Report on an unannounced inspection visit to police custody suites in

Devon and Cornwall

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

13-24 May 2019

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

Glossary of terms

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Contents

Contents

Fact page[1]

Force
Devon and Cornwall

Chief Constable
Shaun Sawyer

Police and Crime Commissioner
Alison Hernandez

Geographical area
Devon, Cornwall and the Isles of Scilly

Date of last police custody inspection
22–30 October 2013

Custody suites	Cell capacity
Barnstaple	13 cells
Camborne	23 cells
Exeter	19 cells
Newquay	11 cells
Plymouth	40 cells
Torquay	36 cells
Isles of Scilly (non-designated)	2 cells

Annual custody throughput
15,603 detainees (1 May 2018–30 April 2019)

Custody staffing
7 inspectors
73 custody officers
98 detention officers

Health service provider
G4S Health Services (UK) Limited

1 Data supplied by the force.

Executive summary

S1 This report describes the findings following an inspection of Devon and Cornwall Police custody facilities. The inspection was conducted jointly by HM Inspectorate of Prisons (HMIP) and HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) in May 2019, as part of their programme of inspections covering every police custody suite in England and Wales.

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

S3 We last inspected custody facilities in Devon and Cornwall Police in 2013. This inspection found that of the 10 recommendations made during that previous inspection, four had been achieved, five had been partially achieved and one had not been achieved.

S4 To aid improvement we have made one recommendations to the force (and the Police and Crime Commissioner) to address the single key cause of concern, and have highlighted an additional 19 areas for improvement. These are set out in Section 6.

Leadership, accountability and partnerships

S5 Overall, the custody services provided by Devon and Cornwall Police had many positive features and the force was generally delivering good outcomes for detainees. We found a very clear strategic focus on protecting and diverting people, especially the most vulnerable, away from police custody. Those who were detained received good care and were treated well. The force had progressed many of the recommendations made during our last inspection and was open to external scrutiny. We were confident that it would take action to address the cause of concern and areas for improvement highlighted in this report.

S6 The leadership and governance arrangements for custody services provided good strategic oversight and management of custody services. Staff were well trained and showed a strong caring culture.

S7 The overall quality of custody records was generally good and the force learnt from any adverse incidents. However, custody officers and staff were not always deployed effectively, and there was an over-reliance on overtime. The force did not consistently follow *Authorised Professional Practice – Detention and Custody* as set by the College of Policing[2], or some of its own policies and guidance, and did not always meet the requirements of code C of the Police and Criminal Evidence Act (PACE) 1984 (PACE) codes of practice.

S8 The collation and monitoring of performance data relating to custody was limited, there were gaps in key areas of custody provision and some data were inaccurate and/or unreliable. This was a cause of concern that we expected the force to address.

S9 While the force had a good understanding of the public sector equality duty, limited service monitoring meant it was unable to demonstrate that its custody services were delivered fairly or how any disproportionate outcomes for detainees were identified and addressed.

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

S10 The force worked well with partners. There had been a positive focus on ensuring children were only brought to custody after all other options had been explored. The arrangements for dealing with detainees with mental ill health were well coordinated and effective.

Pre-custody: first point of contact

S11 The arrangements for dealing with people at first point of contact were good. Frontline officers received sufficient and timely information from the call-handling centre, which helped them take account of any vulnerabilities when deciding whether to take an individual into custody.

S12 There were initiatives to help officers divert individuals away from custody as more appropriate solutions were found, and children were only taken to custody as a last resort. Officers told us they received some good support from mental health professionals, especially those based in the call-handling centre, which helped them deal with mentally unwell people, but reported waiting a long time when they needed to take them to a health-based place of safety

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

S13 Custody staff showed empathy towards detainees and treated them respectfully. Privacy for detainees was good during the booking-in process, but they were not routinely advised of CCTV monitoring in their cell or that cell toilets were obscured from view.

S14 There was a strong focus on meeting the diverse and individual needs of detainees, including females, those observing a faith, transgender detainees and those with a limited understanding of English. Although there were few specific adaptations, the needs of detainees with disabilities were also generally well served.

S15 The approach to identifying and managing risks was generally good. Initial risk assessments were comprehensive, and the observation levels set reflected presenting risks. Checks on detainees were conducted at the required frequency and custody staff consistently paid attention to rousing detainees who were under the influence of alcohol and/or drugs. There was little use of anti-rip clothing, which was good, and many custody officers appropriately mitigated self-harm risks through higher levels of observation. Shift handovers were good and information about the risks posed by and to detainees were shared comprehensively. However, custody officers' approach to removing detainees' personal possessions, such as clothing with cords, footwear and jewellery, was inconsistent and they often did this routinely rather than based on an individual assessment of risk.

S16 Most detainees were booked in promptly after their arrival at the custody suite and detention was generally authorised appropriately. Although we found a few areas where the force did not meet the requirements of PACE code C, it mostly paid good attention to ensuring that detainees' individual rights were administered appropriately. Most cases were progressed swiftly, and there was a clear focus by custody officers to ensure that detainees were released or transferred from custody at the earliest opportunity.

S17 The overall approach to PACE reviews was not good enough. Although detainees were treated with dignity and respect, too many reviews, including those for children and vulnerable adults, were conducted by phone rather than face to face, and a number of areas did not meet the requirements of PACE code C.

S18 The force had a good focus on completing investigations during the first period of detention so that, where possible, detainees did not have to be released while investigations were

ongoing. However, a large number of detainees were released while under investigation and on bail, and it was not clear how well these cases were being managed to minimise the impact that these extended investigations had on detainees.

S19 The complaints procedure was well promoted and the overall approach to complaints was good.

In the custody cell, safeguarding and health

S20 The custody estate had benefited from recent refurbishment, and conditions and cleanliness were very good. Cells were well maintained and there was little graffiti. We did, however, find potential ligature points in all suites, predominantly due to the design of toilets and some benches. The force responded positively to the comprehensive illustrative report we provided during the inspection, which detailed them.

S21 Custody staff generally managed challenging behaviour well, de-escalated situations appropriately and only used force against detainees as a last resort. In the cases we examined, we found that the majority were managed well overall and the force used was proportionate to the risk or threat posed. We did, however, have some concerns, which included poor use of techniques, and referred several cases back to the force for review and lessons to be learned. Overall, the governance and oversight of the use of force in custody was not sufficiently robust and incidents were not sufficiently or accurately recorded.

S22 Staff paid good attention to meeting the welfare needs of those detained in custody. An excellent range of food was available. Detainees were regularly provided with blankets, replacement clothing, toilet paper and reading material. The force was also looking at innovative and safe ways of occupying detainees and had introduced foam footballs in some suites. Detainees' access to showers and exercise was limited, depending on the availability of detention officers.

S23 Custody staff showed a good understanding of safeguarding and how to address concerns. Custody officers tried to secure appropriate adults (AAs) (independent individuals who provide support to children and vulnerable adults in custody) as early as possible into the detention of a child or vulnerable adult, although the different AA provision arrangements across the force area made this difficult to achieve consistently, particularly out of hours. We were not confident that AAs were always considered or secured for adults when there was evidence to suggest that one might have been needed because of the individual's vulnerability.

S24 Children brought in to custody were cared for well. Custody officers focused on minimising the time children spent in custody. Most cases were dealt with promptly and overnight detention was avoided where possible. The cases of children detained overnight received close scrutiny, which included working with partners to identify where improvements could be made. Although requests were made to local authority social services for alternative accommodation for children charged and refused bail, they were rarely met, which was a poor outcome for those affected.

S25 Strategic oversight of health care was appropriate. Quality assurance and clinical governance arrangements were reasonable. Health care professionals were experienced and competent and provided appropriate, and generally timely, care and support to detainees. Overall, medicine management arrangements were sound. Substance misuse services in Cornwall were good, but the inferior service in Devon was leading to inequitable outcomes for detainees. The support provided by mental health liaison and diversion services across the force area was good and was complemented by some innovative outreach support. The

detention of people under section 136 of the Mental Health Act was relatively rare. While

assessments considered necessary in custody mostly took place promptly, it was often a challenge to obtain mental health beds and to transfer detainees if they were subsequently sectioned.

Release and transfer from custody

S26 The releases we observed were mostly properly focused on ensuring detainees, particularly children and those who were vulnerable, were released safely, and arrangements were made to achieve this. Pre-release risk assessments were completed but not always while the detainee was present or involved in the process as required. It was positive that detainees considered a higher risk because of their offence benefited from an enhanced post-interview assessment. A good range of local leaflets were available to direct detainees to services if they needed additional support.

S27 Person escort records for detainees being transferred to another agency were generally completed well, but too often they contained loose-leaf confidential medical information. Court acceptance times varied across the force area so not all detainees had their cases heard in a timely manner.

Cause of concern and recommendation

S28 Cause of concern: The collation and monitoring of data for key areas of custody was insufficient – there were gaps and data were inaccurate and unreliable in a number of areas. This did not support effective performance management of custody services or help assess outcomes for detainees.

Recommendation: **The force should collate accurate data on all areas of custody and scrutinise them to ensure performance is managed effectively. Outcomes for detainees should be consistently monitored and improved**

Introduction

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

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

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

The *Expectations* are grouped under five inspection areas:

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

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

The methodology for carrying out the inspections is based on: a review of a force's strategies, policies and procedures; an analysis of force data; interviews with staff; observations in suites, including discussions with detainees; and an examination of case records. We also conduct a documentary analysis of custody records based on a representative sample of the custody records across all the suites in the force area open in the week before the inspection was announced. For Devon and Cornwall force we analysed a sample of 123 records. The methodology for our inspection is set out in full at Appendix II.

