Report on an unannounced inspection visit to police custody suites in

South Yorkshire

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

10–20 June 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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Force
South Yorkshire Police

Chief Constable
Stephen Watson

Police and Crime Commissioner
Dr Alan Billings

Geographical area
South Yorkshire

Date of last police custody inspection
28 April–2 May 2014

Custody suites	Cell capacity
Barnsley	20 cells
Doncaster	38 cells
Shepcote Lane	50 cells

Annual custody throughput
22,229 detainees between 1 June 2018 and 31 May 2019

Custody staffing
39 custody officers and 1 local policing team sergeant
74 detention officers

Health service provider
Leeds Community Healthcare NHS Trust

1 Data supplied by the force.

Executive summary

S1 This report describes the findings following an inspection of South Yorkshire custody facilities. The inspection was conducted jointly by HM Inspectorate of Prisons (HMIP) and HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) in June 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 South Yorkshire Police in 2014. This inspection found that of the 26 recommendations made during that previous inspection, 11 had been achieved, nine had been partially achieved and six had not been achieved.

S4 To aid improvement we have made three recommendations to the force (and the Police and Crime Commissioner) addressing key causes of concern, and have highlighted an additional 21 areas for improvement. These are set out in Section 6.

Leadership, accountability and partnerships

S5 South Yorkshire Police's custody services focused well on safe detention, but were not delivering consistently good outcomes for detainees. While we found a number of positive features, there were several causes of concern and areas that required improvement. However, the force had made some progress since our last inspection in 2014 and was open to external scrutiny, which meant we were confident that it would take action to improve.

S6 The governance structure for custody provided the service with clear lines of accountability and custody officers and staff delivering it were well trained. However, there was a lack of leadership and direction, which meant the day-to-day operation of the suites was not managed effectively, and custody staff were not always deployed in the most efficient way. This led to some poor outcomes for detainees, such as cell call bells not always being answered promptly.

S7 There were a number of areas where the force was not consistently meeting the requirements of the Police and Criminal Evidence Act 1984 (PACE), code C of its codes of practice or the requirements of section 31 of the Children and Young Person's Act 1933. There was little in the way of local policy on custody and, although the force had adopted *Authorised Professional Practice (*APP*) – Detention and Custody* as set by the College of Policing (see Introduction), some of the practices we observed did not follow APP guidance.

S8 However, the force's approach to adverse incidents was good. Recording of incidents was good and lessons learnt were shared with staff to support improvement.

S9 The force had arrangements for assessing the performance of custody services, but much of the data underpinning them were inaccurate and no data were available for some key areas. This meant the force did not understand how well custody services were performing. In addition, the quality of entries in custody records was not consistently good enough and there was little effective quality assurance.

S10 The force had a good understanding of the public sector equality duty, but lacked data that could have enabled it to assess whether outcomes for detainees were consistently fair and equitable and identify any areas of potential disproportionality.

S11 The force was focused on diverting children and vulnerable people, especially those with mental ill-health away from custody. It worked proactively with partner agencies and had developed some positive initiatives to support collaboration. However, partners often lacked the capacity to help the force improve outcomes for these vulnerable detainees.

Pre-custody: first point of contact

S12 Arrangements for diverting children and vulnerable people away from custody were generally effective. Frontline staff had a good understanding of vulnerability and received good quality information from call-handling staff to help them decide whether to arrest and take an individual in to custody or deal with them through an appropriate alternative.

S13 Children were only arrested as a last resort when other alternatives had been explored, including diversionary action to prevent them from entering the criminal justice system. Frontline officers told us they could also obtain good support from mental health professionals to help them find alternatives to detention for people with mental ill-health.

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

S14 Custody staff generally engaged with detainees respectfully. However, detainees did not have sufficient privacy to allow them to disclose personal information confidentially. Detainees were not regularly informed that CCTV operated in the cell, or that their cell toilet was obscured from view and could be used with a degree of privacy.

S15 The approach to identifying and meeting the individual and diverse needs of detainees was mixed. The needs of non-English speaking detainees and those with physical disabilities were generally well met, although hindered by the design of the suite at Doncaster. The provision of some religious observance items was limited and there were some inconsistent arrangements for those with sight or hearing impairments or comprehension difficulties.

S16 There was little focus on meeting the needs of female detainees. Although a good range of menstrual care products was routinely offered, women were not regularly informed that they could speak with a female member of staff.

S17 The approach to identifying risks was good and many arrangements for managing and mitigating risks were positive. Initial risk assessments were generally comprehensive and observation levels addressed presenting risks and were generally adhered to. Detainees under the influence of drugs and/or alcohol were roused appropriately. Those at risk of suicide or self-harm did not have their clothes removed routinely, and there was no use of anti-rip clothing – any risks were managed through increased levels of observation. Although not always conducted collectively, handovers were properly focused. However, custody staff did not always carry anti-ligature knives, access to cells keys was not controlled well enough, and clothing with cords and footwear with laces were removed routinely without undertaking an individual risk assessment. Cell call bells did not always receive a prompt response and officers conducting close-proximity observations were rarely briefed adequately.

S18 Most detainees were booked into custody quickly and their detention was authorised appropriately. Custody officers were focused on ensuring that cases were progressed swiftly,

although there were sometimes delays while they waited for duty solicitors to arrive or because cases were transferred between investigating officers during shift changes. This potentially led to detainees spending longer in custody than necessary.

S19 There were some weaknesses in ensuring that detainees consistently received information to help them understand their legal rights while in custody. Custody officers clearly explained to detainees their main legal rights while in custody and checked they had understood what they had been told. However, they did not always provide a copy of the leaflet explaining their rights and did not actively offer detainees the PACE codes of practice booklet to read.

S20 Some aspects of the way in which inspectors carried out reviews of detention were positive – for example, many were carried out on time and either in person or by live link. However, there were some significant concerns about the force's failure to meet consistently some important requirements of code C of PACE, and reviews of detention had not taken place at all in some cases, which was a breach of PACE section 40.

S21 The force focused well on completing investigations during the first period of custody. However, a large number of individuals were released under investigation and it was not clear how these cases were subsequently dealt with as quickly and effectively as possible.

S22 Information explaining how to make a complaint was not promoted well enough, and there were no clear arrangements for dealing with complaints while detainees were in custody.

In the custody cell, safeguarding and health

S23 Physical conditions in the two newer suites at Barnsley and Sheffield were generally good, but the Doncaster suite was old and in a state of disrepair. Cleanliness across the estate was not always good enough, but there was little evidence of graffiti. We found potential ligature points in all suites, notably so in Doncaster, and provided the force with an illustrative report detailing them, which received a positive response.

S24 The governance and oversight of the use of force in custody was not robust enough. Data on incidents where force had been used in custody were unreliable, staff did not always submit individual use of force forms to justify the force they had used against detainees and mostly insufficient detail on the use of force was recorded on detention logs. While some of the cases we audited and cross-referenced against CCTV were managed well overall, we had concerns in almost half of the cases we looked at and referred several back to the force for review and learning.

S25 Many aspects of detainee care were poor. Although staff dealt with detainees courteously and most were offered food and drinks at regular intervals, access to reading material, showers and exercise was very limited. The quality of blankets and mattresses was poor and they provided detainees with little warmth or comfort.

S26 Custody staff knew how to identify and address safeguarding concerns. There was, however, insufficient focus on ensuring that appropriate adults (AAs) (independent individuals who provide support to children and vulnerable adults in custody) arrived early on in detention. As a result, some detainees waited a long time before receiving any support. Staff did not always consider securing AAs for vulnerable adults when there was information to suggest they should have had access to one. This potentially meant that these detainees did not receive support when they should have.

S27 Children were treated well in custody and many were dealt with quickly to ensure they were detained for the minimum amount of time, avoiding overnight detention if possible.

However, there were few arrangements in place to meet children's specific needs. There was no consistent approach to monitoring children entering custody, although monitoring had recently been strengthened for those detained overnight. Although few in number, children who were charged and refused bail and who should have been moved to alternative local authority accommodation rarely were, which meant outcomes for them were poor.

S28 Health services had improved since the last inspection. Contract management was robust and governance systems were of a good standard. Most detainees were seen by a health professional promptly and those we spoke to were happy with the health care they had received. The medical facilities at Barnsley and Sheffield were of a high calibre and overall arrangements for medicines management were efficient.

S29 The inequitable provision of substance misuse services meant that detainees in some suites were disadvantaged. It was positive that liaison and diversion teams were embedded in each suite, but resources were sometimes stretched, and, while the provision at Barnsley was very good it was not quite so good at the other sites, which meant detainees received different levels of service.

S30 Custody had not been used as a place of safety for detainees under section 136 of the Mental Health Act 1983 in the previous 12 months. However, some detainees in custody were suffering from acute mental ill-health and, while they generally received prompt mental health assessments, there were some lengthy delays. If they subsequently needed a bed in a mental health inpatient facility, our inspection showed they could experience unacceptable delays before a bed was found. There were also delays while waiting for ambulances to take them there.

Release and transfer from custody

S31 There was a good focus on ensuring that children and vulnerable adults got home safely. However, there were no arrangements for detainees with insufficient means to get home and who lived some distance from the custody suite, which was not good enough.

S32 Pre-release risk assessments were generally completed with detainees, and the force had enhanced arrangements for detainees at greater risk because they had been arrested on suspicion of sexual offences. Support leaflets included local information and were issued to detainees on release. Person escort records for detainees being transferred to the care of other agencies were not always completed thoroughly and too many additional loose-leaf documents were included.

