Report on an unannounced inspection visit to police custody suites in

Durham

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

8–18 July 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
Durham Constabulary

Chief Constable
Jo Farrell

Police and Crime Commissioner
Ron Hogg

Geographical area
County Durham and Darlington Borough

Date of last police custody inspection
12–15 May 2014

Custody suites	**Cell capacity**
Bishop Auckland	9 cells
Darlington	15 cells
Durham City	15 cells
Peterlee	14 cells
Consett (contingency suite)	7 cells
Spennymoor (contingency suite)	5 cells

Annual custody throughput
10,950

Custody staffing

Custody officers	26
Detention officers	32

Health service provider
Total Healthcare

1 Data supplied by the force.

Executive summary

S1 This report describes the findings following an inspection of Durham custody facilities. The inspection was conducted jointly by HM Inspectorate of Prisons (HMIP) and HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) in July 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 Durham Police in 2014. This inspection found that, of the 24 recommendations made during that previous inspection, 15 had been achieved, four had been partially achieved and five 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 19 areas for improvement. These are set out in Section 6.

Leadership, accountability and partnerships

S5 The force had a strong focus on diverting individuals, especially children and vulnerable adults, away from custody, to stop them from entering the criminal justice system and to prevent reoffending, and it worked well with partners to achieve this.

S6 There was a clear governance structure for the respectful and safe delivery of custody, to provide oversight at strategic and operational levels. The force had made progress since the last inspection, although it had not addressed two areas that we made recommendations for, which we have identified in this inspection report as causes of concern.

S7 The custody suites were dated and in need of major refurbishment. The force was developing options for its custody estate but there were no firm plans in place.

S8 Staffing levels in the custody suites were not always sufficient for the safe and respectful treatment of detainees. Custody staff were often stretched and unable to carry out all the tasks required or meet detainee needs promptly – for example, detainees waiting longer than necessary to be released. This was compounded by a lack of day-to-day supervision in the suites. The staffing arrangements were not sustainable for delivering custody services in the future and to achieve the outcomes expected for detainees.

S9 Despite custody staff being under significant pressure at times, they showed a respectful and caring attitude to detainees. This helped to mitigate the inability always to meet detainees' needs promptly, and the impact of some of the poor physical conditions in suites.

S10 The performance management of custody was limited, with gaps and inaccuracies in the recorded data and no routine monitoring of key areas of performance. The quality of custody records varied considerably, and the overall quality assurance of custody was not good enough.

S11 The force was not consistently meeting the requirements of the Police and Criminal Evidence Act 1984 (PACE) or those of PACE code C. We found three breaches of PACE in

relation to reviews of detention, and many other aspects of reviews that did not meet the requirements of code C of PACE.

S12 The force monitored custody throughput by ethnicity and other protected characteristics, and investigated further if any potential disproportionality was identified. There was little monitoring of other aspects of custody, to assess fair outcomes for detainees, but the force's approach in aiming to treat all detainees fairly contributed to it meeting its responsibilities under the public sector equality duty.

S13 There was a good approach to adverse incidents in custody, with a strong focus on encouraging the reporting of these to support learning and improvement. The force was also open to external scrutiny and responded positively to any concerns raised by the independent custody visitors.

Pre-custody: first point of contact

S14 Frontline staff had a good understanding of vulnerability and received good-quality information from the call handling centre, to help them to decide what action to take at an incident, and whether to make an arrest or find an alternative solution to avoid taking the individual to custody.

S15 There was a strong focus on diverting individuals away from custody. Children were only taken to custody as a last resort, and officers told us that they received good support from mental health services, to find appropriate health-based solutions for individuals with mental ill health rather than detaining them.

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

S16 Custody staff engaged with detainees respectfully, building good rapport with them. However, there was limited privacy for detainees at the booking-in desks. Although custody officers did their best to offer privacy to detainees when discussing confidential information, the design of the suites and facilities available often made this difficult. Custody staff did not always tell detainees about how their privacy was affected by closed-circuit television (CCTV) coverage in the suite and in cells, and we found that detainees' dignity had sometimes not been protected.

S17 There was good understanding by custody staff of how to meet the individual and diverse needs of those coming into custody. There were generally sufficient stocks of religious observance materials, and a there was good focus on meeting the needs of female detainees. The needs of detainees with sight or hearing impairments were met, but for those with mobility issues there were few facilities or arrangements to help them. Detainee rights and entitlements in numerous languages were easily accessible by staff, and professional telephone interpreting arrangements generally worked well, but there were delays when interpreters were required to attend the suite in person.

S18 The approach to identifying and managing risk was generally good. Detainee risks were assessed well and observation levels set appropriately. These were mainly kept to, and staff correctly carried them out, including the rousing of detainees who were under the influence of alcohol or drugs. Shift handovers were carried out well, with all staff on duty sharing information about detainees comprehensively. However, there was no prioritisation of detainees waiting to be booked in, to ensure that any risks were properly managed. There was some good support to those at risk of self-harm, but from the few close-proximity observations we observed, the officers conducting them had not been sufficiently briefed,

and there was little use of constant observation through CCTV. Certain items, such as shoelaces, jewellery and any clothing with a cord, were routinely removed from detainees, without individual risk assessment. Cell call bells were not always answered promptly.

S19 Generally, the necessity for arrest was explained well, and custody officers authorised detention appropriately, refusing it when necessary. The force did not have data on how long detainees waited to be booked in and, although most were booked in promptly, we saw some long delays. Cases were not always progressed quickly enough, with delays in carrying out investigations, and waits for interpreters, appropriate adults (AAs; independent individuals who provide support to children and vulnerable adults in custody), health care staff and, on occasions, Crown Prosecution Service decisions. This meant that detainees spent longer than necessary in custody.