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

Wendy Williams
HM Inspector of Constabulary

Peter Clarke CVO OBE QPM
HM Chief Inspector of Prisons

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

Section 1. Leadership, accountability and partnerships

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

Leadership

1.1 Leadership of the provision of custody services in Devon and Cornwall was good. There was a strong focus on safe detention and the respectful treatment of detainees, and a clear strategic objective to divert vulnerable individuals away from custody.

1.2 Staff understood the strategic priority of diverting vulnerable individuals away from custody well and the approach was supported by a number of initiatives. A 'ring before you bring' initiative encouraged officers to consider all possible alternatives to arrest (see paragraph 2.3). There was also the 'vulnerable detainee management scheme' aimed at reducing the number of times vulnerable individuals at high risk of self-harm entered custody. Following a successful trial period in one suite, the scheme was rolled out across the force. At the time of inspection, 133 vulnerable individuals had been identified and comprehensive care plans developed to provide appropriate support to enable the individual to be diverted away from custody (see paragraph 2.4).

1.3 There was a clear governance structure for custody. Overall responsibility for the provision of custody services sat with an assistant chief constable. A superintendent was responsible for criminal justice and a chief inspector for the day-to-day management of custody. This structure provided clear accountability for the safe delivery of custody.

1.4 Effective internal and external governance meetings provided strategic oversight and managed the delivery of custody services. Monitoring of contracted services was also effective and we saw good evidence of force leaders holding partners and providers to account.

1.5 The force had 73 custody officers and 98 detention officers to manage the six custody suites. However, they were not always deployed effectively. During the inspection, we saw staff working extended shifts and on rest days, to meet minimum staffing levels and manage demand. Custody officers were sometimes required to work overtime to cover the role of detention officers, and a number of inspectors undertook the custody role in an acting capacity.

1.6 Initial training for sergeants and detention officers was good. All staff were expected to complete a five-week accredited training course and receive 100 hours of mentoring from a more experienced staff member before undertaking duties. This was complemented by a competency-based workbook that staff had to complete and have signed off.

1.7 Ongoing continual professional development was provided through mandatory officer safety and first aid training sessions. There were also two training days a year addressing national and local custody issues and raising awareness of vulnerabilities such as autism.

1.8 Monitoring of attendance at training sessions was very effective and supervisors were expected to complete risk assessments for staff whose skills had lapsed, to identify what roles they could perform until they had completed training to become re-accredited.

1.9 The force had adopted *Authorised Professional Practice* (APP) as set by the College of Policing (see Introduction) and had a custody working practices document, which provided specific local guidance for staff. However, not all practices we observed complied with APP guidance or the force's own policies.

Areas for improvement

1.10 The force should seek to deploy its staffing resources in the most effective way to ensure safe detention and avoid excessive use of overtime.

1.11 The force should ensure that it consistently follows APP guidance on safe detention.

Accountability

1.12 Limited collation and monitoring of performance data on custody took place. Some data provided to inspectors were inaccurate or unreliable, for example the number of times force was used in its custody suites and the number of strip-searches carried out. There were gaps in data for many key aspects of custody provision, such as the number of individuals attending stations voluntarily for interview, the time detainees waited for mental health assessments in custody, and the time it took to transfer immigration detainees after an IS91 immigration detention warrant was issued. The force also found it difficult to extract data from its custody IT system. These gaps prevented the force from understanding how good its custody services were, identifying trends and improving performance. This was an area of concern that we expected the force to address (see cause of concern and recommendation S28).

1.13 The force did not have sufficient mechanisms in place to assure itself, the Police and Crime Commissioner and the public that the use of force in custody was always safe and proportionate. Data provided were unreliable and, where restraint or force had been used, they were often not properly recorded on the detention log. While some individual use of force forms were provided for the cases we reviewed, not all officers involved in the incidents had completed one as required (see paragraph 4.8).

1.14 Although managers monitored the use of force, which included examining some cases through CCTV, the unreliability of the data limited their effectiveness. This meant that the force could not provide assurance that governance and oversight were sufficiently robust.

1.15 In some areas, the force did not meet the requirements of code C of the Police and Criminal Evidence Act 1984 (PACE) codes of practice on the detention, treatment and questioning of suspects. These are detailed throughout the report, but particular concerns focused on inspectors' reviews of detention (see section on PACE reviews).

1.16 Overall, the quality of custody records was good. Records had more detailed information than we have found in other force inspections. However, drop-down standard text options were sometimes overused, especially when recording observation checks on detainees (see paragraph 3.20).

1.17 The force's quality assurance arrangements involved dip sampling custody records and other custody operations, such as handovers between shifts. The arrangements showed a good focus on making sure that the required standards were being met. Record sampling was carried out by officers at their own suites and from other suites. But custody officers did not always receive individual feedback following the assessments to help improve practice.

1.18 Adverse incidents were recorded and monitored at monthly inspector meetings. Lessons learned were shared in a custody newsletter circulated among staff.

1.19 There had been one death in custody since our last inspection. It was still under investigation pending an inquest.

1.20 The force could not demonstrate how it was meeting the public-sector equality duty in respect of custody. Staff had a good understanding of their responsibility, and had received training on identifying detainees' diverse and individual needs. However, data were limited, particularly on detainees self-defined ethnicity, which was often recorded as 'not stated' (see section on meeting diverse and individual needs). The data on strip-searching, although inaccurately captured, suggested disproportionate outcomes for children and those from a black and minority ethnic background and required further analysis. Without reliable data and effective monitoring, the force could not assess whether its custody services were delivered fairly or identify and address any potential disproportionate outcomes for certain detainees.

1.21 The force was open to external scrutiny and feedback. There was an effective Independent Custody Visitor scheme, and we were told that issues raised were generally dealt with promptly. An external advisory group, whose members were independent of the force, had also been involved in reviews of the custody provision, and a peer review had been undertaken by another police force. The force had also used our inspection reports to identify and address where they could improve services and achieve better outcomes for detainees.

Area for improvement

1.22 The force should monitor and assess whether its custody services are delivered fairly to all detainees, regardless of their protected characteristics, and identify and address any disproportionate outcomes.

Partnerships

1.23 The force had a very clear strategic focus on protecting and diverting vulnerable people from custody and had worked positively with a number of partners to deliver this objective.

1.24 There was a positive focus on ensuring children were only brought to custody as a last resort. Statutory partners, however, did not always have sufficient capacity or the ability to ensure that this priority led to improved outcomes for children. Despite good partnership working, nearly all children who were charged and had bail refused, were detained in custody overnight when alternative accommodation should have been provided by the local authority (see paragraph 4.44).

1.25 The arrangements for working with partners to deal with detainees with mental ill-health were well coordinated and effective.

1.26 In addition to some of the strategic arrangements, there was also a neighbourhood liaison and diversion initiative, where local neighbourhood police officers worked with a range of partner agencies to provide support to vulnerable individuals and prevent them from entering the criminal justice system.

Section 2. Pre-custody: first point of contact

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

Assessment at first point of contact

2.1 Frontline police officers had a good understanding of vulnerability – they identified factors, such as an individual's age or health issues and the circumstances they found themselves in, that determined whether an individual was vulnerable. All children were recognised as vulnerable because of their age. Officers also recognised how further vulnerabilities could arise by taking a person into custody. They reported that there had been training on vulnerabilities, but it was often through e-learning rather than classroom based, which, in their view, limited its effectiveness. However, officers recognised vulnerability concerns and used this to inform their decisions about whether to arrest an individual or find alternative options to divert them away from custody.

2.2 Frontline response officers reported that they received good, timely information from call handlers about incidents and the vulnerabilities of the individuals involved. They were also able to access information on their own mobile devices. This allowed them to make informed decisions about the action they should take.

2.3 The force's strategic focus on diverting vulnerable individuals and children away from custody was translated into operational practice. The 'ring before you bring' scheme, although not consistently used, enabled discussions to take place about whether detention was appropriate or whether an alternative solution should be found (see paragraph 1.2). On one occasion, we noted that discussions took place between the investigating officer and the custody officer about a child who was coming into custody later that day because the option of a voluntary attendance interview[5], which had been fully explored, was not feasible.

2.4 Individuals were also being diverted using the 'vulnerable detainee management scheme', which identified individuals at high risk of self-harm who were regular attendees at custody. Alternatives to custody were fully explored and the duty inspector's authorisation was required if there had been a decision to bring the person into custody (see paragraph 1.2).

2.5 Children were only taken to custody as a last resort. Officers told us that voluntary attendance was used as much as possible, along with alternatives, such as community resolutions, restorative justice options[6], or 'words of advice' (see also paragraph 3.31). They also referred children to the force's youth intervention officers or the local authority youth offending teams so they could engage with the child and where possible prevent them from entering the criminal justice system. Officers said that when children were taken into custody, it was usually because of the seriousness of their offence or the need to prevent the child or others from coming to harm. We did not find any cases where it had not been necessary for the child to be detained in custody.

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5 Under voluntary attendance, suspects involved in lesser offences attend a police station by appointment for interview, avoiding the need for arrest and subsequent detention.

6 In restorative justice programmes, offenders consider the consequences of their offending for all parties and can offer an apology or reparation.