S33 The local court acceptance times were flexible and better than we often see, which meant that detainees frequently had their cases heard before the first available court.

Causes of concern and recommendations

S34 Cause of concern: Custody inspectors did not have sufficient oversight over the day-to-day operation of the custody suites. Staff were not always used effectively to carry out the range of custody duties required, manage risks and provide care, leading to some poor outcomes for detainees. There were no arrangements for managing efficiently those stages of custody that involved non-custody staff to minimise their waiting times and ensure detainees were dealt with as swiftly as possible.

Recommendation: **The force should increase its oversight of custody so that staff are deployed in the most effective way to ensure detainees' needs are met. It should have adequately supervised arrangements for managing those stages of custody that involve non-custody staff so that delays detainees experience are minimised.**

S35 Cause of concern: The data collected by the force were inaccurate and incomplete. They were insufficient to assess the performance of custody services and the outcomes achieved for detainees.

Recommendation: **The force should collect and collate accurate data for all areas of custody to underpin its performance management of the service and ensure that outcomes for detainees can be consistently monitored and improved.**

S36 Cause of concern: The force did not consistently meet the requirements of PACE, code C of its codes of practice, or section 31 of the Children and Young Persons Act 1933, which requires that all detained girls should be in the care of a woman.

Recommendation: **The force must take immediate action to ensure that all custody procedures comply with legislation and guidance, and that officers implement them consistently.**

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*.[2] 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*.[3]

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 South Yorkshire police force we analysed a sample of 139 records. The methodology for our inspection is set out in full at Appendix II.

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

Wendy Williams
HM Inspector of Constabulary

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2 http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/inspection-criteria/
3 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 South Yorkshire Police had a clear governance structure for custody. Under the direction of the assistant chief constable, the criminal justice department had overall responsibility for the custody function. A superintendent was responsible for custody, supported by a chief inspector who took charge of the operational delivery of the service. This structure provided clear lines of accountability for the safe delivery of custody.

1.2 Governance structures provided oversight of custody. Regular meetings took place at strategic and operational levels internally. Strong governance and scrutiny of the contracted health care services in custody ensured detainees had some good outcomes.

1.3 At the time of the inspection, the force was reviewing its custody staffing model. There was a good understanding of the gap in numbers because of planned retirement, and succession planning was well managed.

1.4 However, during the inspection we found staff often worked overtime to maintain minimum staffing levels, and those who were available were not always deployed effectively. There was a lack of leadership, direction and supervision when it came to overseeing the day-to-day operation of the custody suites and ensuring that custody responsibilities, duties and risks were managed in the most effective way. This led to, for example, cell call bells not always being answered promptly, very low levels of access to showers and exercise for detainees and non-custody staff taking detainees to and from the cells, leading to poor key control. It also meant officers carrying out close-proximity watches of detainees at the cell door were insufficiently briefed and inadequately supervised.

1.5 At busy periods, when numerous police officers, solicitors and other visitors were in custody on official business, little supervision was carried out and no effective arrangements were in place to manage the stages of custody that they were involved in, such as consultations or interviews. Such arrangements could have minimised their waiting times and ensured detainees could be dealt with as quickly as possible. The lack of leadership and supervision in the suites needed to be addressed. (See cause of concern S34.)

1.6 The force was committed to initial training and continuous professional development. Newly trained staff shadowed more experienced officers and all were appropriately accredited. Ongoing training included a range of sessions on understanding the needs of vulnerable detainees, including those with mental ill-health and autistic spectrum disorders.

1.7 The force had adopted *Authorised Professional Practice* (APP) – *Detention and Custody* (see Introduction) and there was little local policy. Not all of the practices we observed, however, followed APP guidance.

Accountability

1.8 Although custody performance was scrutinised at strategic and operational meetings and the force had a detailed performance dashboard, much of the data underpinning this were inaccurate. The force found it difficult to pull data from its custody system and much of the data provided to the inspection team was unreliable. This included, for example, data on the number of detainees who were strip-searched and incidents where restraint or force was used in custody suites. The force was not able to provide some data at all, such as for the number of detainees who required an assessment under section 2 of the Mental Health Act. This meant that the force could not properly assess how well it was delivering its custody services, identify trends or inform organisational learning. (See cause of concern S35.)

1.9 The force had insufficient mechanisms in place to assure itself, the Police and Crime Commissioner and the public that the use of force in detention and custody was always safe and proportionate. Data for incidents in custody suites were unreliable, and where incidents were recorded on detention logs, there was insufficient detail, which meant it was difficult to identify all the officers involved and establish what force had been used. While there were governance and oversight processes for monitoring incidents, little cross-referencing with CCTV took place to ensure techniques were proportionate and safely deployed.

1.10 In too many areas, the force did not consistently meet the requirements of the Police and Criminal Evidence Act 1984 (PACE), or code C of its codes of practice. These are detailed throughout the report, but most notably the force was in breach of section 40 of PACE and failed to meet a number of PACE code C requirements for reviews of detention. In addition, the force did not consistently meet the requirements of section 31 of the Children and Young Persons Act 1933 by providing an assigned female member of staff to care for any girl held in custody. (See cause of concern S36.)

1.11 The quality of the recording on detention logs was not good enough. The custody recording system had some pre-populated text to assist staff in completing entries. However, it was not always overwritten or deleted to reflect individual circumstances when necessary, for example, when staff completed their entries after checking on detainees in their cells. Many of the entries therefore were difficult to understand and it was not possible to establish what action had taken place. Some key information was not recorded at all, such as the time when appropriate adults (AAs) or interpreters were called and the time they arrived in the suite, which would have allowed the force to establish how long detainees waited for these services. Very little was recorded to show whether detainees had had access to provision, such as reading material, showers or exercise, from which we could only conclude that they had not been offered or provided.

1.12 Quality assurance processes were not sufficiently robust. Inspectors were required to review 10 records a month at each suite. However, the reviews had not identified the concerns we found, and it was not clear how any findings from these reviews fed back to either individual staff members or informed wider learning.

1.13 Adverse incidents in custody were well recorded and subject to comprehensive review. Lessons learned were shared with staff and used to inform training. The force had had no deaths in custody since our last inspection.

1.14 The force had a good understanding of the public sector equality duty and was one of few forces we have inspected that had a specific objective to monitor outcomes for detainees to ensure that they were fair and equitable. However, the recording of data on detainees' ethnicity was poor. Information provided by the force showed that 9805 custody records did not show the ethnicity of the detainee at all, and during our observations we found that this question was not routinely asked as part of the booking-in process. There were also some

discrepancies in the data provided on gender and age. Without accurate data on protected characteristics, the force could not demonstrate how it was ensuring fair and equitable outcomes for detainees, or identify any areas where there might have been disproportionate treatment that it needed to address. (See cause of concern S36.)

1.15 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. There had been no deaths in custody since our previous inspection.

Areas for improvement

1.16 The force should ensure recording on custody records is full and accurate and clearly reflects the individual action taken for each detainee. It should robustly quality assure custody records to identify and act on any concerns.

1.17 The force should put arrangements in place to assess whether all detainees are dealt with fairly and equitably. It should ensure it understands any areas of disproportionate treatment and acts to address them.

Partnerships

1.18 The force prioritised the diversion of children and vulnerable people away from custody. All staff understood and reflected this in their ways of working. There were some good arrangements with partners to support this approach. For example, there was a positive initiative whereby student police officers spent time with community and crisis mental health teams to gain an insight into the service.

1.19 However, partner agencies often lacked the capacity and capability to improve outcomes. Too many children who were charged and remanded remained in custody overnight when alternative accommodation should have been provided by the local authority. Some detainees were held in custody for too long when they should have been transferred to a health-based place of safety.

1.20 Access to liaison and diversion services was not equitable across the suites and detainees at Barnsley received a better level of service. Access to substance use services also varied and Sheffield and Doncaster detainees received a better service than those at Barnsley.

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 staff had a good understanding of vulnerability, recognising how factors such as age or mental health influenced it, along with the situation or circumstances that a person might find themselves in. They were aware of the force definition of vulnerability, but saw assessment as wide-ranging and requiring individual consideration in each case.

2.2 Officers had received training on vulnerability, including mental health, and sessions on particular topics, for example, child sexual exploitation, were often included in their regular 'street skills' training. Officers used their understanding of vulnerability to decide what course of action to take at an incident, and whether to make an arrest or find an alternative solution to avoid holding the individual in custody.

2.3 Officers viewed the information from the call-handling centre as generally good, despite some recent problems when it changed to a new IT system. Frontline officers could also access information directly on their own hand-held devices. They told us they had sufficient information on which to base their decisions.

2.4 Children were only taken to custody after all other options had been explored, or the nature of the offence made it the only course of action. Alternatives were regularly used including voluntary attendance[4], restorative justice[5] or community resolution[6]. Officers also referred children directly to the youth offending teams or the Prince's Trust so that they could participate in diversionary activities. They involved neighbourhood policing teams if appropriate to work with children to try and keep them out of custody. This reflected the force's strategic approach of diverting children from custody and preventing them, where possible, from entering the criminal justice system.

2.5 Frontline officers were expected to justify robustly bringing a child into custody, and we observed some cases where arresting officers explained how they had considered alternative action. However, our observations and a review of records showed that this did not happen consistently, and there were some cases which, in our view, would have merited further consideration to determine whether it had been necessary to arrest the child and authorise detention.