S20 Custody officers informed detainees of their rights and entitlements, but not all detainees were offered a copy of their rights during the booking-in process. PACE code C was readily available, but custody staff were not aware of the availability of PACE code C annex M documents translated into other languages.

S21 The overall quality and recording of PACE reviews of detention were poor. In addition to some reviews not complying with PACE, or meeting the requirements of PACE code C, some were carried out too late or too early. Although inspectors treated detainees respectfully, the reviews were not conducted well, with little detail recorded and little attention paid to detainee welfare.

S22 Decisions to release on bail or under investigation were generally well made, although the implications of release under investigation were not adequately explained to those being released. The number of outstanding bail cases was low and they were well managed. However, the number released under investigation was high, and it was not clear how well this process was being managed.

S23 Some information about making a complaint was available to detainees, but the emphasis was on making a complaint online, or in person after release. There was no focus on the opportunity to make a complaint while in custody.

In the custody cell, safeguarding and health

S24 Cells were clean and had natural light, but the ageing fabric of the suites showed many signs of wear. Ventilation was not adequate and there were no holding rooms or in-cell handwashing facilities. CCTV coverage was limited, with many blind spots. There were many ligature points across all the suites; we gave an illustrative report detailing these to the force, and this received a positive response.

S25 Data on the use of force in custody were not reliable or accurate, which meant that the force was unable to demonstrate that this was always safe and proportionate. However, we saw some good examples of staff de-escalating situations, potentially avoiding the use of force on detainees, and in most of the cases we reviewed on CCTV the force used had been appropriate.

S26 The standard of care that detainees received was mixed. Although staff showed a caring attitude towards detainees, they were not able always to meet their needs consistently or promptly. Meals and drinks were regularly offered and provided to detainees, but other services, such as showers and exercise, were not always facilitated.

S27 Custody staff knew how to recognise and address safeguarding concerns for children and vulnerable adults. However, there was not enough focus on securing AAs promptly, to provide early support to detainees. Some children and vulnerable detainees waited a long time for their AA to arrive, as they often did not attend until it was time for the detainee to be interviewed. Staff did not always consider securing AAs for vulnerable adults, when there was information to suggest that they should have had access to one, which potentially meant that these detainees did not receive the support they were entitled to.

S28 Children were generally looked after well in custody. Custody staff tried to deal with them quickly, to minimise their time in custody and avoid overnight detention where possible. The force monitored all children entering custody, with additional scrutiny of those held overnight. There had been work with local authority partners, to enable children charged and refused bail to be moved to alternative accommodation. This had resulted in recent improvements, with four children moved to this accommodation, out of eight requests, in the previous year.

S29 Most detainees received an appropriate and timely response from health care services, although the clinical leadership and oversight of physical health services needed strengthening. The force was working with the health care provider to improve the service offered. Insufficient clinical staff presence in the suites was being addressed in a way which was likely to prove effective. Treatment rooms were appropriate, and clinical record-keeping was good. Staff and detainees spoke highly of the service provided by health care professionals.

S30 There were no dedicated substance misuse workers, but a new partnership model was being introduced, which looked promising for improving outcomes for detainees.

S31 At the time of the inspection, the liaison and diversion service was being changed, which meant that moderate and lower-level support was not readily available for detainees. New arrangements were in place but, until these were fully implemented, detainees falling into this category were offered follow-up support and an appointment following their release from custody, so that resources could be directed to seeing higher-risk detainees while in custody.

S32 Assessments for detention under the Mental Health Act 1983 were generally undertaken promptly, with few reports of any long delays in the transfer of detainees to hospital. Only one detainee had been held in custody as a place of safety under section 136 of the Mental Health Act[2] in the previous 12 months, and this had involved an exceptional set of circumstances.

Release and transfer from custody

S33 A comprehensive risk assessment template was used to ensure that detainees, especially children and at-risk vulnerable adults, were released safely; the standard of completion varied, but specific issues were notified to the relevant agencies, and practical help was given to those needing it to travel home. Information about support organisations was available for those being released, but was offered by the custody officer only if they thought it was relevant.

S34 Person escort records for detainees being transferred to another agency were completed well and discussed with the escorting staff, to ensure clarity and that all potential risks to detainees were understood. Some detainees were held in police custody for longer than

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

necessary because of early court cut-off times, exacerbated in some cases because those arrested on warrant for failing to appear at court could not be taken directly to the court.

Causes of concern and recommendations

S35 Cause of concern: There were not always sufficient staff in the custody suites to carry out all the custody processes and meet the needs of detainees promptly. This hindered the effective operation of custody and led to adverse outcomes for some detainees. There was little supervision in the suites to oversee custody services and ensure the safe and respectful treatment of detainees.

Recommendation: The force should ensure that there are sufficient staff in place, who are adequately supervised to deliver the safe and respectful treatment of detainees. This should allow for detainees' needs to be met promptly and for custody processes to be completed effectively and efficiently.

S36 Cause of concern: The performance management of custody was limited. There were gaps in data, including those relating to the use of force, and the accuracy of some data could not be guaranteed. Key areas of performance were not routinely monitored to assess how well custody services were delivered, identify where improvements were needed and monitor outcomes from any improvement actions taken.

Recommendation: The force should effectively monitor the performance of custody services, based on comprehensive and accurate data, and use this to assess performance and identify and act on areas requiring improvement.

S37 Cause of concern: Reviews of detention did not consistently meet PACE or the requirements of code C of its codes of practice. They were poorly conducted and recorded.