2.6 Frontline officers avoided taking individuals detained under section 136 of the Mental Health Act 1983 into custody as a place of safety other than in very exceptional circumstances. They could obtain advice from community mental health teams during the day, and they reported that they received valuable help from the mental health professionals based in the force's call-handling centre between 6pm and 2am. Officers told us that this helped them find ways of dealing with individuals that did not involve detaining them. However, outside these times support was very limited.

2.7 When individuals were detained and taken to either a mental health-based place of safety or the hospital emergency department, response officers reported long waits with detainees. They also told us that they often used their own police vehicles to transport these individuals which, although recognised as inappropriate, was in their view a better outcome for the detainee rather than waiting for an ambulance.

2.8 Where individuals had committed an offence, they were arrested and if any mental health concerns were, or became, evident, they were dealt with in custody.

2.9 The recently opened Crisis Cafés based in the community acted as drop-in centres to support people with mental ill-health. Frontline response officers welcomed them as they were a useful alternative to custody in some circumstances (see paragraph 4.68).

2.10 Frontline officers used their own police vehicles or vans for transporting detainees, depending on their risk. There were no facilities for transporting detainees who were dependent on wheelchairs, but officers said they would use alternatives to custody, such as voluntary attendance, where appropriate.

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 Overall, we saw the majority of custody staff engaging with detainees respectfully and with empathy. We also observed some adopting thoughtful techniques and methods to help improve rapport and promote positive interactions. This included an inspector conducting PACE reviews of detention while sitting down with detainees in their cells, recording detainees' first names only outside their cells and addressing them as sir or madam.

3.2 Privacy was good overall. Most suites offered physically separated booking-in desks, which enabled discreet conversations to take place without intrusions from nearby detainees or officers. However, the layout of the booking-in area in Plymouth did not allow for sufficient privacy and was noisy, and other activities taking place close by were distracting.

3.3 While private conversations were usually possible because of the physical layout of custody suites' booking-in areas, there were other issues that posed a potentially detrimental effect on interactions between detainees and staff. As was noted in our previous inspection, some of the custody officers' desks were too high, such as those at Camborne and Torquay, which could have been intimidating for detainees.

3.4 Detainees were not regularly informed verbally about the presence of CCTV cameras in their cells or told that cell toilets were masked from staff's view (most cell toilets were appropriately obscured on CCTV screens to protect detainees' dignity), despite many of the detention officers we spoke to knowing this was required. Although this information was contained in the custody information leaflet, which we saw detainees routinely receive when they were being booked into custody, the signage referring to CCTV was not prominently displayed in all suites, or where detainees would have been likely to see it, as required by PACE code C paragraph 3.11.

3.5 The force's IT system required each detainee's self-defined ethnicity to be recorded (alongside officers' own assessment) as part of the booking-in process. However, in our observations we found that custody officers did not regularly explore or capture detainees' ethnicity. This meant the force was missing an opportunity to capture important data to better monitor potential disproportionality and outcomes for detainees (see also paragraph 1.20).

Area for improvement

3.6 The force should make detainees aware of how their privacy is affected by CCTV coverage. It should display prominent notices, outlining that cameras are in use in the custody suite and cells, and detainees should routinely be informed about CCTV and the areas in the cell that it covers.

Meeting diverse and individual needs

3.7 The force's custody staff were well prepared and able to meet the wide range of needs of the detainees coming into custody. Custody officers and detention officers had received a variety of training, much of it classroom-based and with ongoing 'refresher' briefings to update their professional knowledge and help them better understand different conditions, preferences and needs of those coming into custody. Recent topics covered included personality disorders, autism and learning disabilities. Further training was scheduled for later in the year, including on religious worship guidance.

3.8 The force had established a custody-specific advisory group to help determine how well it was meeting detainees' diverse needs. As a result, it delivered some sessions to improve staff's knowledge and understanding of transgender community issues. During our conversations with staff their impact was evident - many displayed a confident grasp and some practical experience of how these issues should be managed in custody. We observed a transgender detainee being dealt with well and with understanding, sensitivity and discretion. The detainee told us she felt staff had cared for her well.

3.9 Each custody suite had a well-stocked supply of religious materials, particularly for Muslim detainees, which were mostly respectfully stored. Valuable written guidance and reminders about different faith requirements, including the implications of the Ramadan period that took place during our inspection, were also available at most suites. Detainees' religious observance needs were routinely explored during the booking-in process, and we found staff were aware of them. There were also practical examples of religious needs being appropriately managed in custody.

3.10 Arrangements for detainees with mobility impairments were generally sufficient. There was reasonable mobility access across the custody estate and wheelchair and other walking aids were available at each suite. Custody staff told us they were permitted in cells and we saw some evidence where this was the case, including where some detainees were displaying challenging behaviour which showed that custody staff prioritised the welfare needs of the detainee.

3.11 However, there were relatively few physical adaptations in place to support mobility-affected detainees, such as cells with widened doors or lowered call bells, and some of those that were available were not currently suitable. Following its response to an Independent Office for Police Conduct (IOPC) recommendation, emergency alarm cords had been removed from adapted toilet facilities in some suites. This had had the unintended consequence of making the facilities less safe in other ways because the force had not taken any steps to mitigate against this, such as installing another form of alarm.

3.12 Good support arrangements were in place for those with sight and hearing impediments. There were visual aid band markings on cell walls across much of the custody estate, and Braille versions of the rights and entitlements documents were available at each suite. Hearing loops were installed throughout for hearing impaired detainees (although custody staff had little recent experience or working knowledge of how to use them). While audio versions of the rights and entitlements document were held at some sites, they were not always accompanied by suitable equipment on which to play them.

3.13 A strong focus on meeting the needs of female detainees was evident during our inspection. A well-stocked range of menstrual care products and disposal bags were routinely available at each of the custody suites. All staff to whom we spoke understood their responsibility to safeguard all females entering custody, including the need to offer these products to every individual routinely. However, we did find several examples where this had not happened. Although women and girls were asked if they wanted to speak to a female officer in private,

this was hampered by the limited number of available female staff on each custody team shift. This meant that in some instances officers were not always routinely assigned to this role (or were unaware they had been) or, if they were based outside custody, they were not always immediately available for face-to-face conversations (see also paragraph 4.41).

3.14 Detainees' caring responsibilities were routinely explored in all cases. Each detainee was asked about this when being booked into custody. The custody information leaflet each person received also reminded detainees to tell custody staff about their caring responsibilities.

3.15 Telephone interpreting services were reported to work well overall and there were no significant or recurring service issues. Staff accessed the service by mobile handset or speakerphone. Speakerphone conversations were mostly sufficiently private due to the layout of the environment (see paragraph 3.2). Mobile handsets were not always reliable, however, and we observed a case where interpretation was significantly hindered by repeated equipment failures.

3.16 Interpreting services were largely accessed when booking detainees into custody, but we also saw some other good examples of them being used on other occasions, such as to explain detainees' individual care plans. Although staff reported some delays in securing translators to attend interviews, with no video conferencing facilities being used despite the force's geographical spread and location, they said they would consider releasing a detainee under investigation or on bail (subject to individual risk assessment) to prevent a long stay in custody.

3.17 Custody staff showed a good understanding of their responsibility to inform foreign national detainees' home nation embassy or consulate where requested and could contact them without difficulty. In addition to translated R&E documents, the force's own custody information leaflet was also available in a wide range of other languages. We also observed instances of them being used.

Risk assessments

3.18 Generally, detainees' risks were assessed and managed well. Custody officers were calm and patient while assessing risks during the booking-in process. Initial risk assessments were comprehensive - detailed questions were asked of detainees and arresting/escorting officers, and checks made of the police national computer and other local systems. Risk assessments were also, on occasion, informed by the custody officer's own knowledge of the detainee and any additional information from health care professionals based in custody.

3.19 Observation levels for detainees were commensurate with the risks identified, and generally the same detention officer visited detainees for the duration of their shift, enabling them to make informed assessments of any changes in their behaviour or demeanour, which was good. Observation levels were kept under review and amended to reflect any changes in the risks posed by the detainee. Custody staff understood the requirements for each of the observation levels, particularly level 2 when a detainee is under the influence of either alcohol or drugs and must be roused and spoken with to ensure they are safe while in custody.

3.20 In the main, observation visits to detainees were carried out in accordance with the timeframes that were set. In some instances, custody staff made additional visits on top of what was required, which showed a good level of care. However, they were not always recorded and, when custody record entries were being made, there was an over-reliance on the pre-populated text in the drop-down menu boxes, which were not tailored to the

individual visit. The entries did not therefore include additional details or any interactions with detainees which would have been helpful when reviewing the detainee's risk (see paragraph 1.16).

3.21 Force policy and procedures set out that custody officers should remove cords, laces, belts, jewellery or any other personal items to manage detainees' risks. This was a risk averse approach and disproportionate to the risks posed in some cases. It also did not follow *Authorised Professional Practice* (APP) guidance which states that such decisions should be based on the detainee's individual risk assessment. However, in practice we observed some custody officers adopting the more proportionate approach that we would expect, allowing items of clothing, including cords, shoes with laces and jewellery to be retained by detainees, based on their individual assessment, which potentially minimised any distress caused by their removal.

3.22 We found that custody officers did not routinely place detainees in anti-rip clothing, which was good. If high levels of risks were identified, officers considered using either observation level 3 (constant observation of the detainee on CCTV) or level 4 (close proximity watch of the detainee by police officers sitting at the cell door) to better manage and mitigate the risks of the detainee self-harming.