2.6 Frontline officers reported that they never took individuals detained under section 136 of the Mental Health Act 1983 into custody as a place of safety. They felt there was good support from mental health services to help them with individuals with mental ill-health. Officers felt the mental health triage car, involving a police officer and a mental health

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4 Under voluntary attendance, suspects involved in lesser offences attend a police station by appointment for interview, avoiding the need for arrest and subsequent detention.
5 In restorative justice programmes, offenders consider the consequences of their offending for all parties and can offer an apology or reparation.
6 Community resolution is an alternative way of dealing with less serious crimes, allowing officers to use their professional judgement when dealing with offenders.

professional, provided invaluable advice and assistance, but it was only available in the Sheffield area and for limited hours (see paragraph 4.66). Telephone advice across the force area was available 24/7 from mental health services, although officers said there were sometimes delays in receiving it. Officers told us this advice and assistance meant they could often avoid detaining someone under section 136 of the Mental Health Act by finding a more appropriate solution.

2.7 However, when individuals were detained under section 136 and taken to a health-based place of safety or a hospital emergency department (if they were under the influence of alcohol or were violent and would not be accepted at a place of safety), officers reported long waits with detainees, often in difficult circumstances. Ambulances were called to transport them but, despite an agreement that they should attend within 30 minutes, long waiting times often meant officers used their own police vehicles. They recognised this was not appropriate, but thought it was a better outcome for the detainee than having to wait a long time at the scene.

2.8 Individuals arrested for offences but who had mental ill-health were taken to custody and any health needs dealt with through the health care practitioners based there. However, the force did not have any information on the number of detainees taken into custody who subsequently required a mental health assessment to establish how often this happened. (See cause of concern S35.)

2.9 Officers transported detainees in their police vehicles or a police van depending on the risks posed by the detainee. There were no arrangements for wheelchair users, but none of the officers we spoke with had ever had to deal with a wheelchair user. They said they would make arrangements as needed.

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 good practices that helped improve rapport. They included taking time in the booking-in process to listen to issues detainees had (such as health or family concerns) and trying to resolve them. During Police and Criminal Evidence Act 1984 (PACE) reviews of detention, we saw a custody inspector sitting down next to the detainee in the cells and adopting a less authoritative figure. However, we saw some instances where the interaction was less respectful, for example when communicating instructions to detainees during strip-searches. Detainees were also walking around custody suites in their socks, despite plimsolls being available (see also paragraph 4.22 and area for improvement 4.27).

3.2 Detainees had limited privacy, despite the new custody suites in Barnsley and Sheffield. Both suites had screens separating the booking-in desks, which provided physical privacy, but conversations between custody officers and detainees could easily be overheard. The ageing structure and physical design of the custody suite at Doncaster meant there was no privacy at the booking-in desks, where it was noisy and distracting with numerous other activities taking place close by. As a result, detainees could have been reluctant to disclose personal or confidential information.

3.3 All the suites had discrete booking-in desks, to use for detainees being dealt with for sensitive offences. These offered additional privacy for other detainees to discuss sensitive or confidential information, but they were not often used. At Doncaster, the desk was close to the main booking-in area, so it did not provide sufficient privacy that would have enabled detainees to disclose confidential information, although on one occasion we did see it being used well. However, we also observed a detainee who was unwilling to disclose confidential information, yet staff did not consider using the private facility to enable them to do so. Detainees brought to the booking-in desks to make telephone calls also lacked sufficient privacy across all the suites, including sometimes while they were speaking to their legal representatives.

3.4 Interactions between detainees and staff were also detrimentally affected by the high custody officer desks at Barnsley and Sheffield, which could have been intimidating for some detainees.

3.5 Signs referring to CCTV were displayed at all the custody suites where detainees would have been likely to see them, as required by PACE code C, paragraph 3.11. However, detainees were not regularly informed verbally about the presence of CCTV cameras in the suite and their cells, and although toilets were appropriately obscured on CCTV screens at all the custody suites to protect detainees' dignity, staff did not always tell detainees that this was the case, which may have stopped them using them. Detainees were often escorted to their

cells by the arresting officers rather than detention officers, so the information was not provided consistently.

Areas for improvement

3.6 Detainees should be able to make telephone calls, especially to legal representatives, in sufficient privacy so that they are not overheard by others.

3.7 The force should ensure detainees are made aware of how their privacy is affected by CCTV coverage in the suite and are routinely informed about the areas in the cells it covers, and in particular that toilets are obscured from view.

Meeting diverse and individual needs

3.8 The force's custody staff were well prepared and able to understand and manage the wide range of needs of those coming into custody. Custody and detention officers received a variety of training, which was ongoing and consisted of classroom-based courses and e-learning. This had included mental health awareness, the vulnerability assessment framework, and autism. Despite not having received any formal training, they recognised the needs of transgender detainees, and, in one case we looked at, met them well.

3.9 Custody officers routinely asked detainees when booking them into custody if they had any religious observance and/or dietary requirements. There were sufficient stocks of religious observance material for those following Christianity or Islam, and they were respectfully stored – although in some of the custody suites the Qur'an, for example, was only available in Arabic. However, no provision was made for detainees following any other faith, such as Judaism, Hinduism or Sikhism, at any of the custody suites, and custody staff did not have an understanding or awareness of the requirements of any other faith. This meant not all detainees who wished to observe their religion while in custody could do so.

3.10 Arrangements for detainees with mobility impairments were generally sufficient at Barnsley and Sheffield, and mobility access was reasonable, but the facilities at Doncaster were poor. Wheelchairs were available at all suites and we were told they were allowed in cells. Apart from Doncaster, access to showers, toilets and exercise yards was easy, cell call bells were located at a suitable height and some thick mattresses were available for detainees who required extra comfort.

3.11 Support arrangements for detainees with sight or hearing impairments were inconsistent. There were visual aid band markings on cell walls, and Braille versions of the rights and entitlements documents at Barnsley and Sheffield, but none at Doncaster. There were audio versions of the documents at Barnsley and Doncaster, but none at Sheffield. None of the custody suites had easy-to-read rights and entitlements booklets for children or detainees who had difficulties in comprehending written versions. Custody staff across all the custody suites informed us they were unaware of hearing loops to assist detainees with limited hearing.

3.12 There was little focus on meeting the needs of women detainees. They were not routinely informed that they could speak to a female staff member. Female members of custody staff were not routinely available and were not always on every shift, which made it difficult to provide this support to detainees immediately, but even when they were on shift, this service was not always offered. The force had made a policy decision not to follow *Authorised Professional Practice* (APP) – *Detention and Custody* guidance (see Introduction) on the basis that it was unable to meet the requirements. This meant that detained women were not able

to speak with a female member of staff to discuss gender-specific issues, which they might have found embarrassing to talk about with male custody staff. However, there were well-stocked ranges of menstrual care products and disposal bags available at each of the custody suites and they were offered to women as part of the booking-in process.

3.13 Custody staff showed a good understanding of their responsibility to inform foreign national detainees' home nation embassy or consulate of their detention where required, or when requested, and could contact them without difficulty. We observed this happening when foreign nationals were brought into the custody suites.

3.14 A telephone interpreting service was available across all the custody suites. Custody officers told us the service worked well and was easy to use, and there were no significant or recurring service issues. Custody staff used the service through two-way mobile handsets or speakerphones, usually in a quieter room. We observed this service being used to help detainees understand the reasons for their detention, their rights and entitlements and other aspects of the custody process.

3.15 Rights and entitlements documents were available in a number of languages, which were easily accessible through the force's IT system. We saw them being handed to detainees where English was not their first language.

Area for improvement

3.16 The force should strengthen its approach to meeting the individual and diverse needs of detainees by:

- **providing a wide range of religious observance material**
- **offering suitable aids to ensure detainees with hearing or sight impairments or comprehension difficulties can receive information, including on their rights and entitlements, in a format that is appropriate to their individual needs**
- **ensuring that women detainees can speak with a female member of staff in line with APP guidance.**

Risk assessments

3.17 Detainees were not always booked in swiftly (see paragraph 3.30) and some waited for long periods in holding rooms during busy periods. There was no evidence that detainees were triaged to identify children or vulnerable detainees promptly or to prioritise them during the booking-in process.

3.18 Custody officers focused appropriately on the welfare of detainees and identifying risks while booking them in. They interacted well with detainees to complete standardised risk assessments, responded to individual needs and asked appropriate supplementary and probing questions. They did not, however, always question the arresting/escorting officer to establish if they had any additional information about the detainee that might affect their care plan. Staff routinely referred to warning markers on the police national computer and other information held locally on the force's IT system Connect, which conducted checks across several operating systems for information relating to a detainee to further inform their risk assessment.

3.19 In most cases, initial care plans reflected observations at a level that was commensurate with presenting risks. In general, custody officers reviewed changes in demeanour and other risk

factors and responded appropriately to manage them. The required frequency of checks on detainees was mostly adhered to, but checks were not always documented in sufficient detail in detention logs. Rousing checks on detainees under the influence of alcohol or drugs were conducted appropriately. However, the checks were not always consistently carried out by the same member of staff, which meant it was harder for a detention officer to build a rapport with detainees and potentially identify any behaviour or mood changes, which could have affected their safety. This posed potential risks, particularly to those who were under the influence of drugs and/or alcohol, and did not follow APP guidance.