Recommendation: The force should take immediate action to ensure that all custody procedures comply with legislation and guidance, and that officers implement them consistently. The way in which reviews are conducted, and the standard and recording of them, should be improved.

Introduction

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

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

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

The *Expectations* are grouped under five inspection areas:

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

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

The methodology for carrying out the inspections is based on: a review of a force's strategies, policies and procedures; an analysis of force data; interviews with staff; observations in suites, including discussions with detainees; and an examination of case records. We also conduct a documentary analysis of custody records based on a representative sample of the custody records across all the suites in the force area open in the week before the inspection was announced. For the Durham force we analysed a sample of 94 records. The methodology for our inspection is set out in full at Appendix II.

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

Wendy Williams
HM Inspector of Constabulary

Peter Clarke CVO OBE QPM
HM Chief Inspector of Prisons

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3 Available at http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/inspection-criteria/
4 Available at 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 There was a clear governance structure for the respectful and safe delivery of custody. Custody was part of the crime and response command under the direction of the assistant chief constable (ACC). Although the senior management team all had far wider responsibilities than just custody, there were clear lines of responsibility for custody through a chief superintendent, detective superintendent and chief inspector. Two custody inspectors were responsible for the operational delivery of custody.

1.2 The governance structure provided oversight of custody through regular meetings. There were quarterly custody management meetings, chaired by the ACC, to look at strategic issues, and two weekly custody accountability group meetings, which were more operationally focused. These meetings had structured agendas set out against the *Expectations for Police Custody*,[5] which provided a good framework and included a wide range of topics for discussion. Running alongside these were the regular force threat and risk meetings, to which custody matters could be referred, where appropriate, for wider consideration by the force.

1.3 The custody suites were dated and in need of major refurbishment to meet modern-day standards and the needs of detainees. This was recognised by the force as a key area of risk. Options were being developed to reconfigure the custody estate, and work had been carried out to assess demand, but there were no firm plans in place.

1.4 Staffing levels in the custody suites were not always sufficient for the safe and respectful treatment of detainees. This had been raised in a recommendation in our previous inspection report, and was now a cause of concern. The establishment consisted of 26 custody sergeants and 32 detention officers, but at the time of the inspection there were staff absences. There was a reliance on overtime to staff the suites, using officers from both custody and elsewhere in the force. Our observations in the suites showed that custody staff were often stretched and unable to carry out all the tasks required or meet detainee needs promptly (see cause of concern and recommendation S35).

1.5 The staffing situation had led to adverse outcomes for some detainees. Although risks were managed by ensuring that most cell visits to check on the welfare of detainees were carried out on time, our observations showed that limited staff availability sometimes resulted in detainees waiting longer than necessary to be released; cell check visits carried out while also dealing with telephone enquiries; telephones ringing without being answered; and the inability to offer showers and exercise, even when requested. When police sergeants and constables worked overtime as detention officers, they were not able to perform all the functions of the role – for example, administering medication – which meant that the custody officers had to do this. The staffing arrangements in the suites were not sustainable

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

for delivering custody services in the future, and to achieve the outcomes expected for detainees (see cause of concern and recommendation S35).

1.6 Some of the concerns described above were compounded by a lack of day-to-day supervision in the suites. Although custody managers at all levels recognised the importance of being visible in the suites, this was not routinely achieved. The force had tried to address this by way of regular newsletters to staff, and video blogs. However, most of the custody staff we spoke to said that there was little supervisory presence in the suites, and that it was difficult to contact their managers if they needed them. They felt that little was being done to address their serious concerns over the general lack of staffing in the suites, and to provide additional resources, especially when requested on a day-by-day basis. In addition, some aspects of supervision which should have been provided routinely by custody inspectors, particularly in relation to the quality assurance of custody services, were not carried out because of insufficient time and resources (see cause of concern and recommendation S35).

1.7 Despite custody staff being under significant pressure at times, they showed a respectful and caring attitude to detainees. This helped to mitigate the inability always to meet detainees' needs promptly, and the impact of some of the poor physical conditions in suites. In our view, staff did a good job, often in difficult circumstances.

1.8 There was some good training for custody staff. Initial training was comprehensive and followed the Detention and Custody Learning Programme, as set by the College of Policing, supported by appropriate shadowing and mentoring arrangements. There were two continuing professional development days a year for all custody staff, which provided a good mixture of refresher and legal training, as well as topics on a range of vulnerabilities such as autism and child sexual exploitation. This training was also given to officers performing custody roles on overtime.

1.9 The force had adopted the College of Policing *Authorised Professional Practice – Detention and Custody* (APP), although some of the practices we observed did not follow APP guidance. While there were some additional local policies covering partnership working, there were few others to help to guide, and ensure that staff understood, local force expectations.

1.10 There was good oversight of services provided to custody by external providers. The force monitored the health service contract, to assess how well it was performing, and to explore and agree better ways of working as part of its approach. There were also regular meetings with the providers of appropriate adults (AAs; independent individuals who provide support to children and vulnerable adults in custody) and the professional telephone interpreting service, to monitor outcomes and identify where improvements were needed.

Area for improvement

1.11 The force should agree and implement clear plans for the future of the custody estate, with clear timescales for delivering these so that all detainees are held in a suitable environment and can have their needs appropriately met.

Accountability

1.12 The performance management of custody was limited. The force was not able to supply some of the data we asked for– for example, in relation to mental health assessments in custody. It used a performance dashboard, which provided a range of information, but this mainly related to the throughput of detainees, and the accuracy of some of the data could not be guaranteed. In addition, there were gaps, such as the length of detention and how

long detainees had waited for support from an AA (see also paragraph 4.33). Some information could be obtained by running searches against key words or phrases if the force had concerns around an area of activity, but this was done reactively and not as a matter of course. Key areas of performance were not routinely monitored, to show how well custody services were delivered, identify where improvements were needed and monitor outcomes from any improvement actions taken. This had been a recommendation in our previous inspection report and was now a cause of concern (see cause of concern and recommendation S36).