3.23 Staff did not sufficiently manage the risks posed by detainees who were waiting in the holding rooms to be booked in. Priority was given, in line with force policy, to detainees brought in by armed response officers or arrested for drink-driving offences. There was no policy for triaging vulnerable detainees or children to assess whether they should be prioritised. Although custody officers informed us that they might prioritise these detainees in practice, it was difficult if they were the only custody officer on duty at the time. This meant that children or other vulnerable detainees could wait in holding rooms along with other detainees without any account being taken of their particular vulnerabilities and the risks they posed (see paragraph 4.39).

3.24 Custody staff at all the suites routinely carried anti-ligature knives and keys while visiting detainees in their cells. This practice allowed them to respond immediately to any emergency situations that might arise, should a detainee try to harm themselves.

3.25 To improve its approach to managing detainees' risks, the force had invested in equipment so that some cells were equipped to monitor the detainee's life signs and trigger an alarm if anything adverse was detected. This was being trialled prior to an evaluation of the scheme. The force had also introduced the Custody Early Warning Scores system (CEWS), a means of assessing potential risks for detainees which could potentially impact on their safety and well-being while in custody. It allowed custody staff to carry out, record and score physical health checks, which would alert them to any concerns that could help in managing risks. However, many of the custody staff we spoke to did not feel confident in using the system (see also paragraph 4.57).

3.26 Cell call bells, which detainees used to request assistance or information from custody staff, were explained to detainees well, which ensured they understood how to use them, and they were answered promptly. However, there were some occasions when they were muted without a custody officer's approval or oversight, which did not conform to APP guidance.

3.27 Handovers between custody shifts were good and carried out well between the incoming and outgoing custody staff, including health care and liaison and diversion staff when they were available. Handover sheets were detailed, ensuring the information provided to staff on the incoming shift was comprehensive, and all aspects of the detainee's safe detention were discussed and understood. They focused on detainee welfare and case progression and took place in private and were recorded on CCTV with audio recording. Following the handover,

incoming custody officers introduced themselves to detainees and enquired about their welfare and well-being. This approach was thorough and comprehensive, in line with our expectations.

Area for improvement

3.28 The force should strengthen its approach to managing detainees' risks by:

- **tailoring entries on custody records to reflect individual cell visits;**
- **consistently basing decisions on the removal of cords, laces, belts and jewellery from detainees on their individual risk assessment;**
- **ensuring that children and vulnerable detainees are considered for prioritisation on arrival at custody suites so that they are booked into custody as soon as possible; and**
- **only muting cell call bells in exceptional circumstances and with the express authority of custody officers.**

Individual legal rights

3.29 Arresting officers generally explained the grounds and necessity for arrest well in the presence of the detainee (for example, to allow the offence to be investigated promptly and effectively) while they were being booked into custody. However, we found in our review of custody CCTV that there were occasions when this did not happen - custody officers did not ask for the reason for an arrest and arresting officers did not outline the necessity for it, which did not meet the requirements of paragraph 4.3 of PACE code G.

3.30 Custody officers regularly explained to detainees why their detention was being authorised, and checked they understood what was being said. Custody officers told us they rarely refused detention once a person had been brought into the custody suites, but were confident about doing so if necessary. We found no cases where detention had been inappropriately authorised.

3.31 The force made use of alternatives to custody in the form of restorative justice processes, fixed penalty notices, community resolutions and voluntary attendance (see paragraphs 2.3, 2.4 and 2.5). Although officers told us they made good use of voluntary attendance the force was unable to provide accurate data on its use and could not assess how often it was used as an alternative to custody.

3.32 Waiting times between detainees arriving at custody suites and detention being authorised were generally good. We saw many detainees being taken straight through to the booking-in desks, but we also observed some detainees waiting over an hour to be booked into custody, particularly during custody shift handover periods. Waiting times were monitored by the force and showed average waiting times of 14 minutes for adults and 20 minutes for children. Our own analysis of custody records also showed a similar, positive picture - there was an average waiting time between arrival and detention authorisation of 13 minutes, which compared well against several forces inspected recently.

3.33 Custody officers had a clear focus on ensuring that cases were progressed quickly so that detainees were released or transferred from custody at the earliest opportunity. Our observations showed that, in general, the time detainees spent in custody was minimised as much as possible. However, custody officers told us that investigations were not always progressed promptly. Delays were attributed to time spent waiting for: appropriate adults (independent individuals who provide support to children and vulnerable adults in custody); Crown Prosecution Service advice; accommodation under section 2 of the Mental Health

Act; and the arrival of escorts to transfer detainees held under the Immigration Act to immigration removal centres.

3.34 The force had seen a 13% decrease (18 cases) in the number of immigration detainees brought into custody over the previous three years. While the force monitored the overall length of time immigration detainees spent in custody, it was unable to provide data that showed the average time between serving an IS91 immigration detention warrant and the time of transfer to alternative accommodation. This made it difficult for the force to assess whether the escort contractor was prolonging a detainee's time in police custody by failing to collect them promptly.

3.35 During the booking-in process, we regularly observed custody officers interacting positively with detainees, establishing a good relationship with them and checking that they had understood what they had been told. Custody officers explained to detainees their three main rights - to have someone informed of their arrest, to consult a solicitor and access free independent legal advice and to consult the PACE codes of practice. We also observed them providing the detainee with a leaflet about their rights and entitlements. However, our review of custody CCTV showed that not all detainees were given the rights and entitlements leaflet to read, which did not meet the requirements of paragraph 3.2 of PACE code C and meant there were inconsistent working practices.

3.36 Several copies of the July 2018 PACE code A to H booklets were available at all custody suites. Information on PACE code C was included in the codes A to H compilation booklet. We frequently observed custody officers explaining this to detainees and informing them that the booklet was available if they wished to read it. However, they were not always pro-actively offered.

3.37 Posters informing detainees of their right to free legal advice were not displayed in all the custody suites, which did not meet the requirements of PACE code C, paragraph 6.3. However, during our inspection, the force put up posters in those suites where they had not been displayed.

3.38 Although information about detainees' rights and entitlements could be, and were, obtained in other languages, not all custody officers or inspectors to whom we spoke were aware of PACE code C, annex M. This meant that not all non-English speaking detainees were provided with a range of written translated documents about their detention in their own language as required.

3.39 During our inspection, we observed custody officers appropriately providing authorisation for DNA samples to be taken but without fully informing detainees of the force's retention and disposal policy. The system for collecting DNA and other samples was effective, but not all sample fridges were secured. This might not have sufficiently protected the integrity of stored samples.

Area for improvement

3.40 The force should consistently meet the requirements of PACE code C. In particular by:

- **ensuring that officers provide the grounds and necessity for arrest for all detainees;**
- **giving all detainees the rights and entitlements leaflet;**
- **making custody officers aware of the availability and importance of translated documents and providing them to detainees (in line with PACE code C, annex M).**

PACE reviews

3.41 Overall the force's approach to PACE reviews was not good enough (see paragraph 1.15). While we saw inspectors treating detainees with dignity and respect, several aspects of the review process for continued detention did not always comply with the requirements of the PACE codes of practice, and records were often limited in detail.

3.42 Although many PACE reviews were conducted on time, a significant number took place over the phone, with the inspector recording that they were at another suite and it was too far to travel. In our custody record analysis, only 34 out of 122 reviews were carried out face to face with a detainee.

3.43 When deciding whether to conduct a face-to-face review of a detainee's detention, reviewing officers should consider the health, age and vulnerability of the detainee. However, inspectors told us that due to travelling times they would only conduct a face-to-face review with a detainee at the custody suite where they were working. This was particularly poor for children and vulnerable detainees for whom we expect reviews to be conducted in person. The force's practice did not meet the requirements of paragraph 15.3C of PACE code C.

3.44 Custody inspectors told us that they would often check if an inspector was available to conduct a face-to-face review at the suite where the detainee was held, but due operational commitments and shift patterns an inspector was not usually available.

3.45 The force had provided a live link video system in each custody suite to enable PACE reviews of continued detention to be conducted with detainees. Inspectors and custody staff told us that reviewing officers did not use this system often and that when they could not carry out a face-to-face review, used the telephone instead. Inspectors did not record why the use of a live link was not practicable. This did not follow the requirements of 15.9B of PACE code C, which states that a telephone review is not permitted where facilities for a review using a live link exists and it is practicable to use them.

3.46 Where reviews had taken place while the detainee was asleep, most were carried out overnight. In most cases, we saw detainees being informed that a review had taken place as soon as possible after they were awake, which was good.

3.47 We observed some PACE reviews in which detainees were told that their continued detention was being authorised before the reviewing officer had given the detainee the opportunity to make representations on their continued detention. This did not meet the requirements of paragraph 15.3 of PACE code C. In addition, inspectors did not remind the detainee of their right to free legal advice before carrying out the review. While in all cases the inspector reminded the detainee of this right later in the review, this did not meet the requirements of paragraph 15.4 of PACE code C.

3.48 The working pattern of custody inspectors meant that the volume of reviews for one inspector affected the way in which reviews were carried out. Inspectors told us they often had 20 to 30 reviews to do on an average shift. The reluctance of reviewing inspectors to travel to other suites or to use live video links to conduct reviews and the unavailability of other inspectors meant many of the requirements of PACE code C were not met. These failings undermined the effectiveness and purpose of the detention review process, and meant the needs of children and vulnerable detainees in particular were not met.

3.49 A number of reviews were carried out by 'acting' inspectors. Although the force provided us with information to show that these officers had been authorised to carry out the role, the ad hoc arrangements - using 'acting' inspectors operating on a shift-by-shift basis rather than

substantive inspectors available elsewhere in the force - were not in the best interests of detainees.