3.20 Staff generally felt confident managing the risk associated with suicide and self-harm and did so competently, and it was positive that the force did not use anti-rip clothing. Instead, the force made appropriate use of close-proximity watches, which were conducted by either detention officers or arresting officers, to prevent a detainee from self-harming. Not all custody officers briefed staff conducting these watches sufficiently, and we observed several changes of personnel taking place, none of whom were briefed by the custody officer. We were advised this was routine practice. Custody staff did not conduct any physical checks of detainees under close-proximity observation. These practices posed potential risks for detainees and did not follow APP guidance. In addition, custody officers did not supervise the staff conducting the watches sufficiently. In our review of use of force cases on CCTV, we identified a few close-proximity watches involving poor practice, which we referred to the force (see paragraph 4.9).

3.21 We observed that cell call bells were not always answered promptly and in one suite, we saw custody staff routinely muting them without the appropriate authority of a custody officer, which posed potential risks to detainees trying to summon assistance.

3.22 It was positive that all detention officers carried anti-ligature knives, but we found that some custody officers and inspectors did not. The allocation of cell keys was not always managed well enough. In all the suites, we saw non-custody staff taking or being routinely handed cell keys to move detainees between the cells, interview rooms and booking-in desks, which undermined custody staff's control of the custody suite. These staff did not have access to anti-ligature knives when attending the cells. These practices posed a potential risk to vulnerable detainees.

3.23 Despite appropriate use of close-proximity observations, we saw that detainees' belts, clothing with cords, and footwear with laces was routinely removed without having undertaken an individual risk assessment. This was a disproportionate response to managing risks and did not follow APP guidance.

3.24 Handovers we observed were properly focused on risk, detainee welfare and case progression. However, there was no collective handover involving all incoming and outgoing staff and briefings often took place between individual custody officers or detention officers. Although they were available, health care professionals were not involved in handovers. It was positive that detainees were visited by a custody officer following the handover.

3.25 Custody officers in all the suites advised us they had collective responsibility for all detainees in custody or on their side of the suite, which meant there was a lack of dedicated and accountable oversight for each individual detainee.

Area for improvement

3.26 The approach to managing detainees' risks should be improved. In particular:

- **custody staff should conduct observation checks consistently and record them in sufficient detail in detention logs**
- **all officers involved in a close-proximity watch should be briefed by a custody officer**
- **call bells should be answered promptly and only muted with custody officer authority**
- **only custody staff should have access to cell keys and all custody staff should carry anti-ligature knives**
- **detainees' clothing and footwear should only be removed if an individual risk assessment considers it necessary**
- **all custody staff should be involved collectively in shift handovers**
- **each detainee should always be allocated a designated custody officer.**

Individual legal rights

3.27 Arresting officers generally explained the grounds and necessity for arrest well in the presence of the detainee while they were being booked into custody. However, there were occasions when arresting officers did not explain the necessity for arrest in sufficient detail, and, where this was the case, custody officers did not always seek a further explanation from them to ensure the arrest was necessary. Custody officers clearly explained to detainees why their detention was being authorised, and checked they understood what was being said.

3.28 The force used restorative justice processes, fixed penalty notices, community resolutions and voluntary attendance as alternatives to taking an individual to custody (see also paragraph 2.4), and custody officers told us that detention was rarely refused. Information provided by the force for the 12 months to 31 May 2019 showed this to be the case – detention was refused on 81 occasions, in the context of 22,147 detentions authorised.

3.29 However, custody officers told us that they often felt under pressure from senior managers to accept detention when the code G necessity test might not have been met in full. Operational officers and custody staff also told us that the focus on incidents of domestic abuse had led to an increase in the number of arrests being made and that diversion opportunities or alternatives to custody were not always considered. Data supplied by the force for the three years up to 31 May 2019 showed that the number of adult detainees had increased by 15% and the use of voluntary attendance for adults as an alternative to custody had declined by 31%. These figures, which appeared unusual, and operational officers' comments about domestic abuse arrests, meant the force needed to ensure that it understood the data so it could be confident that all detentions were necessary as required by PACE code G.

3.30 Waiting times between detainees arriving at custody suites and detention being authorised were good. We saw many detainees being taken straight through to the booking-in desks, but we also observed occasions where some detainees waited over an hour to be booked into custody. Frontline response officers also told us that at Sheffield they could wait a long time with detainees in the holding rooms, without any interaction with custody staff or means of attracting their attention to indicate they were still waiting. Waiting times were monitored by the force and showed an average wait of 14 minutes for adults and 16 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 18 minutes, which compared well with a number of forces inspected recently.

3.31 Custody officers had a clear focus on ensuring that cases were progressed swiftly so that detainees were released or transferred from custody as soon as possible. However, we were told that investigations were not always progressed promptly. Delays were attributed to detainees' cases being transferred between operational police teams when shifts changed, waits for Crown Prosecution Service advice and duty solicitors representing too many detainees and only able to deal with one detainee at a time, which meant others had to wait.

3.32 The force had seen a 54% decrease (a reduction of 158 cases) in the number of immigration detainees brought into custody over the previous three years. The force monitored the overall length of time immigration detainees spent in custody and provided data that showed the average time between an IS91 (immigration detention) warrant being served and the time of transfer to alternative accommodation was 15 hours and 14 minutes, which was not excessive.

3.33 Custody officers clearly explained to detainees their three main rights while in custody (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 regularly observed custody officers interacting positively with detainees, establishing a good relationship with them and checking that detainees had understood what they had been told. However, the facilities at Doncaster did not allow detainees to speak privately on the telephone with their legal representatives, if they wished to do so. (See paragraph 3.3 and area for improvement 3.6.)

3.34 Several copies of the July 2018 PACE code C booklets were available at all the custody suites, but they were not always offered to detainees as they should have been. The rights and entitlements leaflet was out of date (it was dated May 2014) but was replaced with the most up-to-date version during our inspection. However, while being booked into custody, not all detainees were given a copy of the rights and entitlements leaflet to read, which did not meet the requirements of paragraph 3.2 of PACE code C. (See cause of concern S36.)

3.35 Posters informing detainees of their right to free legal advice were not displayed in any of the custody suites, which did not meet the requirements of PACE code C paragraph 6.3. During our inspection, the force promptly rectified this.

3.36 Although detainee rights and entitlements documents could be obtained in other languages, not all custody officers and inspectors with whom we spoke were aware of PACE code C annex M. As a result, not all non-English speaking detainees were provided with a range of written translated documents about their detention in their own language as required. (See also paragraph 3.15.)

3.37 During our inspection, we observed custody officers appropriately providing authorisation for DNA samples to be taken but not fully informing detainees of the force's retention and disposal policy. The system for collecting DNA and other samples was effective, but not all samples were kept in locked and secured refrigerators, which might not have sufficiently protected their integrity.

Area for improvement

3.38 Custody officers should be aware of the availability and importance of translated documents and provide them to detainees in line with PACE code C, annex M.

PACE reviews

3.39 Although there were positive aspects to the force's approach to PACE reviews of detention, there were also a number of significant concerns. We saw inspectors focus on the welfare of the detainee, treating detainees with dignity and respect, and carrying out a post-review risk assessment for the detainee to assess any changes which might occur if a further period of detention was to have been authorised.

3.40 We found that many PACE reviews were conducted on time and often with the detainee in person or through the force's live link facility (which had been installed in each custody suite). Very few were carried out by telephone. In our custody record analysis (CRA), we found 73% (64 out of 88 custody records) of first reviews were carried out either face to face or using the live link, which was good. Reviews of continued detention did not always comply with the requirements of the PACE codes of practice and PACE. (See cause of concern S36.)

3.41 When deciding whether to conduct a review of a detainee's detention face to face or by telephone, reviewing officers should consider the health, age and vulnerability of the detainee. However, inspectors told us that they often only considered travelling times. Although they might check if another inspector was available at the suite to conduct the review, they would only conduct a face-to-face review with a detainee at the custody suite where they were working. This did not take account of the needs of children and vulnerable detainees where we expect reviews to be in person, and did not meet the requirements of paragraph 15.3C of PACE code C. (See cause of concern S36.)

3.42 Where reviews had taken place while the detainee was asleep, they were appropriate as most were overnight during the detainee's period of rest. However, in most cases the detainee was not informed that a review had taken place as soon as possible after they were awake, which meant the requirements of paragraph 15.7 PACE code C were not being met. (See cause of concern S36.)

3.43 We observed some PACE reviews in which detainees were told that their continued detention was being authorised before the reviewing officer had given them the opportunity to make representations regarding their continued detention. This did not meet the requirements of paragraph 15.3 of PACE code C and was in breach of PACE section 40. 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. In our CRA, we identified 11 cases (8% of all reviews) where a review of a detainees' detention was required but was not carried out. This was a breach of PACE section 40. (See cause of concern S36.)

3.44 Reviews were poorly recorded on custody records. They lacked detail and relied on pre-populated text supplied by the IT system and were not always tailored to reflect the individual circumstances of the detainee. The focus of the reviews seemed to be driven by process rather than by what benefited the detainees. They did not pay sufficient attention to ensuring that their continued detention was necessary or that they understood their continued rights and entitlements.

