT custody. (1.23)

6.9 Counter Terrorism Policing and forces should work together to ensure that information on the protected characteristics of detainees is gathered accurately and monitored to show fair and equal treatment at force and national level. (1.24)

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

6.10 Detainees should be routinely advised (both verbally and in published notices) that they are being filmed on CCTV, but that cell toilets cannot be seen by staff. (3.5)

6.11 Forces should ensure that sufficient religious artefacts for the main faiths are readily available in accordance with PACE code H requirements. (3.11)

6.12 Some elements of detainee risk should be better managed. In particular:
   • checks of detainees should take place in the detainee’s cell
   • detainees’ clothing and footwear should only be removed on the basis of an individual risk assessment
   • all custody staff should be involved collectively in shift handovers. (3.25)

6.13 Officers should carry out PACE and TACT reviews of detainees in accordance with relevant legislation and the requirements of PACE codes C and H. (3.44)

6.14 Custody officers and reviewing officers should have a clear understanding of the ‘relevant times’ for both PACE and TACT detainees. (3.45)

In the custody cell, safeguarding and health care

6.15 Forces should ensure that all TACT custody facilities are subject to regular fire evacuation testing. (4.11)

6.16 All staff involved in the use of force against a detainee should submit an individual use of force form. (4.18)

6.17 Handcuffs should be removed from compliant detainees at the earliest opportunity. (4.19)

6.18 Counter Terrorism Policing should provide guidance and a clear framework for custody officers to engage with partner agencies where there are safeguarding concerns about detainees to ensure that sensitive information is shared appropriately. Forces should set up arrangements to achieve this. (4.45)

6.19 Counter Terrorism Policing should provide guidance on the provision of appropriate adult services to children and vulnerable adults that clarifies training and vetting requirements. It should work with forces to ensure that all detainees needing an appropriate adult receive a consistent level of support. (4.46)
6.20 Police forces that commission health services for detainees held in TACT suites should ensure that there is robust clinical governance, suitable provision of emergency medical equipment and integrity of clinical supplies. (4.55)

6.21 Detainees in TACT custody should receive health care and treatment in accordance with national clinical guidelines, with any deviation from these only on the basis of an individual clinical assessment. (4.65)

Examples of good practice

6.22 The availability of Yankauer’s suction catheters in one suite provided health care professionals with an effective means to clear a patient’s airway during emergency resuscitation, which was least injurious to the patient. (4.12)

6.23 An agreement between the police and health partners in one force, with a shared commitment to addressing health needs and maintaining safety and confidentiality, enabled non-emergency prompt and effective responses to detainees with dental, mental health and physical needs. (4.56)
Appendix I: 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 normally unannounced but, due to the involvement of the sector in developing the Expectations for detainees in TACT suites, information requirements and the planning needed for this inspection, the forces were aware of it and were formally notified one month before it started. We visited the forces over several weeks during January and February 2019. Our methodology includes the following elements, which inform our assessments against the criteria set out in our Expectations.

Document review
The forces were asked to provide a number of key documents for us to review. These included the custody policy and/or any supporting policies specifically relating to TACT custody, 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 TACT custody; and performance management information.

Key documents, including performance data, were also requested from commissioners and providers of health services in the custody suites.

Data review
Forces were asked to complete a data collection template, based on TACT custody data for the previous 36 months. The template requested a range of information, including: custody population and throughput; demographic information; the average time in detention; children in detention; and detainees with mental ill health. This information was analysed and used to provide contextual information and help assess how well the force performed against some key areas of activity.

Custody record analysis
A documentary analysis of custody records was carried out on the custody records opened in the year preceding the inspection across all the TACT custody suites. The analysis focused 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.

Case audits
We carried out in-depth audits of all cases where the detainee was arrested under TACT and dealt with under PACE code H, and several cases where detainees were held in the TACT custody suite but detained under PACE code C. These audits assessed how well the force managed vulnerable detainees and specific elements of the custody process. They examined a range of issues to assess how well detainees were treated and cared for in custody. For example, the quality of the risk assessments, whether observation levels were met, the quality and timeliness of reviews of

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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.
detention, if children and vulnerable adults received timely support from appropriate adults, and whether detainees were released safely. Where force was used against a detainee, we assessed whether it was properly recorded and if it was proportionate and justified.

Observations in custody suites
Inspectors spent time during the inspection in custody suites assessing their physical conditions and, when detainees were in the suites, observing operational practices and how detainees were dealt with and treated. We spoke directly to operational custody officers and staff, and to detainees, to hear their experience first hand. We also spoke with other non-custody police officers and health professionals to obtain their views on how custody services operated. We looked at custody records and other relevant documents held in the custody suite to assess the way in which detainees were dealt with, and whether policies and procedures were followed. We also looked at CCTV footage, where this was available, to observe detainees entering custody and throughout their stay.

Interviews with key staff
During the inspection we carried out interviews with key officers from the forces and Counter Terrorism Policing. These included: chief officers responsible for custody; custody inspectors; and officers with lead responsibility for areas such as mental health and children. We spoke 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. We also spoke with the coordinator for the independent custody visitor scheme for the force.

Focus groups
During the inspection we held focus groups with custody officers and custody staff. The information gathered informed our assessment of a variety of custody processes and how detainees were treated.

Feedback to force
The inspection team provided an initial outline assessment to Counter Terrorism Policing at the end of the inspection to give it the opportunity to understand and address any issues at the earliest opportunity. We also gave individual verbal feedback and a report on potential ligature points for its own custody suite to each force inspected. This detailed report gives our full findings and recommendations for improvement. We expect the Counter Terrorism Policing to develop an action plan in response to our findings, and we will make a further visit approximately one year after our inspection to assess progress against our recommendations.
## Appendix II: Inspection team

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<th>Name</th>
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<tr>
<td>Kellie Reeve</td>
<td>HMI Prisons team leader</td>
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<tr>
<td>Fiona Shearlaw</td>
<td>HMI Prisons inspector</td>
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<tr>
<td>Norma Collicott</td>
<td>HMI Constabulary and Fire &amp; Rescue Services inspection lead</td>
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<td>John Allen</td>
<td>HMI Constabulary and Fire &amp; Rescue Services inspection officer</td>
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<td>Mark Callaghan</td>
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<td>Anthony Davies</td>
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<td>Patricia Nixon</td>
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<td>Vijay Singh</td>
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<td>Paul Tarbuck</td>
<td>HMI Prisons health and social care inspector</td>
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<tr>
<td>Helen Ranns</td>
<td>HMI Prisons researcher</td>
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<td>Joe Simmonds</td>
<td>HMI Prisons researcher</td>
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