Area for improvement

3.50 The force should strengthen its approach to detention reviews, fully meet the requirements of PACE code C and improve outcomes for detainees by:

- **increasing the number of face-to-face interviews, especially for children and vulnerable detainees, through deploying inspectors in the most effective way and making use of the live link facilities; and**
- **improving the quality of reviews to ensure that detainees understand why they are still being detained and recording reviews in full for the custody record.**

Access to swift justice

3.51 The force focused on completing investigations during the first period of detention to avoid releasing detainees pending further investigation. Our analysis of custody records identified that out of 122 detainees, 90 (74%) had their cases concluded during the detainees' first period in custody. This was a good outcome for those detainees.

3.52 However, despite the force having a 'bail and released under investigation' (RUI) policy, and officers telling us that cases were progressed as quickly as possible, there seemed to be a large number of RUI cases outstanding. During our inspection, there were 3228 active RUI cases, of which 2840 cases were more than 28 days old. It was not clear how the force managed them or reduced the investigation time to minimise the impact that extended periods of ongoing investigation can have on detainees.

3.53 We observed custody officers providing notices to detainees regarding their RUI status and providing a clear verbal explanation of what RUI meant. But they did not always explain the consequences if detainees approached witnesses or interfered with the course of justice.

Area for improvement

3.54 The force should ensure that detainees released under investigations are made fully aware of the consequences if they approach any witnesses or interfere in the course of justice while they remain under investigation.

Complaints

3.55 The force had a published policy on the management of complaints made by detainees while in custody. Custody staff we spoke to had a good knowledge of the policy and could explain what the policy required and what action they would take should a complaint be made while a detainee was in custody.

3.56 There were posters outlining the force's complaints procedure in all the custody suites and in the custody reception areas. The rights and entitlements leaflet included a section on how to make a complaint and detainees were often provided with an additional force leaflet during the booking-in process explaining what happens in custody and how to make a complaint.

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

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

Physical environment is safe

4.1 Physical conditions in the Devon and Cornwall custody suites were very good. Despite the suites being old (except for the Exeter suite) they had been refurbished recently and were well maintained and had good access to natural light. There was very little graffiti in the cells. During the inspection, temperatures in the suites and cells were mostly suitable, but staff told us they could not control the heating in any of the suites because it was managed remotely. We found two suites that were cold.

4.2 We found potential ligature points in all the suites, predominantly due to the design of toilets and some benches. During the inspection, we provided the force with a comprehensive illustrative report detailing them, to which it responded positively.

4.3 Cells were very clean and in good condition. All had toilets but very few had in-cell handwashing basins (see also paragraph 4.26). The cell call bells we tested were functioning properly. CCTV was operating across the suites and there were cameras in all cells. However, there were some blind spots and gaps in CCTV coverage, including a lack of audio in cell corridors in three of the suites, which meant detainees and staff were not adequately protected (see also paragraph 4.11).

4.4 Custody officers and detention officers conducted daily checks of the physical environment, including cells and communal areas, against a pre-determined checklist, which ensured a consistent approach. The checks were recorded to show they had been completed. However, we found a small number of gaps across some of the suites when staff had not recorded whether any checks had taken place. Any damage or faults were recorded locally and reported online or by telephone to a central department. In most cases, minor faults received a prompt response, but staff told us that some cells had been out of action for prolonged periods, which our observations confirmed.

4.5 Custody staff had a reasonable awareness of fire evacuation procedures and knew how and where detainees should be evacuated to in an emergency. However, most told us that they had not been involved in a fire drill in the past 18 months, which contravened legal requirements. Fire evacuation routes were not always readily identifiable, and most suites did not display any fire evacuation plans, which was a risk, particularly as we were told that many staff worked overtime in suites they might have been unfamiliar with.

4.6 Health care staff were all trained to deliver immediate life support and their routine presence in suites provided an effective level of support in the event of a detainee collapsing or experiencing an acute health difficulty. All custody staff had received first aid training which was appropriate to the demands and risks faced and staff we spoke with were confident about delivering a first-on-scene response. Emergency equipment was available in

all suites. The contents were appropriate and included an automated external defibrillator. All equipment was checked every day and restocked after use.

Area for improvement

4.7 All staff should be involved in regular fire drills and the force must ensure that they adhere to fire regulations.

Safety: use of force

4.8 The governance and oversight of the use of force in custody was not robust enough. The force collected data on the use of force in custody, but we were not confident that it was accurate (see paragraph 1.12). Staff involved in incidents did not always complete the individual use of force forms required to justify using force against detainees. Information recorded in detention logs did not always make it clear that force had been used, and when it did, the entries often lacked sufficient detail to justify the use.

4.9 Data provided by the force showed that all custody staff were up to date with their officer safety training. Staff we spoke with confirmed they took part in two training days per year, including those covering scenarios specific to custody.

4.10 Custody staff generally dealt patiently and reassuringly with some challenging and vulnerable detainees which often de-escalated situations and meant the use of force could be avoided. Force was only used on detainees as a last resort.

4.11 Through our case audits, custody record analysis and examination of data supplied by the force, we identified 19 recent cases involving the use of force, which we reviewed in depth. This included cross-referencing against CCTV footage. CCTV recordings were only kept for 90 days and the footage we viewed at three of the suites did not include audio coverage in the cell corridors. There were several blind spots, which limited the effectiveness of our review (see also paragraph 4.3). Most incidents were handled well overall and the force used was proportionate to the risk or threat posed. We did, however, identify a range of lessons that could have been learned in over half of these cases. For example, some techniques were poor and there was a lack of attention paid to maintaining detainees' dignity during the removal of clothing (see also paragraph 4.15). We shared these cases with the force for review and lessons to be learned.

4.12 We were told that custody inspectors and a few custody officers reviewed a small number of cases where force had been used each month. The process involved some cross-referencing against CCTV footage. Although it was better than we often see, it was still not robust enough to assure senior managers that the force used in custody was always proportionate to the risks or threat posed, or to identify any lessons that could be learned to improve practice.

4.13 Handcuffs were applied routinely when transporting detainees to custody suites. In some cases, they were removed promptly on arrival, but in too many cases their application continued on compliant detainees for too long while they waited to be booked in, particularly if the detainee arrived during the handover period. This included handcuffs remaining in place on a child for two hours and 13 minutes.

4.14 Data provided by the force indicated that 3,173 detainees had been strip-searched in the 12 months to 30 April 2019. This represented about a fifth of all detainees during that period and was high in comparison to other forces inspected. However, these figures were

inaccurate as they also included the removal of clothing for safety reasons or to replace it with anti-rip clothing as part of a section 54 search[7], rather than strip-searching requirements under PACE code C.

4.15 Searches and the removal of clothing were generally conducted in cells, and where relevant, custody staff ensured that CCTV monitors were switched off or screened to maintain privacy. In the cases we reviewed on CCTV, mostly good attention was paid to maintaining the dignity of detainees during the process (however, see also paragraph 4.11). Strip-searching and the removal of clothing for other reasons, with or without force, were, however, not always justified or recorded well enough in custody records.

Areas for improvement

4.16 The governance of the use of force in custody should be sufficiently robust to provide assurance that when force is used it is justified and safe and proportionate to the risk posed.

4.17 Strip-searching detainees and the removal of their clothing for other reasons should be adequately justified with the rationale clearly recorded on the custody record.

Detainee care

4.18 The force displayed a particularly strong culture of treating detainees with care and consideration throughout our inspection and detainees' welfare interests were at the forefront throughout. This view was endorsed by feedback the inspection team received from the local Independent Custody Visitor (ICV) scheme and detainees we spoke to.

4.19 All suites held a good supply of toiletries and replacement clothing (grey tracksuit tops and bottoms), including socks and underwear for detainees of both genders. Where footwear had been confiscated for investigative or perceived risk reasons, replacement flip flops were available and usually issued to detainees while they remained in custody. However, we did see some instances where they were not issued, which meant detainees had to move around the custody suite in bare feet or socks. Plimsolls were also available in various sizes for detainees on release if they were required. We found an example of this in our case audit reviews - a vulnerable female leaving Newquay custody was issued with plimsolls and additional layers of clothing to make her more comfortable on her onward journey. At some suites, we found that supplies of reading glasses were also available to detainees, which was positive.

4.20 Although supplies varied, each suite held a good basic supply of books and magazines for detainees to read, and some offered a wide selection. Child-focused material was available at each suite, which was good, and some suites also had a reasonable selection of foreign language items. Pens and paper were also permitted in cells, subject to individual risk assessment. As part of its commitment to improving detainees' experiences in custody, the force had begun to assess alternative ways of keeping detainees occupied in their cells. As a result, it had introduced the use of foam footballs at two suites, which was pending wider rollout across the remainder of the custody estate. We felt this was a worthwhile initiative - it received positive feedback from the detainees and staff we spoke to.

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

4.21 An extensive supply of fresh food and other consumables were available at all suites. The provision was substantially superior in range and quality compared to what was available at most other custody suites recently inspected. Porridge, cereal (with fresh milk), cereal bars or microwave meals were provided at breakfast, cooked meat and vegetarian pasties were available for lunch and there were fresh sandwiches at evening meal times. This was supplemented by other items, such as fruit, crisps and biscuits. Each suite also stored a good range of standard microwave meals, which were all within their sell-by date, and detailed dietary guidance helped inform staff. Hot and cold drinks (tea, coffee, hot chocolate, water and fruit cordials) were also available. Custody staff could make alternative arrangements if locally available items were not suitable for a detainee's particular medical or other dietary requirement by purchasing items from nearby shops, with the detainee's agreement. Detainees had access to food and drink throughout the day rather than at rigid meal times, and staff offered them to detainees as they were taken to their cells and at regular other points during their time in custody.