Area for improvement

3.45 The force should strengthen its approach to reviews of detention to improve outcomes for detainees. In particular by:

- **improving the quality of reviews to ensure that detainees are able to make representations regarding their detention and fully understand why they are still being detained**
- **fully recording the details of the review and reflecting the individual circumstances of the detainee.**

Access to swift justice

3.46 The force was focused on completing investigations during the first period of detention to avoid releasing detainees subject to further investigation. Our analysis of custody records identified that out of 139 detainees, 83 (60%) had had their cases concluded during their first period in custody. This was a good outcome for those detainees.

3.47 However, despite the force having a bail and released under investigation (RUI) policy, based on the information provided, there was a large number of bail and RUI cases outstanding. During our inspection, there were 5624 active RUI cases and 1804 active bail cases. It was not clear how the force managed them or reduced the investigation time to minimise the impact extended periods of RUI and bail could have on detainees.

3.48 We observed custody officers providing notices to detainees regarding their RUI status and providing a clear verbal explanation regarding what RUI meant. However, they did not always explain the consequences should detainees approach witnesses or interfere with the course of justice.

Complaints

3.49 The force did not have a policy on complaints made by detainees while in custody and custody staff we spoke to generally felt that detainees wishing to complain would be directed to make a complaint once they were released. Information explaining how to make a complaint was contained in the rights and entitlements document, and posters were displayed in all cell areas. However, the posters did not explain to detainees how to make a complaint while in custody.

Area for improvement

3.50 Custody staff should ensure detainees know how they can make a complaint about their care and treatment before they leave custody and all staff should understand how to take a complaint and how it should be dealt with.

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 South Yorkshire were variable. The two new suites at Barnsley and Sheffield were of a good standard – they were well maintained and had a suitable temperature. The majority of the cells had toilets and in-cell handwashing basins, as well as good access to natural light and functioning cell call bells. However, the suite at Doncaster was in a very poor state of repair, for example, it had cells that were cold and damp and had crumbling walls. There were satisfactory cleaning arrangements for the suite, but the cells were only superficially clean, and would have benefited from a deep clean. There was, however, very little graffiti.

4.2 We found potential ligature points in all the suites, predominantly because of the design of toilets and some benches, notably so at Doncaster. At the end of the inspection we provided the force with a comprehensive illustrative report detailing them, which received a positive response.

4.3 CCTV operated across the suites, but was only present in four of the cells at Doncaster. It functioned well, but coverage in cells and communal areas at Doncaster was extremely limited, which posed a potential risk to detainees and staff.

4.4 Custody officers and detention officers carried out daily checks of cells and communal areas against a pre-determined checklist. However, while checks were recorded as having been completed, they were conducted inconsistently and did not identify many of the issues we found during the inspection, including the potential ligature points. Any damage or faults were recorded locally and reported online or by telephone to a central department. Minor faults were, in most cases, dealt with promptly by onsite maintenance staff.

4.5 Custody staff had a good understanding of the fire evacuation procedures. Most told us that they had been involved in a fire evacuation exercise, in the past 12 months, which formed part of annual custody training. Fire evacuation routes were not always clearly identifiable, which could have posed a risk to staff who did not routinely work in the suites. Fire evacuation plans and incident management bags (containing fire evacuation plans and other equipment) were readily accessible in all suites. There were insufficient handcuffs for evacuation purposes in two suites.

Area for improvement

4.6 Custody staff should carry out thorough and consistent maintenance checks of custody suites to identify systematically any damage, faults or potential ligature points.

Safety: use of force

4.7 The force collected data on the use of force in custody but they were not reliable. Staff involved in incidents did not always complete the forms required to justify use of force against detainees. Custody officers did not routinely ask arresting and escorting officers if force, including the application of handcuffs, had been used prior to arrival in custody. 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 its use. This meant robust governance and oversight of the use of force in custody was limited.

4.8 Most staff were up to date with their required officer safety training. During our observations, staff were generally patient and reassuring in their interactions with some challenging and vulnerable detainees, potentially avoiding having to use force against them. However, our CCTV reviews did not always show the same picture – sometimes a lack of engagement with detainees impeded the de-escalation of incidents.

4.9 We saw several response officers conducting close-proximity observations in cells who were carrying their Taser, which detainees could have found threatening. This also conflicted with force policy, which suggested that staff working in custody should not carry a Taser.

4.10 Through our case audits, custody record analysis (CRA) and data supplied by the force, we identified 17 recent cases involving the use of force that we reviewed in depth, including cross-referencing 15 of them against CCTV footage. The CCTV retention policy across South Yorkshire was only 30 days, which restricted opportunities to scrutinise incidents, and the limited coverage at Doncaster prevented us from reviewing two incidents that happened in cells that did not have CCTV.

4.11 Some of the incidents we reviewed were handled well and we judged that the force used was proportionate to the risk or threat posed. We did, however, identify lessons that could have been learned in eight cases – for example, some poor techniques were used, which could have potentially injured detainees, and there was a lack of attention paid to maintaining detainees' dignity during the removal of clothing. We referred several cases to the force for review and learning.

4.12 We were told that custody inspectors reviewed a small number of cases where force had been used each month. However, it was not done consistently or robustly enough to assure senior managers that the force used was always proportionate to the risks or threat posed, or to identify any lessons that could be learned and improve practice.

4.13 Handcuffing practice was more proportionate and considered than we often see. Handcuffs were not applied routinely while detainees were being transported to custody suites and in most cases, they were removed promptly after arrival.

4.14 Data provided by the force indicated that 1,075 detainees had been strip-searched in the 12 months to 31 May 2019. This represented 8% of all detainees held during that period and included the removal of clothing for safety reasons under section 54 of the Police and Criminal Evidence Act 1984 (PACE), which should not have been categorised as strip-searching.

4.15 At Barnsley and Sheffield, custody staff told us detainees would generally be strip-searched in designated search rooms. We reviewed some cases where detainees were either strip-searched or had clothing removed for safety reasons where poor attention was paid to maintaining their dignity. Strip-searching and the removal of clothing for other reasons, with or without force, was not always justified or recorded well enough in custody records.

Areas for improvement

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

4.17 Detainees should only be strip-searched or have clothing removed when there is sufficient justification, which should be clearly recorded on the detention log.

Detainee care

4.18 Many aspects of detainee care were poor. Although we found that staff interacted courteously and well with detainees, there were some areas where insufficient attention was paid to meeting their needs and providing services as set out in *Authorised Professional Practice* (APP) – *Detention and Custody* guidance.

4.19 Meals were provided at rigid set times, and we saw detainees often having to request meals instead of custody staff offering them proactively. Although some custody staff we spoke to recognised that meals and drinks should not be restricted to specific meal times, the culture in custody did not support or facilitate this. Our CRA showed that 98 detainees out of 139 (71%) were offered a meal while in custody.

4.20 There was a variety of microwave meals, including some vegetarian options. All were within their use-by dates, and hot drinks, such as tea, coffee and hot chocolate, and breakfast items, such as porridge, cereal bars and sachets of orange juice, were available at all the custody suites. Detailed dietary and religious guidance helped custody staff understand whether food was suitable for any individual detainee's requirements. However, there was no provision for any variation from these meals, such as money to buy alternative food items if the available options were unsuitable. The force did not consider offering detainees spending long periods of time in custody a more varied diet.

4.21 Barnsley and Sheffield had separate kitchens where they prepared meals for detainees. In Doncaster, there was no such facility and detainees' meals had to be taken to the kitchen area used by custody staff to be prepared. There was also no hot water, so hot water was brought in flasks from the adjoining custody staff kitchen area to provide warm drinks for detainees.

4.22 All the custody suites held a good supply of toiletries and replacement clothing (grey tracksuit tops and bottoms), including underwear for detainees of both genders. This included replacement footwear (plimsolls) in various sizes. However, they were not routinely provided to detainees, and we saw many detainees in their cells and in the custody suites only in their socks (see also paragraph 3.1).

4.23 The provision available to ensure detainees were warm and comfortable was insufficient. The stocks of blankets and mattresses were thin and unsuitable. This view was also expressed by detainees we spoke to and custody staff themselves. Detainees regularly had to be given additional blankets and mattresses, often at their own request. The cells at Doncaster had heating fans, which were noisy, and did not provide detainees with suitable conditions in which to sleep.

4.24 There was limited reading material, such as books or magazines, across all the suites, and very little for children or anything in languages other than English. Pens and puzzles were available at Barnsley, but we did not see them being handed out to detainees during our visits. Our observations and review of custody records showed that detainees were not

routinely offered or provided with reading material. Our CRA found only five out of 139 detainees and only one of those detained for more than 24 hours had been offered them.

4.25 Detainees could not regularly have a shower or exercise, even those held overnight and for extended periods in custody. This was clear from our own observations, from speaking to custody staff, and from the cases we looked at. Our CRA showed that only two of 139 detainees had been offered any exercise, one of whom had been held for over 24 hours. This was particularly poor. Only three of 139 detainees had been offered a shower, all of whom had been held for over 24 hours, which was also particularly poor.

4.26 Because some detainees were taken to the cells by arresting officers rather than detention officers, no consistent information was being given to detainees about what they could expect or were entitled to, or how they could use the cell call bells to request food, drinks, reading material or other items, such as additional blankets. Toilet paper was not provided routinely or based on a risk assessment in line with APP guidance, which meant detainees had to ask, but this was not always fully explained to them.