1.13 The governance and oversight of the use of force were not sufficient to demonstrate that any force used in custody was always safe and proportionate. Although use of force was considered at the force's ethics and legitimacy board, the data used to inform this oversight were not accurate. Not all incidents were captured, use of force forms were not completed for all incidents, the type of force used could not be easily identified for monitoring, and, although all incidents involving the use of force should have been reviewed against closed-circuit television (CCTV) footage, this did not always happen. Most of the incidents we reviewed on CCTV showed that when force had been used, it had been appropriate and proportionate. However, without accurate data and robust quality assurance, the force could not assure itself, the Police and Crime Commissioner and the public that the use of force in detention and custody was always safe and proportionate.

1.14 The force was not consistently meeting the Police and Criminal Evidence Act 1984 (PACE), or the requirements of PACE code C. Some reviews of detention were carried out by officers who were not appropriately authorised to do so, which was a breach of PACE section 107(C). Some PACE reviews had not been conducted at all, with nothing recorded to explain why this was the case, which was a breach of PACE section 40(7). Some detainees had been told that their continued detention was being authorised before the reviewing officer had given the detainee the opportunity to make representations regarding their continued detention, which was a breach of PACE section 40(12). Many other aspects of reviews of detention did not meet the requirements of code C of PACE. In addition, the overall quality and recording of reviews were poor. This was a cause of concern that we expected the force to address urgently (see also section on PACE reviews, and cause of concern and recommendation S37).

1.15 The quality of custody records varied considerably. Some were comprehensive and clear, but others had information missing, making it difficult to establish the actions that had taken place. Some entries had been copied and pasted in from other records or used pre-populated text without being edited or personalised to reflect the circumstances of the detainee.

1.16 The overall quality assurance of custody was not good enough. The force had brought in independent reviewers to look at custody records and handovers, which was a positive initiative to increase their capacity and to provide external scrutiny, and was resulting in some useful feedback for the force to learn from. However, the lack of both dip-sampling by officers with custody expertise, and of analysis of data limited the effectiveness of this scrutiny, and meant that areas for improvement were not always identified. For example, some of our concerns, such as the poor quality of the reviews of detention, had not been picked up for further examination, and, despite the force emphasising the need for face-to-face reviews with inspectors, there were still too few taking place.

1.17 There was a good approach to adverse incidents in custody, with a strong focus on encouraging the reporting of these to support learning and improvement. There were effective recording mechanisms, with incidents captured and considered centrally to inform wider learning, and also within custody to provide individual feedback as appropriate, and to custody staff more generally. Changes were introduced when needed, to address any concerns raised.

1.18 There had been one death in custody since the previous inspection. This had occurred recently, in June 2019, and was under investigation by the Independent Office for Police Conduct (IOPC) at the time of the inspection.

1.19 The force reviewed detainee throughput at its ethics and legitimacy board, to monitor any changes or themes in relation to protected characteristics, such as ethnicity, and acted on this to assess any disproportionality of treatment. For example, this had led to some work to understand the reasons for any increases in the number of detainees from a specific ethnic group. The force had also carried out an exercise to assess any disproportionality in the strip-searching of detainees. However, other than throughput, there was little assessment of whether other custody practices and processes delivered fair outcomes for detainees. Nevertheless, the force's approach to ensuring that it treated all detainees fairly, which was also supported by training for staff, contributed towards it meeting its responsibilities under the public sector equality duty.

1.20 The force was open to external scrutiny. It had a good relationship with the independent custody visiting services and was responsive to any issues raised by the visitors. It had also introduced changes following a peer review by another police force.

Area for improvement

1.21 The force should ensure that 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.

Partnerships

1.22 The force had a strong focus, with a clear strategic direction, on diverting individuals, especially children and vulnerable adults, away from custody and to stop them from entering the criminal justice system or reoffending. They worked well with partners to deliver this.

1.23 There were diversion schemes to support this approach, including the Checkpoint Critical Pathways scheme. This offered individuals who met the required criteria an alternative to the criminal justice process. Individuals entering the scheme received support from the force and appropriate partner agencies, to address the underlying reasons for their offending and find ways of addressing these. The scheme had yet to be evaluated, but anecdotal evidence and early signs suggested that it was proving successful in diverting some individuals away from offending behaviour and custody (see also paragraph 3.34).

1.24 The force also worked with partner agencies to agree multi-agency plans of action for individuals who regularly came into contact with the police. This scheme, known as 'familiar faces', aimed jointly to manage an individual's behaviour while safeguarding them from potential harm, and prevent them, where possible, from entering the criminal justice system (see also paragraph 2.4).

1.25 There was good partnership working with mental health services, to keep individuals with mental ill health out of custody by finding more appropriate health-based outcomes for them. Only one person detained under section 136 of the Mental Health Act 1983 (see footnote 2) had been in police custody in the previous year, and the circumstances for this had been exceptional (see also paragraph 4.64).

1.26 The force had also worked with its local authority partners to ensure that children in custody who had been charged and refused bail were transferred to other accommodation.

This had resulted in some recent improvements, with the local authorities arranging accommodation for some children (see also paragraph 4.41).

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 and mental ill health influenced it, along with the situation or circumstances that a person might find themselves in. All children were regarded as vulnerable because of their age. Officers were aware of the force definition of vulnerability, but saw assessment as wide ranging, and used their professional judgement to give individual consideration in each case.