4.22 Custody staff were also particularly mindful of some detainees' personal circumstances and were happy to offer multiple meals (for example to homeless detainees) where they thought it was in their best interests.

4.23 Detainees also generally had good access to other welfare provision. They were set out in more detail in the force's own custody information leaflet so that detainees were more aware of what they could expect while in custody. We considered this leaflet to be a valuable addition to the standard rights and entitlements document and were encouraged to see it being issued routinely.

4.24 Once they were taken to their cell for the first time, detainees were usually informed of how they could contact staff and obtain food and drink. They were also usually offered blankets and reading material to make them feel more comfortable. While detention officers generally only occasionally offered these items during subsequent welfare visits, we were confident that staff would deal with detainees' requests where possible and saw some evidence that this happened. Custody staff also asked detainees if there was anything they needed at other times, such as when incoming custody officers introduced themselves to every detainee. Our custody record analysis (CRA) supported other evidence showing that detainees had good access to welfare provision. Our CRA found that 46 of the 123 (37%) detainees in the sample were offered reading material, as were nine of the 13 (69%) who were detained for more than 24 hours, which was better than we often find.

4.25 However, while detainees' access to some welfare provision was good, it was not extended to showers or outside exercise. In our CRA, only 17 of 123 records assessed (14%) found evidence of the detainee being offered a shower, including only five of the 13 (39%) who were detained for over 24 hours. This declined even further where exercise was concerned - only three detainees (2%) had been offered it, none of whom were being held for over 24 hours, which was poor. Staff said they would always try to arrange access where possible, but acknowledged they were not always available to do so.

4.26 Detainees' restricted access to washing facilities was further compounded by the lack of in-cell handwashing basins across most of the force's custody estate, which meant they had to be escorted out of their cell to wash their hands. While we did see some instances of this happening, the evidence and feedback from staff did not reassure us that this would regularly happen promptly enough (see also paragraph 4.3).

4.27 In accordance with *Authorised Professional Practice* guidelines, custody staff across the force, provided toilet paper automatically to each detainee, subject to any individual risk factors, which we welcomed.

Area for improvement

4.28 The force should increase detainees' access to showers and exercise, particularly when they are held overnight or for extended periods of time.

Safeguarding

4.29 The force prioritised safeguarding by making it 'everyone's business'. It was well embedded in custody services. All the officers and staff we spoke with knew how to identify safeguarding concerns and understood their responsibilities. There had been some training to support staff in their roles as part of core custody training, and additional training days with presentations on topics, such as autism and personality disorders.

4.30 Custody officers asked arresting and investigating officers during the booking-in process whether any safeguarding referrals had been made using the force-wide vulnerability screening tool (ViST) form. ViST forms were graded on a traffic light system - red cases signalled that the arresting officers should put immediate safeguarding measures in place. Investigating officers were alerted to any safeguarding concerns that arose in custody and were expected to address them. Custody officers could access the information held on the ViST forms and if required, deal directly with other agencies. If necessary, they made their own referrals, and ensured that children and vulnerable adult detainees were released safely.

4.31 The force was introducing a 'trauma-informed' policing approach to detainees. This focused on the complex needs of children and vulnerable adults and how they and their life experiences, contributed to their behaviour, enabling officers to tailor their response. This involved giving detainees quiet areas in custody and understanding how they coped with stress. We observed a very challenging child, who displayed agitated behaviour, shred the flip flops he had been given over a period of about 20 minutes. The custody officer allowed this to continue because he had had previous experience of the child's behaviour and saw this as a coping mechanism. When the situation was calmer the cell was cleared of the flip flop debris. This proved a better way of dealing with the child and meant he was not caused further distress by removing the flip flops from him.

4.32 There was a clear focus on securing appropriate adults (AAs) for children and vulnerable adults as early as possible into their detention. Custody officers, in the main, requested AAs promptly and expected them to attend so that detainees' rights and entitlements could be read or re-read with them. Arresting officers also tried to arrange for family members or friends to be present before arriving in custody with the detainee to assist with early AA support. In many of the cases we looked at and observed, early AA support was available for children and vulnerable adults both at the start and throughout the different stages of custody.

4.33 However, there was some inconsistency in the AA service as arrangements across the force area varied. Custody officers contacted family members in the first instance, but where it was not appropriate, or they were unable to attend promptly, they called the local authority social services department or youth offending service (YOS).

4.34 In three suites - Exeter, Barnstaple and Torquay - AAs generally were the local authority's own staff or those from its commissioned scheme The Appropriate Adult Scheme (TAAS). TAAS provided trained AAs on a 24/7 basis. They attended promptly when called to go through detainees' rights and entitlements, remaining or returning to custody as necessary to support the detainee through other stages of custody, such as when fingerprints were taken or interviews conducted. TAAS provided AAs for children and vulnerable adults (except in Torquay which relied on social services staff or a volunteer scheme to assist vulnerable

adults). The force, social services department and the TAAS jointly monitored the scheme, and the service generally worked well.

4.35 The other suites depended on social services departments, YOS staff, or volunteer schemes. They did not guarantee a prompt response, were not routinely available 24/7, and AAs were often unable to attend until the detainee was ready for interview, which could be some time into detention. This meant detainees received an inconsistent service depending on the custody suite they were in. However, although we found some long waits for AAs to arrive, and custody officers reported some problems, especially out of hours, in many of the cases we observed and reviewed, AAs arrived without undue delay to support detainees.

4.36 Most custody officers we spoke with said they were confident in assessing whether an AA was needed for a vulnerable adult. They told us they would consider a range of factors, including their previous history and any information or advice from health professionals. However, we looked at a few cases where there was evidence to suggest a vulnerability, but where an AA was not considered or the need for one not recorded. The force did not monitor how many vulnerable adults received the support of an AA to help assess how well this aspect of the service worked.

4.37 Guidance was available for AAs, and custody officers said they would hand it out to those unfamiliar with the role.

4.38 The force gathered information on AA request and arrival times, although it was not always adequately recorded on custody records and records were not comprehensive for every detainee who required this support. It used the information to identify where improvements were needed. Custody officers were also expected to complete forms if there had been concerns over an AA's attendance for an inspector to review. The Office of the Police and Crime Commissioner (OPCC) was considering how a force-wide AA scheme could be developed to provide a consistently good level of service for all children and vulnerable adults.

4.39 Children brought into custody were well cared for. We observed custody staff interacting with children positively, meeting their needs and providing reassurance. Some suites had designated child cells, while in others, they were placed in cells in quieter parts of the suite. This helped keep children away from adult detainees. However, if there were delays during the booking-in process, there was no triaging system, which meant that children could be waiting with adult detainees in holding areas.

4.40 We were told family members could stay with their child, where appropriate, either in the cell or in an interview or visiting room and found some evidence of this happening. We were told the force's use of foam footballs to help distract detainees while they were in the cell had been used successfully with children (see also paragraph 4.20).

4.41 Girls were assigned a female officer to look after their welfare, in line with the Children and Young Persons Act 1933. The female custody staff who carried out this role showed a good understanding of what was expected. However, when custody staff requested a female officer from another police department because of a lack of female custody staff on the shift, it did not ensure that the girl was spoken with or visited (see paragraph 3.13).

4.42 Custody officers were very focused on minimising the time children spent in custody and avoiding overnight detention. The force expectation was that children were only held in custody overnight for serious offences, where they were under the influence of alcohol and/or drugs, or where there were safeguarding concerns for the child or others. Otherwise it was expected that they should have been returned to their family or care home. In general, we found this to be happening. In a number of cases we looked at, children were dealt with promptly, sometimes late into the evening, and if the investigation could not be

completed in time, they were either bailed or released under investigation so that they did not have to be detained overnight.

4.43 The strategic custody inspector closely monitored all children held overnight to ensure that this was justified. Custody officers completed forms for these children to justify holding them overnight and provide a rationale. The information was collated as a rolling log of cases and reviewed by the inspector. It was also used to inform discussions at quarterly youth detention review forum meetings with partner agencies, which were attended by representatives from the force and the four local authorities in Devon and Cornwall. At the meetings, concerns could be raised and addressed, and areas identified where improvements were needed. Children in custody were also discussed at local youth justice forums.

4.44 When children were charged and refused bail, custody officers asked the relevant local authority social services department to provide alternative accommodation for the child. Local authorities have a statutory duty to provide appropriate alternative accommodation in these circumstances. But these requests were rarely met. Information provided by the force showed very few children were moved. In the year immediately before the inspection, of the 29 children held overnight who should have been moved, nine requests were made for secure accommodation but only one child was moved; 20 requests were made for appropriate non-secure accommodation, but only two children were moved. This left children who were not moved with a poor outcome (see also paragraph 1.24).

4.45 However, good partnership work was being undertaken to improve the position. A scheme had been introduced in Exeter to provide one bed space in foster care, with the carers trained to look after children in these circumstances. The foster carers were responsible for looking after the child and taking them to the next available court sitting. This had allowed one of the two children who needed non-secure accommodation to be moved.

Areas for improvement

4.46 The force should ensure that early AA support for children and vulnerable adults is consistently available across all force areas.