Area for improvement

4.27 The force should significantly improve its approach to how it cares for detainees by:

- **offering meals and drinks proactively throughout detainees' period in detention not just at specified and rigid meal times, and providing a more varied diet to detainees in custody for extended periods**
- **providing replacement footwear to detainees while they are in their cells and walking around the custody suites**
- **improving the quality of the mattresses and blankets so that detainees are sufficiently warm and comfortable**
- **increasing the range of reading material, especially for children and those whose first language is not English, and offering them consistently**
- **increasing detainees' access to showers and exercise, particularly when they are held overnight or for extended periods of time**
- **ensuring that all detainees consistently receive the information they require about the care they can expect in custody when they are taken to their cell.**

Safeguarding

4.28 Officers and staff we spoke with had a good understanding of the importance of safeguarding. The force safeguarding policy, despite not covering issues specific to custody, emphasised that safeguarding was everyone's responsibility, and it was clear staff understood this. Training on vulnerability had supported staff's understanding of safeguarding and awareness of how to recognise concerns.

4.29 Safeguarding referrals for children and vulnerable adults were made to the force's specialist teams and to the multi-agency working arrangements team so that appropriate action could be considered. Arresting or investigating officers were responsible for making these referrals. Custody officers alerted them if any concerns arose in custody that needed addressing. However, in the cases we reviewed, some detainees were already known to services, but we saw little or no reference to safeguarding referrals. Custody officers provided little oversight to ensure that referrals were being made as required or to identify what concerns had been raised and arrangements put in place. This oversight would have helped them look after the detainee while they were in custody and inform arrangements for their safe release.

4.30 There was insufficient focus on securing appropriate adults (AAs) (independent individuals who provide support to children and vulnerable adults in custody) to provide early support to detainees. Instead of arranging for AAs to attend as promptly as possible to go through detainees' rights and entitlements and provide support to help them understand them and their journey through custody, AAs often did not arrive until it was time for the detainee to be interviewed. While we observed some custody officers trying to contact family members shortly after the detainee arrived in custody, this was not always the case.

4.31 Arresting or investigating officers were often expected to arrange AAs as part of their case progression, which generally meant asking them to attend at the time of interview. Custody officers had little oversight over when AAs were called and when they were due. This meant some detainees waited a long time before an AA arrived to support them. The cases we observed and the records we reviewed showed that waiting times varied. Where interviews were arranged quickly, AAs arrived promptly so as not delay to them. They went through detainees' rights and entitlements, the detainee was interviewed and any other processes, such as fingerprinting, were undertaken. Where the investigation took longer, there were long waits – of up to about 20 hours in some cases. Requests for AAs and arrival times were poorly recorded on custody records so the force could not assess how long detainees waited for AAs and the reasons for any delays.

4.32 Custody officers tried to obtain family members to act as AAs in the first instance, and sometimes arresting officers arranged for family or carers to attend. Alternatively, officers had easy access to the AA scheme, which operated across the force and consisted of trained volunteers. AAs arrived promptly, usually within 45 minutes of being called, which was the target time. The scheme was available from 8am until midnight, but custody officers told us that volunteers stayed on after that time if it meant the detainee could be dealt with more promptly.

4.33 Custody officers decided whether a vulnerable adult required an AA based on their risk assessment, a variety of other factors, including any markers or previous history, and following advice from the health care professionals in custody. We observed some vulnerable adults receiving support from AAs, but from a number of the case records we reviewed, we found custody officers had not considered whether an AA was needed when there was information to suggest the detainee should have had access to one. This potentially meant that some vulnerable adults did not receive the support they were entitled to.

4.34 Guidance was available for AAs in the suites and we saw it being handed out to family members and those not familiar with the role. Different versions of the guidance were used across the suites when one agreed version for all would have ensured a consistent approach.

4.35 Children were treated well in custody and custody officers and staff focused on establishing a positive relationship with them. They were kept away from adult detainees in cells on a designated wing or in quieter areas of the cell blocks. Staff arranged telephone calls so that children could speak with their parents, and custody staff told us that parents could stay with their children in a custody room or cell. However, we did not observe this or find any examples of this happening in the cases we reviewed. In all the cases we observed and reviewed, children were returned home safely to the care of an adult.

4.36 However, the force had few arrangements in place to provide children with specific support. They were not prioritised during the booking-in process, which meant they could be held with adult detainees in the holding areas, especially when it was busy. No easy-to-read rights and entitlements documents were available to help them understand their rights, although a photocopied guide to custody for children was sometimes handed to them. Although it was the force's policy to review the detention of children every four hours, the records we looked at did not demonstrate that this was happening consistently. In one case, a child left

custody after eight hours without having had a review of detention. In addition, girls were not consistently in the care of a woman as legally required by the Children and Young Persons Act 1933. (See cause of concern S36.)

4.37 The liaison and diversion teams based in the custody suites were expected to see all children entering custody to carry out welfare checks and screen those aged 16 and over. They would then involve other agencies and make safeguarding referrals if necessary. However, from the cases we looked at, this did not happen consistently across all suites.

4.38 Custody officers focused well on minimising the time children spent in custody and avoiding overnight detention by bailing or releasing children under investigation. We observed cases and looked at custody records where this had happened and children were dealt with promptly and returned home.

4.39 The force's monitoring of children entering custody was limited and the approach across the suites was not consistent. Monitoring of children held in custody overnight had recently been strengthened and custody officers were required to provide daily information on each child for the custody inspectors and the chief inspector, explaining why overnight detention had been necessary. These cases were then discussed with senior managers across the force as part of the daily management meeting, which brought greater scrutiny to the detention of children overnight. However, apart from this, any assessment of how children were dealt with depended on custody inspectors' sampling of records, which did not take place routinely or consistently.

4.40 There was no consistent approach across the force area to monitoring children in custody with partner agencies. The strategic safeguarding board chaired by the assistant chief constable regularly met with partners, and children in custody formed part of their discussions, including the provision of alternative accommodation. The force had also worked with local authorities to promote work on the requirements of the Concordat on Children in Custody (government guidance for police forces and local authorities in England on their responsibilities towards children in custody) to try and improve the position regarding the transfer of children to other accommodation. However, there were no formal force-wide partnership meetings at an operational level to monitor outcomes for children entering custody more closely or to identify where improvements were needed and how best to implement them.

4.41 Children charged and refused bail so they could attend the next available court hearing were rarely moved to alternative accommodation provided by the local authority. Local authorities have a statutory duty to provide appropriate alternative accommodation in these circumstances. Requests were made but despite an escalation process, they were not usually met. Information provided by the force for the year up to 31 May 2019, showed 54 children should have been moved to other accommodation and 51 requests were made – 25 for secure accommodation and 26 for other appropriate accommodation – but only four children were moved. This was a poor outcome for those children.

Areas for improvement

4.42 The force should ensure that custody officers have sufficient oversight of the safeguarding arrangements for children and vulnerable adults in custody to inform their care and help manage their safe release.

4.43 The force should strengthen its approach to securing AAs for children and vulnerable adults by:

- **requesting them early into a detainee's detention so that support is provided as quickly as possible**
- **increasing custody officers' oversight to ensure there are no undue delays when other officers are delegated the responsibility for obtaining an AA**
- **recording request and arrival times so that the time detainees spend in custody before their AA arrives can be measured and delays identified and addressed**
- **ensuring that all adult detainees who are vulnerable and need an AA receive one.**

4.44 The force should improve its care for children in custody by:

- **having tailored arrangements to meet the particular needs of children**
- **monitoring children entering custody closely to ensure they are dealt with as swiftly as possible and their needs met**
- **establishing effective arrangements with partners across the force to monitor and improve outcomes for children, especially those held overnight and charged and refused bail who should be moved from custody to alternative accommodation.**

Governance of health care

4.45 Detainees in South Yorkshire police custody received health services from Leeds Community Healthcare NHS Trust as part of a regional contract. Contract management was robust and the service specification drove changes in the service model and quality. NHS standards of governance underpinned the way the police and trust governed the service and involved the use of Datix (an electronic incident tracking system). The custody health service was good. A chief inspector was responsible for monitoring service delivery and local issues were resolved efficiently.

4.46 Health care professionals (HCPs) – registered nurses and paramedics – were now embedded in each suite 24 hours a day, and a forensic medical examiner (FME) was available to visit. A second 'resilience' HCP was based at Sheffield, which had improved response times, although the HCP would assist at other suites if necessary. The trust scrutinised professional credentials and provided an intensive induction. Some HCPs were being prepared for extended roles, such as advanced practice and non-medical prescribing. The joint approach and commitment to workforce modernisation was well thought out and innovative. A weekly programme of pertinent HCP training was open to all HCPs and led by FME educators – it was the first such weekly programme we have seen. Mandatory HCP training and documented clinical supervision were good.

4.47 The medical room at Barnsley and the two at Sheffield had recently been built and were of a high standard. The room at Doncaster was dated but functional. Interpreting services were available, although rarely used. Good attention was paid to compliance with standards of infection control, rooms were cleaned every day and HCPs were aware of the requirement to ensure forensic samples were not contaminated. Systems for the supply and management of clinical stock were efficient.

4.48 Each custody suite had an emergency bag of essential medical equipment (with two at Sheffield), an automated external defibrillator (AED) and oxygen. Drugs for emergency use

were securely stored but accessible. The equipment was checked every day. All custody staff knew how to access and use the essential equipment, including the AED and oxygen.

4.49 The management of written medical records had improved following the introduction of SystmOne (an electronic clinical information system) and now complied with the Data Protection Act.

4.50 We were informed that work had begun to improve arrangements for the transfer of patients to hospitals – the force hoped to address the timeliness of ambulance emergency responses which, at times, were said to be unacceptably protracted.