2.2 Officers had received both classroom-based and e-learning training on vulnerability. This had included mental health issues, and sessions on particular topics, such as autism and child sexual exploitation, were often included in their regular training days. Officers used their understanding of vulnerability to decide on the course of action to take at an incident, and whether to make an arrest or find an alternative solution to avoid taking the individual to custody.

2.3 Officers told us that they received good-quality and timely information from the call handling centre, with updates given to them as information became available, and that they had sufficient information to help them to make decisions when responding to an incident.

2.4 Frontline officers demonstrated a strong focus on diverting individuals away from custody and the criminal justice system. They told us that they could make referrals to partner agency schemes, such as a peer mentoring scheme, which aimed to address the causes of offending behaviour through support. Frontline and neighbourhood policing officers also spoke positively about the 'familiar faces' scheme (see also paragraph 1.24) and described examples of how individuals had been helped.

2.5 Children were only taken into custody after all other options had been explored, or the nature of the offence made it the only course of action. Officers were clearly focused on achieving the best outcome for the child and used alternatives to custody, including voluntary attendance,[6] restorative justice[7] and community resolution[8] (see also paragraph 3.34). Frontline officers were expected to have a robust justification for bringing a child into custody, as custody officers would only authorise the detention of a child if they were satisfied that all other options had been exhausted. Data provided by the force showed that the number of children entering custody since the previous inspection had decreased steadily.

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

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

[8] Community resolution is an alternative way of dealing with less serious crimes, allowing officers to use their professional judgement when dealing with offenders.

2.6 There was good support for frontline officers from mental health services, to help them to deal with individuals with mental ill health. Officers told us that the mental health team based in the call handling centre provided invaluable advice and assistance, including attending incidents if required. However, this support was only available from 2pm until midnight. Outside of these hours, officers had access to telephone advice from the mental health crisis teams but we were told that it was sometimes difficult to contact the team and that they offered a lower level of support. The advice and assistance provided often enabled officers to avoid detaining individuals under section 136 of the Mental Health Act 1983 (see footnote 2), by finding a more appropriate solution. Officers told us that when individuals were detained under section 136, they would never take them into custody as a place of safety (see also section on mental health).

2.7 However, when individuals were detained under section 136 and taken to a mental health-based place of safety or a hospital emergency department (if they had a physical injury, were under the influence of alcohol or were violent and would not be accepted at a place of safety), officers reported some long waits with detainees, often in difficult circumstances. Although there were arrangements with partners jointly to assess the risks posed by the detainee and whether police officer presence was needed, and the escalation process if waits were extended, officers said that, in practice, this made little difference in reducing their waiting times with detainees. The force monitored information in relation to these delays, to give it a better understanding of the position.

2.8 Individuals arrested for offences but who had mental ill health were taken into custody, and any health-related needs were dealt with through the health care practitioners based there. Officers told us that there was good support for these individuals and that their health needs were addressed before any actions were taken in regard to the offence. However, the force did not have any information on the number of detainees taken into custody who subsequently needed a mental health assessment, to establish how often this happened.

2.9 Detainees were transported in police vehicles or a police van, depending on the risks they posed.

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 Most custody staff engaged with detainees respectfully and with empathy. We observed some good practices which helped to improve and build rapport and positive interactions. This included asking detainees how they wished to be addressed, such as by their first names. The detainees we spoke to said that they had been treated respectfully.

3.2 However, there had been some instances where the interaction had been less respectful. Some CCTV footage we viewed showed detainees being strip-searched but not then encouraged to put on the replacement clothing, which had been just left in their cell. These detainees had remained naked in their cell for some time and could be observed on the CCTV monitors in the custody area, which compromised their dignity (see also paragraph 4.18). Footwear was routinely removed, rather than assessing whether this was necessary because of the risks posed, which resulted in detainees walking around the custody suite, and in their cells, either wearing their socks or barefooted, despite plimsolls being readily available, which was undignified (see also paragraph 4.27 and area for improvement 4.29).

3.3 The ageing structure and physical design of all the custody suites provided limited privacy at the booking-in desks. Conversations between custody officers and detainees could easily be overheard, which could have made detainees reluctant to disclose personal or confidential information. Custody officers were aware of this issue, and attempted to mitigate it by booking in only one detainee at a time, allowing information to be disclosed privately and out of earshot of others.

3.4 All of the custody suites, with the exception of Bishop Auckland, had discrete booking-in desks for use, for example, with detainees being dealt with for sensitive offences, but they were not always used when necessary. There were no facilities at any of the suites to connect telephone calls to the cells, including those between the detainee and their legal representative. This meant that detainees were often brought to the booking-in desk to make or receive telephone calls, which lacked privacy (see also paragraph 3.41).

3.5 Notices advising detainees, and others, that CCTV was in operation in the suites were not displayed consistently across the custody suites, and detainees were not regularly informed verbally about this or if the cell they were in had CCTV cameras monitoring them (see also paragraph 4.5). Although all in-cell toilets were appropriately obscured on CCTV screens, staff did not always tell detainees that this was the case, which may have stopped them using them, and detainees had to ask for toilet paper, which was undignified (see also paragraph 4.28 and area for improvement 4.30).

3.6 Interactions between detainees and staff were also detrimentally affected by the high booking-in desks at Peterlee, Durham and Bishop Auckland, which could have been intimidating for some detainees.

Areas for improvement

3.7 Custody staff should ensure that detainees who are strip-searched are left appropriately clothed.

3.8 Detainees should be able to make telephone calls, especially those to legal representatives, in sufficient privacy.

3.9 The force should ensure that detainees are made aware of how their privacy is affected by closed-circuit television (CCTV) coverage in the suite, including the cells it covers and in particular that toilets are obscured from view. Notices advising detainees that CCTV is in operation throughout the custody suite should be clearly and prominently displayed in all custody suites.