4.47 The force should continue to work with partners so that children charged and refused bail are moved to alternative accommodation rather than staying in custody.

Governance of health care

4.48 G4S Health Services (UK) Limited delivered physical health care services in all suites. Cornwall Partnership NHS Foundation Trust and Devon Partnership NHS Trust provided criminal justice liaison and diversion (CJLD) services across the respective counties. Strategic oversight of health delivery was appropriate and contract performance issues addressed promptly through joint police and provider meetings. This oversight focused on activity. Although underperformance was appropriately challenged, the direct impact of contract variations on detainees' health outcomes was not always apparent from the data (see cause of concern S28). Scrutiny in this area could have been strengthened to gain a better understanding of detainees' well-being while in custody.

4.49 Operational relationships between all health care providers and the force were good. We found staffing arrangements to be generally proportionate to detainees' needs. Access to health care professionals (HCPs) was through a mix of nurses and paramedics who were generally embedded in all suites. Although this was not a contractual requirement, custody

staff and detainees valued the impact it made. Specialist support and advice were provided over the phone by peripatetic forensic medical examiners (FMEs) covering both counties. The FMEs also provided direct input if required, or if HCPs were unavailable. We found that extensive travelling times, the lack of capacity within existing rotas, problems with short-term absence cover, coupled with particular ongoing issues at Exeter, had placed the service under some pressure. Despite this we found no evidence of significant adverse outcomes for detainees.

4.50 Quality assurance and clinical governance arrangements were in place to ensure the service was delivered effectively. At present, only one regional officer supported the team across the counties, which meant HCPs worked largely independently, although plans were being implemented to further enhance support and oversight. They included the recruitment of a health care lead staff member in each suite and establishing contingency HCP cover, which were both positive developments.

4.51 A full range of clinical policies was available electronically, which staff were familiar with. Systems for reporting and reviewing incidents were in place and an independent health complaints process, which detainees had used, was clearly advertised. G4S clinical records were hand written, which presented some difficulties when it came to information governance and auditing. Records were securely stored and the content was largely legible and captured key clinical contact with detainees. Records were removed for storage every month limiting the availability of clinical information on detainees returning to custody, which could have affected continuity of care.

4.52 The performance data we reviewed and our case audits indicated that most detainees were generally seen promptly and in line with contract expectations. Response times were linked to clinical and forensic priorities, which was appropriate. In our CRA, response times were an average of 53 minutes, but some detainees did not have to wait and were seen immediately. A very small number of detainees waited too long to be seen - the longest wait in our CRA was 15 hours and 51 minutes, which was due to difficulties in obtaining health input in the Camborne suite on a particular shift.

4.53 Essential training for all staff was reasonable and mandatory training requirements were being met. Professional development opportunities were more limited and many staff said they had to find them themselves. However, HCPs and medical staff could access peer group meetings to support reflective practice (which involves peer reviewing of practice) and share lessons learned.

4.54 Treatment rooms were clean and mainly complied with infection prevention standards. Most consultations took place in private unless risk indicators suggested otherwise. Clinical equipment and general stock availability was good.

Patient care

4.55 Custody staff made appropriate referrals based on detainees' identified needs emerging from risk assessment or at the request of the detainee. Relationships between custody staff and HCPs were good, which helped ensure access to health care staff was prompt and appropriate. Detainees we spoke to broadly appreciated the care they received and the HCPs and FMEs we met were experienced practitioners with the appropriate competencies to deliver effective detainee care. Records we reviewed demonstrated that detainees had appropriate care and treatment plans that aimed to keep them safe.

4.56 Professional interpreting services were available if required and detainees' consent to share information was routinely sought and recorded. All significant risk and medication issues

were appropriately captured in the custody record. However, we found examples where too much personal information had been unnecessarily posted on the custody record.

4.57 The force was piloting a Custody Early Warning Scores system (CEWS) which was designed to allow custody staff to capture health indicators. Custody staff and health professionals mostly felt it was a potentially useful development, that enabled custody staff to better gauge any potential health concerns and provide HCPs with some core data, particularly where they were absent from the custody suite. We felt the system required further evaluation to ensure custody staff had the competence and confidence to obtain and use the clinical information appropriately to manage detainees' risks (see also paragraph 3.25).

4.58 Overall, we found medicine management arrangements to be sound. There was a good range of patient group directions (PGDs) (which authorise appropriate HCPs to supply and administer prescription-only medicine) to ensure detainees received effective care and some PGDs were being developed based on experiences in custody, such as antibiotics for dog bites. Drug cupboards were secure and medicines safely stored. Internal stocks that were accessible only to health care staff were well managed. Detainees had access to individual prescription medication once it had been validated by an HCP. It was then held in locked cupboards as part of their personal property. Custody staff had access to and were trained to administer naloxone (a drug to manage a substance misuse overdose) and could also supply nicotine replacement therapy, both of which could impact positively on detainees' safety and well-being.

4.59 Detainees received symptomatic relief for drug and alcohol withdrawal where appropriate, although those due to attend court only received this support for the duration of their stay in police custody. There was evidence that detainees could access community-prescribed opiate substitution treatment. We saw several examples where HCPs and police staff were proactive in ensuring appropriate support was maintained, but we found access was variable and too dependent on individual HCPs.

4.60 Detainees who were due prescribed medication did not always receive a sufficient amount when they were taken to attend their court hearing.

Area for improvement

4.61 The force should ensure that detainees attending court have a sufficient quantity of their prescribed medication with them and available for them to take.

Substance misuse

4.62 The force did not use targeted drug testing to steer individuals into treatment initiatives. In the Cornish suites, dedicated substance misuse workers from drug and alcohol agency Cornwall Addaction offered face-to-face support to detainees with drug and alcohol problems, and ongoing community support if they required it. However, none of the Devon suites had this level of input, which meant detainees across the suites had different levels of access to services. However, the mental health CJLD teams offered a level of support that covered all vulnerabilities, which involved directing detainees to community-based drug and alcohol services, although there was no recognised professional referral pathway and detainees were expected to refer themselves. We judged this approach to be too limited.

4.63 Custody staff proactively supported harm minimisation initiatives by providing detainees with sterile injecting equipment when they left custody, if it was required.

Area for improvement

4.64 Detainees with drug and alcohol problems in Devon custody suites should have direct access to specialist support.

Mental health

4.65 The two trusts offering mental health liaison and diversion services within custody provided good support. Services were mostly available seven days a week (8am to 5pm) and were largely embedded across the suites, with some marginal variation in smaller, less busy sites. We judged services were meeting needs, and custody staff and detainees valued them. Referrals were appropriately determined by custody staff based on detainees' risks and behaviour and most individuals were seen before leaving custody. Detainees who could not be seen were offered a follow-up appointment after release from custody, which was good. We saw some impressive outreach support being provided to individuals post-custody, particularly to those who might not have met the threshold for secondary services, but were experiencing immediate and pressing social and psychological distress. The support time and recovery workers employed by the trust also provided effective links to ongoing community support. In addition, specialist mental health support was being piloted as part of the community neighbourhood schemes, an innovative approach to diverting vulnerable people away from custody (see paragraph 1.26).

4.66 We were told that the time taken to access a Mental Health Act assessment in custody was generally good and some suites had close working relationships with local community teams and hospital services. However, we were also advised that there could be delays in this process and that further difficulties could occur in accessing a hospital bed and then to arrange suitable transport promptly enough. Although we asked for data to indicate the scale of any of these difficulties, none was supplied. Such delays could have been leading to detainees spending too long in custody (see cause of concern).

4.67 Detainees held in custody as a place of safety under section 136 of the Mental Health Act in the previous 12 months were only detained in exceptional circumstances. When there had been cases, the measure had been proportionate to the risk faced.

4.68 Joint working between the police and mental health services was good and established governance arrangements were in place. A mental health practitioner provided some support within the force's control room to assist and advise officers in the community. Although this service had some scope to send staff to attend crisis situations, it was limited. Crisis Cafés based in the community and staffed by mental health charity Mental Health Matters had been introduced in the region. They supported those with vulnerabilities and had had contact with people 478 times (through 226 visits and 252 telephone calls) in their first six weeks. The initiative focused on preventing vulnerable people from being unnecessarily detained (see also paragraph 2.9).

Section 5. Release and transfer from custody

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

Pre-release risk assessment

5.1 In general, we found that detainees were released from custody safely. Custody officers checked initial and ongoing risk assessments to inform their safe release. We saw several releases take place and they were conducted well - detainees participated in the process, and all risks were discussed and mitigated where possible. However, the way in which pre-release risk assessments (PRRA), which assessed detainees' risks before release, were completed varied, and some were not always good enough. Not all custody officers completed the PRRA with the detainee present, which meant that their risks and safety on release were not discussed with them. This did not conform to *Authorised Professional Practice* guidance and did not ensure the detainee's safety once they had been released from custody.

5.2 Enhanced post-interview risk assessments were carried out for detainees perceived as higher risk (particularly alleged sexual perpetrators). This provided the management of the risks that these individuals posed to themselves and others with an additional level of assurance.

5.3 There were informative support leaflets with details of various support and advice agencies, and contacts for a wide range of local and national support organisations. They were given to all detainees before their release for further information or support.

5.4 Custody officers understood the importance of ensuring that all detainees travelled home safely after their time in custody. Suitable arrangements were made to release children into the care of an adult and to help vulnerable detainees to get home. For those detainees without the means to arrange their own travel, custody officers had access to Click Travel, a travel management platform, where they could obtain rail and bus tickets. They could also use the services of local taxis to ensure detainees could get home safely.