4.51 The storage of medicines and the management and disposal of discarded medications remained good, and there were clear audit trails. Daily checks of the well-organised stock were completed. Some medicines reference books were out of date, but recent electronic versions were available on the trust's computers.

4.52 Medicines standard operating procedures and signed patient group directions (PGDs) (which authorise appropriate HCPs to supply and administer prescription-only medicine) were available in each medical room. Nurses administered medicines under PGDs so that custody staff no longer had to hold or administer medicines.

Patient care

4.53 In our CRA, 42% of detainees required an HCP while they were detained, which had resulted in about 1150 calls to the trust every month in 2018–2019 and 92% of detainees were seen within 60 minutes (the target was 95%). Our CRA found response times of up to one hour and four minutes. Many detainees had complex and chronic presentations and we saw empathetic interactions between HCPs and detainees. Detainees we spoke with were happy with their care and we observed positive working relationships between custody staff and HCPs.

4.54 There continued to be a comprehensive approach to acquiring consent, and evidence-based medical assessments were available on SystmOne. Clinical records were of a high standard and were audited by the trust. HCPs placed a summary of care onto Connect (see paragraph 3.18) as well as on SystmOne, which was a duplication that took up their time.

4.55 Subject to authentication, medicines were continued, including methadone (an opiate substitute), and the force made reasonable attempts to collect prescribed medication from detainees' home addresses. Symptomatic relief for alcohol and substance withdrawal was available, including nicotine replacement therapy.

Substance use

4.56 Different local authorities commissioned different substance use service providers in each conurbation. At Sheffield, drug workers were embedded from 7am to 10pm (shorter hours at weekends); at Doncaster, they worked between the custody suite and local court, but at Barnsley there were no drug workers present in the custody suite. This meant that opportunities to involve detainees in work on their addictions at a time of crisis and advise them on harm minimisation were inequitable between the custody suites.

4.57 In all custody suites, officers referred detainees whose attendance at appointments was a condition of bail. At Doncaster and Sheffield, drug workers offered detainees assessments, harm-minimisation advice and referrals to community services for alcohol problems. They

also provided opiate substitution therapy prescribing, training on naloxone (a drug to manage substance use overdose) and clean injecting material. Drug workers followed up out-of-hours referrals.

4.58 Detainees under the age of 18 were informed about specialist children's services as necessary, and services were said to be responsive.

Area for improvement

4.59 The force should analyse the needs of detainees in consultation with the commissioners of substance use services, develop models of service that are equitable and provide detainees with access to services efficiently.

Mental health

4.60 South West Yorkshire Partnership NHS Foundation Trust (SWYFT) had taken over mental health liaison and diversion services across the three suites from April 2019, and teams were now embedded across the suites, which was an improvement since the last inspection.

4.61 Services in Barnsley were good, and plans were in place to deliver the same model in Doncaster and Sheffield. Barnsley received services seven days a week, but in Doncaster and Sheffield they operated five-day weeks with shorter hours. While the provision in Barnsley met detainees' needs and was valued by custody staff and detainees, staffing shortages and the absence of some governance systems across the other two suites were affecting the care available to detainees. This was an inequitable service and, at times, meant detainees were held in custody too long while waiting to see the liaison and diversion teams.

4.62 Custody staff made appropriate referrals based on risks and behavioural presentations. Not all individuals could be seen before leaving custody, especially at Doncaster and Sheffield. However, detainees who could not be seen were provided with a leaflet with service contact details, and could make contact if necessary. Some outreach support was offered to individuals post-custody, which was good, although staff's availability to provide it was limited, particularly in Doncaster and Sheffield. Teams arranged appointments for ongoing community support, including substance use and housing services and GPs.

4.63 Staff told us that access to Mental Health Act assessments 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 the transfer process, and that it could be difficult to access hospital beds and expedite suitable transport. Data across the three suites was not available to indicate the scale of these issues, which could have meant detainees spent too long in custody.

4.64 Data suggested that there had not been any cases of a detainee being held in custody as a place of safety under section 136 in the previous 12 months.

4.65 Joint working between the force and mental health services was good. However, governance arrangements were yet to be established across all three custody suites and problems in accessing clinical information before April 2019 had yet to be resolved.

4.66 A police officer worked with the community crisis mental health team, who managed the street triage scheme from 4pm to 12am, Monday to Friday, and 4pm to 2am Saturday and Sunday, which was a positive initiative. Staff we spoke with felt this helped divert vulnerable individuals away from custody. (See also paragraph 2.6.)

Area for improvement

4.67 The force should analyse, in consultation with the commissioners of mental health services, the needs of detainees and develop models of service that are equitable and provide detainees with access to services efficiently.

Section 5. Release and transfer from custody

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

Pre-release risk assessment

5.1 Detainees were present at and involved in pre-release risk assessments (PRRAs). The PRRAs generally reflected the initial risk assessment, which was based on information obtained before and throughout their period in custody. However, they were not always completed using the PRRA template and in some cases the Connect system (see paragraph 3.18) was only updated once the detainee had left the custody suite. In our case audits, we found some PRRAs lacked rigour.

5.2 Other than for children and those identified as vulnerable, little emphasis was placed on ensuring all detainees got home safely. Arrangements for detainees who lived some distance from the custody suite and who did not have the means to make their way home were not always good enough. Travel warrants were not available and there was no access to petty cash to pay for transport. We were not confident that all detainees were released safely – staff told us they expected adult detainees, even when they had no means, to find their own way home. Custody officers did not routinely ask detainees how they were getting home or if they had the means to do so, but some stated they might arrange telephone calls to assist a detainee with their arrangements. Custody staff informed us that if vulnerable people had no transport, they would ask police officers to take them home, but this depended on the availability of officers and could not be relied on.

5.3 On release, all detainees were given a support leaflet with useful local telephone numbers. The leaflet at Barnsley was more comprehensive than the others. However, not all custody officers explained the purpose of the leaflet in full, or what the community support agencies could provide. The leaflets were only available in English.

5.4 Investigating officers dealing with detainees involved in sexual offence cases were responsible for organising enhanced release arrangements, which involved providing details of available support and maintaining contact with detainees after their release.

5.5 The standard of the information in the person escort records (PERs) we examined was variable. Several PERs contained risk markers and information that was not specific enough to identify if risks were current or historical. Too many loose-leaf forms were included, such as risk assessments, details of medical conditions and medications administered, instead of recording the information directly onto the PER, which should have been the definitive risk information/management document.

Areas for improvement

5.6 Detainees who are vulnerable because they have no means of getting home should receive assistance to make their way home safely.

5.7 All relevant information to ensure the safe transfer of a detainee should be recorded in PERs.

Courts

5.8 Custody staff told us that the local magistrates' courts generally accepted detainees until between 2pm and 3pm on most days. However, on occasion, courts had refused detainees earlier than this, including during the inspection when Doncaster Magistrates' Court refused to accept a detainee who had been on the morning list and another who had been arrested around lunchtime. There was no explanation for this, but it meant detainees remained in police custody unnecessarily. These matters were rarely escalated to senior managers. It was positive that detainees arrested on warrant between 10am and 2pm could be taken directly to court cells, bypassing police custody, with the agreement of police and court liaison staff, which meant their cases were heard at the earliest opportunity.

5.9 In many cases, custody staff attached personal documentation intended for a detainee, such as follow-up drug assessment appointments, charge sheets and release under investigation notices, to the outside of their property bags on transfer to court. This practice did not respect the privacy of the detainee and did not guarantee that they would receive the documents on release – we saw court escort staff remove the documents and staple them to the PER. As there are legal implications if a detainee fails to attend a drug assessment appointment, this practice was inappropriate.

Area for improvement

5.10 Personal documentation for a detainee should be issued to them or be appropriately transferred with them when they are transported to court.

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

Causes of concern and recommendations

6.1 Cause of concern: Custody inspectors did not have sufficient oversight over the day-to-day operation of the custody suites. Staff were not always used effectively to carry out the range of custody duties required, manage risks and provide care, leading to some poor outcomes for detainees. There were no arrangements for managing efficiently those stages of custody that involved non-custody staff to minimise their waiting times and ensure detainees were dealt with as swiftly as possible.

Recommendation: The force should increase its oversight of custody so that staff are deployed in the most effective way to ensure detainees' needs are met. It should have adequately supervised arrangements for managing those stages of custody that involve non-custody staff so that delays detainees experience are minimised. (S34)

6.2 Cause of concern: The data collected by the force were inaccurate and incomplete. They were insufficient to assess the performance of custody services and the outcomes achieved for detainees.

Recommendation: The force should collect and collate accurate data for all areas of custody to underpin its performance management of the service and ensure that outcomes for detainees can be consistently monitored and improved. (S35)

6.3 Cause of concern: The force did not consistently meet the requirements of PACE, code C of its codes of practice, or section 31 of the Children and Young Persons Act 1933, which requires that all detained girls should be in the care of a woman.