Meeting diverse and individual needs

3.10 Custody and detention officers were well prepared for, and able to understand and manage, the wide range of needs of those coming into custody. They received regular training as part of their continuing professional development, covering a wide range of topics, including awareness of autism, recognising vulnerability, dealing with immigration detainees and foreign national offenders, mental health awareness and recognising the needs of transgender detainees.

3.11 Custody officers routinely asked detainees if they had any religious observance and/or dietary requirements when booking them into custody. They also usually asked detainees to self-define their ethnicity, which was subsequently collated and monitored.

3.12 There were sufficient stocks of religious observance materials for those following Christianity or Islam, and these were respectfully stored, although at Bishop Auckland the Qur'an was not wrapped in a cover, as required when handling the book. However, no such provision was made for detainees following any other faiths – for example, Judaism – although at Darlington and Peterlee, the Hindu text 'Bhagavad Gita' was available. Custody staff did not have an understanding or awareness of the requirements of any of the other faiths. This meant that some detainees who wished to observe their religion while in custody might not have been able to do so.

3.13 Arrangements for detainees with mobility impairments were not good enough. There were no adapted showers or toilets at Durham and Bishop Auckland, and the doors of the adapted showers at Darlington and Peterlee, and of the toilets at Darlington, did not provide sufficient privacy. There were no wheelchairs or other walking aids at any of the custody suites. Custody staff said that they expected detainees to have these with them when they were brought into custody. Access to exercise yards was limited, and only possible at Durham and Peterlee. There were no cells designed specifically to help detainees with disabilities, and no lowered call bells, although extra-thick mattresses and pillows were available for detainees who needed additional comfort.

3.14 There were good support arrangements for detainees with sight or hearing impairments, with visual aid band markings on cell walls, Braille versions of the rights and entitlements documents at all the custody suites, and hearing loops to assist detainees with limited hearing. However, none of the custody suites had sign language DVDs or audio tapes, or easy-to-read rights and entitlements booklets for children or detainees who had difficulties in understanding written versions.

3.15 There was a good focus on meeting the needs of female detainees. Notices were clearly displayed at all the custody suites regarding the services that women could expect while detained. During booking-in, female detainees were routinely told that they could speak to a female staff member, and were generally offered hygiene products, of which there was a well-stocked range, and we saw custody officers drawing women's attention to the notice 'advice for female detainees'.

3.16 Custody officers had a good understanding of their responsibility to inform foreign national detainees' home nation embassy or consulate, when required or requested, and could contact them without difficulty.

3.17 Professional telephone interpreting services were available in all the custody suites. Custody officers told us that the service was easy to use, and was accessed using two telephones connected to the same line, enabling three-way conversations. However, they also told us that there were considerable delays when interpreters (particularly those required for Polish- and Romanian-speaking detainees) were required to attend for interview purposes. These delays led to detainees remaining in custody for longer than necessary or having to be released under investigation pending interpreting arrangements being made (see also paragraph 3.37).

3.18 Rights and entitlements documents were available in numerous languages, which were easily accessible by custody staff through the force's computer system.

Area for improvement

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

- **having a sufficient range of religious observance material to enable all detainees to observe their faith, should they so wish, while in custody**
- **having arrangements to help detainees with mobility impairments manage in their cell, and for them to shower and use the toilet with sufficient privacy and dignity**
- **helping detainees with comprehension difficulties to receive and understand information, including on their rights and entitlements, in a format that is appropriate to their individual needs**
- **ensuring that detainees have timely access to interpreters and are not kept in custody for longer than necessary while waiting for them to attend.**

Risk assessments

3.20 Although detainees were usually booked in promptly on entering the custody suites, some had waited for long periods in vehicles outside. When delays occurred, little triaging took place to identify children, vulnerable individuals or potential risks presented by detainees waiting to be booked in.

3.21 Custody officers conducted the initial risk assessments with tact and sensitivity, and had a clear emphasis on identifying risks. There was good interaction with detainees, enabling the standardised risk assessment to be completed thoroughly and resulting in individual needs being identified and addressed. Detainees who did not engage with the risk assessment

process were placed on appropriate observation levels until their risks could be properly assessed. Not all cells had CCTV coverage but if detainees were deemed to be at higher risk of self-harm, they were generally placed in cells covered by CCTV, so that they could be monitored intermittently.

3.22 Custody staff routinely referred to information held on the Durham Constabulary 'PoliceWorks' computer system, and to warning markers on the Police National Computer to inform their assessment of risk.

3.23 Staff understood the different ways in which detainees presented medical or mental health issues, and in most cases responded appropriately by making the requisite referrals to health services staff and/or the liaison and diversion team.

3.24 Care plans generally reflected observations at a level that was proportionate to the identified risks, and were reviewed during the period of detention. From our case audits and observations, we saw observation levels being reduced and increased when appropriate, with the rationale noted on the custody record. The practice of rousing detainees who were under the influence of drugs and/or alcohol was good.

3.25 The use of level 3 and 4 observations had until recently required the authority of a superintendent, and some custody officers told us that this had deterred them from using these levels. This policy had been rescinded approximately two weeks before the inspection and we saw a number of detainees on level 4 (close-proximity) observations. However, staff undertaking the observations had not been properly or sufficiently briefed, and rarely had comfort breaks facilitated. There was still little use of level 3 (constant observation using CCTV) observations.

3.26 In most cases, checks on detainees adhered to the required frequency, but there was a lack of detail recorded on the detention logs. Checks were not always conducted by the same staff member, which did not follow APP guidance, and this lack of continuity made it more difficult to identify any changes in the detainee's mood or behaviour, or potential risks, particularly for those who were under the influence of drugs and/or alcohol.