5.5 Person escort records (PERs), which provided information to other agencies taking responsibility for detainees being transferred rather than released, were generally completed well. They included details of potential risks, including self-harm and health concerns, and outlined detainees' medication requirements. However, some of the information or incidents that had occurred did not always have a date, which made a meaningful assessment of the detainees' risks difficult.

5.6 Confidential detainee medical information was routinely inserted inside the PER but not in a separate envelope marked 'confidential', which was inappropriate.

Areas for improvement

5.7 Detainees should always be present during the PRRA process so that their risks can be fully discussed and arrangements made to mitigate them where needed.

5.8 Confidential documents such as medical information, should be placed in sealed envelopes marked 'confidential' and should accompany PERs forms.

Courts

5.9 Custody staff informed us court acceptance times varied throughout the force area and led to different outcomes for detainees when it came to having their cases heard promptly. Acceptance times for detainees at Plymouth and Exeter magistrates' courts often extended later into the working day and generally enabled them to be seen promptly. However, this was not the case at Truro and Bodmin magistrates' courts where they convened on alternate days and with different early cut off times for accepting detainees. Those held at either Camborne or Newquay custody suites were potentially held in police custody longer than necessary because they missed the court acceptance time.

5.10 A live link was available at the custody suites to enable detainees to have their case heard through a video link to court. However, they were not used frequently because the arrangements underpinning them did not support their effective use. This meant the force missed the opportunity to provide detainees with better outcomes by limiting travel times and potentially providing better access to their court hearing.

Area for improvement

5.11 The force should work with HM Courts & Tribunals Service to enable all detainees to have their cases heard promptly.

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

Cause of concern and recommendation

6.1 Cause of concern: The collation and monitoring of data for key areas of custody was insufficient – there were gaps and data were inaccurate and unreliable in a number of areas. This did not support effective performance management of custody services or help assess outcomes for detainees.

Recommendation: The force should collate accurate data on all areas of custody and scrutinise them to ensure performance is managed effectively. Outcomes for detainees should be consistently monitored and improved. (S28)

Areas for improvement

Leadership, accountability and partnerships

6.2 The force should seek to deploy its staffing resources in the most effective way to ensure safe detention and avoid excessive use of overtime. (1.10)

6.3 The force should ensure that it consistently follows APP guidance on safe detention. (1.11)

6.4 The force should monitor and assess whether its custody services are delivered fairly to all detainees, regardless of their protected characteristics, and identify and address any disproportionate outcomes. (1.22)

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

6.5 The force should make detainees aware of how their privacy is affected by CCTV coverage. It should display prominent notices, outlining that cameras are in use in the custody suite and cells, and detainees should routinely be informed about CCTV and the areas in the cell that it covers. (3.6)

6.6 The force should strengthen its approach to managing detainees' risks by:

- tailoring entries on custody records to reflect individual cell visits;
- consistently basing decisions on the removal of cords, laces, belts and jewellery from detainees on their individual risk assessment;
- ensuring that children and vulnerable detainees are considered for prioritisation on arrival at custody suites so that they are booked into custody as soon as possible; and
- only muting cell call bells in exceptional circumstances and with the express authority of custody officers. (3.28)

6.7 The force should consistently meet the requirements of PACE code C. In particular by:

- ensuring that officers provide the grounds and necessity for arrest for all detainees;
- giving all detainees the rights and entitlements leaflet;

- making custody officers aware of the availability and importance of translated documents and providing them to detainees (in line with PACE code C, annex M). (3.40)

6.8 The force should strengthen its approach to detention reviews, fully meet the requirements of PACE code C and improve outcomes for detainees by:
- increasing the number of face-to-face interviews, especially for children and vulnerable detainees, through deploying inspectors in the most effective way and making use of the live link facilities; and
- improving the quality of reviews to ensure that detainees understand why they are still being detained and recording reviews in full for the custody record. (3.50)

6.9 The force should ensure that detainees released under investigations are made fully aware of the consequences if they approach any witnesses or interfere in the course of justice while they remain under investigation. (3.54)

In the custody cell, safeguarding and health care

6.10 All staff should be involved in regular fire drills and the force must ensure that they adhere to fire regulations. (4.7)

6.11 The governance of the use of force in custody should be sufficiently robust to provide assurance that when force is used it is justified and safe and proportionate to the risk posed. (4.16)

6.12 Strip-searching detainees and the removal of their clothing for other reasons should be adequately justified with the rationale clearly recorded on the custody record. (4.17)

6.13 The force should increase detainees' access to showers and exercise, particularly when they are held overnight or for extended periods of time. (6.13)

6.14 The force should ensure that early AA support for children and vulnerable adults is consistently available across all force areas. (4.46)

6.15 The force should continue to work with partners so that children charged and refused bail are moved to alternative accommodation rather than staying in custody. (4.47)

6.16 The force should ensure that detainees attending court have a sufficient quantity of their prescribed medication with them and available for them to take. (4.61)

6.17 Detainees with drug and alcohol problems in Devon custody suites should have direct access to specialist support. (4.64)

Release and transfer from custody

6.18 Detainees should always be present during the PRRA process so that their risks can be fully discussed and arrangements made to mitigate them where needed. (5.7)

6.19 Confidential documents such as medical information, should be placed in sealed envelopes marked 'confidential' and should accompany PERs forms. (5.8)

6.20 The force should work with HM Courts & Tribunals Service to enable all detainees to have their cases heard promptly. (5.11)

Section 7. Appendices

Appendix I: Progress on recommendations from the last report

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

Main recommendations

There should be urgent work at a strategic level by the police and health services to ensure that custody suites are only used as Mental Health Act 1983 section 136 places of safety in exceptional circumstances. (2.28)	**Achieved**
Devon and Cornwall police should engage with HM Courts and Tribunals Service to ensure that early court cut-off times and the lack of court availability do not result in unnecessarily long stays in custody. (2.29)	**Partially achieved**

Treatment and conditions

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

Recommendations

Staff should receive up-to-date awareness training on child protection and safeguarding. (4.11)	**Achieved**
Notices that CCTV cameras are in use should be clear and prominently displayed. (4.12)	**Partially achieved**
Pre-release risk assessments should be detailed, meaningful and based on an assessment of detainees' needs while in custody, and the custody record should reflect the position on release and any action needed. (4.28)	**Partially achieved**
Handcuffs should be removed from detainees after their arrival in the custody suite, unless a risk assessment indicates this is necessary for the safety of staff and others. (4.40)	**Partially achieved**

Individual rights

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

Recommendation

Appropriate adults to support young people aged 18 and under and vulnerable adults in custody should be available without undue delay, including out of hours. (5.9)	**Partially achieved**

Health care

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

Recommendations

Clinical examination rooms should comply with infection control standards. (6.9)	**Achieved**
Nursing staff should not be employed for long consecutive shifts to ensure that they remain safe to practice. (6.18)	**Achieved**
All detainees should have the opportunity to access substance misuse services when required. (6.20)	**Not achieved**

Appendix II: Methodology

Police custody inspections focus on the experience of, and outcomes for, detainees from their first point of contact with the police and through their time in custody to their release. Our inspections are unannounced and we visit the force over a two-week period. Our methodology includes the following elements, which inform our assessments against the criteria set out in our *Expectations for Police Custody*.[8]

Document review

Forces are asked to provide a number of key documents for us to review. These include: the custody policy and/or any supporting policies, such as the use of force; health provision policies; joint protocols with local authorities; staff training information, including officer safety training; minutes of any strategic and operational meetings for custody; partnership meeting minutes; equality action plans; complaints relating to custody in the six months before the inspection; and performance management information.

Key documents, including performance data, are also requested from commissioners and providers of health services in the custody suites and providers of in-reach health services in custody suites, such as crisis mental health and substance misuse services.

Data review

Forces are asked to complete a data collection template, based on police custody data for the previous 36 months. The template requests a range of information, including: custody population and throughput; demographic information; the number of voluntary attendees; the average time in detention; children; and detainees with mental ill health. This information is analysed and used to provide contextual information and help assess how well the force performs against some key areas of activity.

Custody record analysis

A documentary analysis of custody records is carried out on a representative sample of the custody records opened in the week preceding the inspection across all the suites in the force area. Records analysed are chosen at random, and a robust statistical formula provided by a government department statistician is used to calculate the sample size required to ensure that our records analysis reflects the throughput of the force's custody suites during that week.[9] The analysis focuses on the legal rights and treatment and conditions of the detainee. Where comparisons between groups or with other forces are included in the report, these differences are statistically significant.[10]

Case audits

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

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

9 95% confidence interval with a sampling error of 7%.

10 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.

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

Observations in custody suites

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

Interviews with key staff

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

Focus groups

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

Feedback to force

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

Appendix III: Inspection team

Kellie Reeve	HMIP team leader
John Allen	HMIP inspector
Fiona Shearlaw	HMIP inspector
Norma Collicott	HMICFRS inspection lead
Marc Callaghan	HMICFRS inspection officer
Anthony Davies	HMICFRS inspection officer
Patricia Nixon	HMICFRS inspection officer
Vijay Singh	HMICFRS inspection officer
Steve Eley	HMIP health and social care inspector
Tania Osborne	HMIP health and social care inspector
Dayni Johnson	CQC inspector
Matthew Tedstone	CQC inspector
Joe Simmonds	HMIP researcher
Patricia Taflan	HMIP researcher