Recommendation: The force must take immediate action to ensure that all custody procedures comply with legislation and guidance, and that officers implement them consistently. (S36)

Areas for improvement

Leadership, accountability and partnerships

6.4 The force should ensure recording on custody records is full and accurate and clearly reflects the individual action taken for each detainee. It should robustly quality assure custody records to identify and act on any concerns. (1.16)

6.5 The force should put arrangements in place to assess whether all detainees are dealt with fairly and equitably. It should ensure it understands any areas of disproportionate treatment and acts to address them. (1.17)

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

6.6 Detainees should be able to make telephone calls, especially to legal representatives, in sufficient privacy so that they are not overheard by others. (3.6)

6.7 The force should ensure detainees are made aware of how their privacy is affected by CCTV coverage in the suite and are routinely informed about the areas in the cells it covers, and in particular that toilets are obscured from view. (3.7)

6.8 The force should strengthen its approach to meeting the individual and diverse needs of detainees by:

- providing a wide range of religious observance material
- offering suitable aids to ensure detainees with hearing or sight impairments or comprehension difficulties can receive information, including on their rights and entitlements, in a format that is appropriate to their individual needs
- ensuring that women detainees can speak with a female member of staff in line with APP guidance. (3.16)

6.9 The approach to managing detainees' risks should be improved. In particular:

- custody staff should conduct observation checks consistently and record them in sufficient detail in detention logs
- all officers involved in a close-proximity watch should be briefed by a custody officer
- call bells should be answered promptly and only muted with custody officer authority
- only custody staff should have access to cell keys and all custody staff should carry anti-ligature knives
- detainees' clothing and footwear should only be removed if an individual risk assessment considers it necessary
- all custody staff should be involved collectively in shift handovers
- each detainee should always be allocated a designated custody officer. (3.26)

6.10 Custody officers should be aware of the availability and importance of translated documents and provide them to detainees in line with PACE code C, annex M. (3.38)

6.11 The force should strengthen its approach to reviews of detention to improve outcomes for detainees. In particular by:

- improving the quality of reviews to ensure that detainees are able to make representations regarding their detention and fully understand why they are still being detained
- fully recording the details of the review and reflecting the individual circumstances of the detainee. (3.45)

6.12 Custody staff should ensure detainees know how they can make a complaint about their care and treatment before they leave custody and all staff should understand how to take a complaint and how it should be dealt with. (3.50)

In the custody cell, safeguarding and health care

6.13 Custody staff should carry out thorough and consistent maintenance checks of custody suites to identify systematically any damage, faults or potential ligature points. (4.6)

6.14 The governance and oversight of the use of force in custody should be improved and provide assurance that when force is used it is safe and proportionate to the risk or threat posed. (4.16)

6.15 Detainees should only be strip-searched or have clothing removed when there is sufficient justification, which should be clearly recorded on the detention log. (4.17)

6.16 The force should significantly improve its approach to how it cares for detainees by:

- offering meals and drinks proactively throughout detainees' period in detention not just at specified and rigid meal times, and providing a more varied diet to detainees in custody for extended periods
- providing replacement footwear to detainees while they are in their cells and walking around the custody suites
- improving the quality of the mattresses and blankets so that detainees are sufficiently warm and comfortable
- increasing the range of reading material, especially for children and those whose first language is not English, and offering them consistently
- increasing detainees' access to showers and exercise, particularly when they are held overnight or for extended periods of time
- ensuring that all detainees consistently receive the information they require about the care they can expect in custody when they are taken to their cell. (4.27)

6.17 The force should ensure that custody officers have sufficient oversight of the safeguarding arrangements for children and vulnerable adults in custody to inform their care and help manage their safe release. (4.42)

6.18 The force should strengthen its approach to securing AAs for children and vulnerable adults by:

- requesting them early into a detainee's detention so that support is provided as quickly as possible
- increasing custody officers' oversight to ensure there are no undue delays when other officers are delegated the responsibility for obtaining an AA
- recording request and arrival times so that the time detainees spend in custody before their AA arrives can be measured and delays identified and addressed
- ensuring that all adult detainees who are vulnerable and need an AA receive one. (4.43)

6.19 The force should improve its care for children in custody by:

- having tailored arrangements to meet the particular needs of children
- monitoring children entering custody closely to ensure they are dealt with as swiftly as possible and their needs met
- establishing effective arrangements with partners across the force to monitor and improve outcomes for children, especially those held overnight and charged and refused bail who should be moved from custody to alternative accommodation. (4.44)

6.20 The force should analyse the needs of detainees in consultation with the commissioners of substance use services, develop models of service that are equitable and provide detainees with access to services efficiently. (4.59)

6.21 The force should analyse, in consultation with the commissioners of mental health services, the needs of detainees and develop models of service that are equitable and provide detainees with access to services efficiently. (4.67)

Release and transfer from custody

6.22 Detainees who are vulnerable because they have no means of getting home should receive assistance to make their way home safely. (5.6)

6.23 All relevant information to ensure the safe transfer of a detainee should be recorded in PERs. (5.7)

6.24 Personal documentation for a detainee should be issued to them or be appropriately transferred with them when they are transported to court. (5.10)

Section 7. Appendices

Appendix I: Progress on recommendations from the last report

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

Strategy

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

Main recommendation

Quality assurance processes should include monitoring trends, identifying areas for improvement, using learning from incidents and demonstrating how recommendations are implemented by frontline staff to ensure the safe treatment of detainees. (2.35)	**Achieved**

Recommendations

South Yorkshire Police Service should collate data on the number of strip-searches carried out and on the use of force. (3.8)	**Partially achieved**
ICVs access to detainees should be prompt and arrangements should be put in place to ensure this is expedited during busy periods. (3.11)	**Achieved**
The police service should ensure that a positive intervention is clearly defined, so that staff can report and learn from these incidents, to ensure the continued safety of detainees. (3.18)	**Achieved**

Treatment and conditions

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

Main recommendations

All detention logs and risk assessments should be legible to ensure the welfare and safe detention of people in police custody. (2.36).	**Achieved**
The use of head guards, with handcuffs and leg restraints to prevent self-harm should cease and alternative arrangements in keeping with best practice should be introduced to deal with extreme cases of self-harm. (2.37)	**Achieved**

Recommendations

Booking-in desks should allow detainees and staff to communicate effectively and in private. (4.9)	**Partially achieved**
Custody staff should have a clearer focus on the needs of all detainees, particularly women, young people, those with disabilities and detainees who wish to practise their religion in custody. (4.10)	**Partially achieved**
The quality and consistency of initial risk assessments should be improved to ensure detainees' safety. A comprehensive risk assessment should in all instances be completed, and the management of risk should be consistent with the outcome of the risk assessment. (4.26)	**Achieved**
All custody staff should be involved in the same shift handover, which should be recorded. (4.27)	**Not achieved**
PRRAs should be detailed, meaningful and based on an ongoing assessment of detainees' needs while in custody; the custody record should reflect the needs of the detainee on release and any action that needs to be taken. All detainees should on release be offered accurate, up-to-date information about organisations that can provide them with support. (4.28)	**Partially achieved**
Anti-ligature knives, which should only be used in an emergency, should be issued to all staff who undertake cell visits. (4.29)	**Not achieved**
Strip-searching should be correctly documented, authorised and recorded as a positive or negative search. (4.34)	**Achieved**
Cells should be well maintained, properly heated and ventilated. (4.42)	**Partially achieved**
There should be clear detailed records of daily cell checks with a means of recording defects, including any ligature points that have been repaired. (4.43)	**Partially achieved**
A stock of thick mattresses should be available. (4.50)	**Partially achieved**
All detainees held overnight and those who require one should be offered a shower, which they should be able to take in private. (4.51)	**Not achieved**
All detainees who require food should be offered good quality meals that have sufficient calorific content at regular intervals. (4.52)	**Partially achieved**
Detainees should be offered outside exercise if they are held for long periods or overnight. (4.53)	**Not achieved**

Individual rights

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

Recommendations

Information about detainees' rights and entitlements should always be available and accessible in a range of formats to meet specific needs. (5.13)	**Partially achieved**
South Yorkshire police should ensure that there are no unnecessary delays in progressing detainees' cases because 'handover folders' are created and passed on. (5.14)	**Not achieved**
Senior police managers should engage with HM Courts and Tribunal Service to ensure that detainees are not held in police custody for longer than necessary. (5.24)	**Achieved**
Detainees should be able to make a complaint about their care and treatment before they leave custody. (5.29)	**Not achieved**

Health care

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

Recommendations

Clinical rooms should comply with relevant standards of infection control and contemporary standards for forensic sampling. (6.8)	**Achieved**
The management of medical records should be in accord with the Data Protection Act and conform to Caldicott principles on the use and confidentiality of personal health information. (6.9)	**Achieved**
Detainees subject to section 136 of the Mental Health Act 1983 should not enter police custody unless there are exceptional circumstances. (6.25)	**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*.[7]

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.[8] 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.[9]

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,

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

8 95% confidence interval with a sampling error of 7%.

9 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.

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

Observations in custody suites

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

Interviews with key staff

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

Focus groups

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

Feedback to force

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

Appendix III: Inspection team

Kellie Reeve	HMI Prisons team leader
John Allen	HMI Prisons inspector
Fiona Shearlaw	HMI Prisons inspector
Norma Collicott	HMI Constabulary and Fire & Rescue Services inspection lead
Marc Callaghan	HMI Constabulary and Fire & Rescue Services inspection officer
Patricia Nixon	HMI Constabulary and Fire & Rescue Services inspection officer
Vijay Singh	HMI Constabulary and Fire & Rescue Services inspection officer
Paul Tarbuck	HMI Prisons health and social care inspector
Dayni Johnson	Care Quality Commission inspector
Joe Simmonds	HMI Prisons researcher
Patricia Taflan	HMI Prisons researcher