3.27 Custody staff generally knew how to assess and respond to risks associated with suicide and self-harm. Anti-rip clothing was not widely used to manage these risks but when it was, the rationale was recorded on the custody record. However, the use of higher levels of observations were not always explored before clothing was removed; in some instances we observed, we considered that that this would have been a more appropriate response.

3.28 Cell call bells were not always answered promptly. We observed staff routinely muting them without informing the custody officer, thereby preventing any control measures being considered to mitigate the increased risk. This, along with not routinely recording the action or justification, did not follow APP guidance and posed a potential risk to detainees.

3.29 Most custody staff carried anti-ligature knives but not all sets of keys had these attached. There was a lack of control of cell keys in some suites, with non-custody staff routinely being given or taking cell keys and moving detainees to and from interview rooms. We observed some of these officers using the sets of keys that lacked anti-ligature knives, which presented a risk of not being able to respond effectively to any potential self-harm incidents encountered in a cell.

3.30 There was a risk-averse approach in all custody suites, which resulted in the removal of personal items, including clothing with cords, footwear with laces, belts and jewellery, without an individual risk assessment. This was a disproportionate response to managing risks, particularly for those assessed as low risk, and did not follow APP guidance.

3.31 The handovers we observed were conducted in areas that were covered by audio and video recording, and, with the exception of the health care team, involved all custody staff. They concentrated on detainee risks, and medical, vulnerability and welfare needs, and there was good exchange of information between attendees. Regular dip-sampling took place, to review the quality of handovers. Detainees were visited by an incoming custody officer following the handover.

Area for improvement

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

- **the same custody staff should conduct observation checks and record them in sufficient detail in detention logs**
- **cell call bells should be answered promptly, only muted with the custody officer's authority and properly recorded in the detention log**
- **all custody staff should carry anti-ligature knives**
- **detainees' clothing, footwear and jewellery should be removed only if the individual risk assessment suggests that this is necessary.**

Individual legal rights

3.33 Arresting officers in most cases explained well the circumstances of, and need for, the detainee's arrest to custody officers in the presence of the detainee. Custody officers clearly explained to detainees the reasons for authorising their detention, and recorded these on the custody record. Custody officers told us that they rarely refused detention once a person had been brought to the custody suites, primarily because of discussions they had had with arresting officers before the arrival of the detainee. However, they said that they were confident in refusing detention if the circumstances did not justify it, and we saw this take place on one occasion during the inspection, which was appropriate.

3.34 Alternatives to custody were available through restorative approaches, community resolutions and voluntary attendance. However, the number of voluntary interviews had decreased by 30% in the last three years, from 4,017 voluntary attendees in the year to June 2017, to 2,823 in the year to June 2019. These individuals were booked in on the electronic voluntary attendance system, often by interviewing officers using custody suite booking-in terminals, and the interviews took place in custody suite interview rooms. This was contrary to the intended ethos of the process, which was to divert individuals from police custody. Deferred prosecution schemes[9] – for children in the form of referrals to the youth offending service, and for adults in referrals to the Checkpoint Critical Pathways scheme – were well embedded within the custody suites, and we saw some detainees being appropriately referred to these schemes (see also paragraphs 1.23 and 2.5).

3.35 Our custody record analysis (CRA) showed an average waiting time of 18 minutes from detainees arriving at a custody suite to being booked in, which was comparable to our findings in other forces. Although most detainees were booked in promptly, we saw some long delays. At one suite, this was because many detainees were arrested almost simultaneously as part of a pre-planned operation, but we also saw some delays of between

[9] Deferred prosecution schemes involve individuals voluntarily agreeing to fulfil certain requirements as an alternative to prosecution, but if they fail to meet the requirements, the prosecution can be re-instigated.

45 minutes and an hour in another suite, which was too long, particularly when this involved vulnerable and compliant detainees, who might have remained in handcuffs throughout this period (see also paragraph 4.17). The force was unable to supply any data on average waiting times.

3.36 Custody officers were aware of the need to minimise time in detention and to progress cases quickly. Some custody officers were active in liaising with investigating officers to ensure that cases were progressed as quickly as possible, particularly when these involved vulnerable detainees. However, investigations were not always progressed promptly. Detention was lengthened by delays due either to outstanding enquiries not being completed when response officers were busy with other activities, or to the non-allocation or non-availability of investigating officers. During the inspection, a vulnerable female detainee with mental health issues was held in custody for just over 21 hours before she was interviewed, as no one was available to obtain the statements necessary to progress her case. She was subsequently released under investigation within two hours of the start of her interview.

3.37 Custody staff told us that delays also resulted from waiting for interpreters (see also paragraph 3.17 and area for improvement 3.19), AAs (see also paragraph 4.33 and area for improvement 4.43), health care staff (see also paragraph 4.52), liaison and diversion staff and, on occasions, Crown Prosecution Service decisions. In one case record we looked at, a non-English-speaking detainee had been held in custody for just over 15 hours because the interpreting service had not been able supply an interpreter for his interview. This detainee had subsequently been released with no further action when it was established from CCTV footage that he was not the offender. The force was unable to supply any data on average detention times.

3.38 Custody staff said that they had a good relationship with Home Office immigration enforcement officers but that many immigration detainees were not moved on to immigration removal centres until 24–48 hours after being served with an IS91[10] warrant of detention. We saw one immigration detainee being transferred just over seven hours after their IS91 was served, but the force was unable to supply any data on the number of immigration detainees held or the average time that they spent in police custody.

3.39 Custody officers advised detainees of their three main rights (the right to have someone informed of their arrest, the right to consult a solicitor and access free independent legal advice, and the right to consult the PACE codes of practice) during booking in. A written notice was available, setting out a detainee's rights and entitlements, but not all custody officers routinely offered this to detainees to read, which did not meet the requirements of paragraph 3.2 of PACE code C.[11]

3.40 Detainees were told that they could inform someone of their arrest, and staff facilitated this. Detainees were often allowed to speak to their nominated representative while still at the booking-in desk, which was positive.

3.41 Posters informing detainees of their right to free legal advice (including in foreign languages) were displayed in all the custody suites, and all detainees were offered free legal representation. If a detainee declined, custody officers did not always record why they did not wish to use the service. There were enough interview rooms in all custody suites for detainees to consult their legal representatives in private. Those wishing to speak to legal representatives on the telephone could do so in private, but on occasions we saw this taking

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[10] An IS91 warrant of detention is served on an immigration detainee when there is no reasonable alternative action – for example, if there is a likelihood that they may abscond or that their removal from the UK is imminent.

[11] PACE code C is the revised Code of Practice for the detention, treatment and questioning of persons by police officers.

place at booking-in desks (see also paragraph 3.4). Legal representatives were routinely given a printout of the front sheet of their client's custody record on arrival at the suites.

3.42 Detainees were told that they could read the PACE codes of practice during booking in, and several copies of the up-to-date PACE code C booklets were available at all the custody suites, although these were not routinely explained or proactively offered to detainees, as they should have been.

3.43 Although detainees' rights and entitlements could be obtained in languages other than English (see also paragraph 3.18), only one of the custody officers we spoke to was aware of the availability of translated PACE code C annex M documents, which were on the custody intranet site. This meant that not all non-English-speaking detainees would be provided with a range of written translated documents about their detention in their own language, as required.

3.44 The management of refrigerators and freezers was poor in some custody suites. We found some old elimination DNA samples and exhibits in a few of the suites, including the contingency suites, which required attention as these should not have been stored in the custody environment. None of the sample refrigerators in the custody suites had locks, which meant that the integrity of stored samples may not have been sufficiently protected.

Area for improvement

3.45 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

3.46 PACE reviews were undertaken by dedicated custody and operational duty inspectors across the force area, and they treated detainees courteously and with dignity and respect when conducting these. However, overall, we identified many serious concerns in the way that these reviews were conducted, as we found breaches of PACE section 40 and a number of instances where the requirements of PACE code C had not been met (see cause of concern and recommendation S37).

3.47 In our CRA, we identified three cases (6% of all reviews looked at in the sample) in which a review of a detainees' detention was required but had not been carried out, and there was no explanation recorded. This was a breach of PACE section 40(7).

3.48 We found that many reviews had been conducted on time, but few had been conducted face to face with the detainee. In our CRA, only 35% (18 out of 51 custody records) of first reviews had been carried out face to face, which was poor. Some reviews had been carried out early. One detainee had received a first review while he was asleep, only three hours 41 minutes after his detention had been authorised, with no rationale recorded for why this had been brought forward. Similarly, in our CRA and during the inspection we found that several reviews were conducted late; the grounds for and extent of the delays were not recorded (in accordance with paragraph 15.13 of PACE code C).

3.49 When reviews had taken place while the detainee was asleep (in 18 out of 51 custody records (35%) in our CRA), this had not always been in recognised rest periods, and sometimes there was evidence in the logs that the detainee had been awake shortly beforehand. In most cases, the detainee had not been informed as soon as possible after waking that a review had taken place (in accordance with paragraph 15.7 of PACE code C).

When conducting a review over the telephone, inspectors did not routinely record their location and why they were unable to attend the custody suite where the detainee was being held (in accordance with paragraph 15.14 of PACE code C).

3.50 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 about 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(12). In addition, inspectors did not remind detainees of their right to free legal advice before carrying out the review (in accordance with paragraph 15.4 of PACE code C), although in all cases the inspector reminded the detainee of this right later in the review.

3.51 Reviews were often poorly recorded on custody records. The records lacked detail and had an insufficient focus on detainee welfare, and there was some reliance on pre-populated text supplied by the computer system, rather than always tailored to reflect the individual circumstances of the detainee (see also paragraph 1.15). The focus of the reviews appeared to be on process rather than for the benefit of the detainees in ensuring that their continued detention was necessary.

Access to swift justice

3.52 The force was focused on completing investigations during the first period of detention, to avoid releasing detainees subject to further investigation. In our CRA, 63 out of 94 detainees (67%) had had their cases concluded during their first period in custody, which had been a good outcome for these detainees.

3.53 When custody officers identified that there was insufficient evidence to charge detainees, decisions to release them under investigation or to seek authorisation to bail them from senior officers were made through the appropriate channels. However, we saw some detainees being released under investigation who were not told of the consequences if they tried to compromise the investigation into their case, and they were not always issued with the relevant paperwork that explained the consequences of approaching witnesses or interfering with the course of justice.

3.54 The progress of bail cases was closely monitored by the custody management team, which was responsible for ensuring that enquiries were pursued and applicable bail periods adhered to. At the time of the inspection, there were only 57 active bail cases dating from after April 2017 (when the legislation changed). By contrast, there were 2,383 active cases where detainees had been released under investigation. Although these cases were reviewed monthly by supervisors, it was not clear that they were being actively investigated or that this process was being effectively managed to reduce investigation time and minimise the impact that extended periods of release under investigation can have on detainees.

Complaints

3.55 Information on the complaints process was displayed in force posters in all cell areas, but the font size was small, the content was not immediately apparent and they were available only in English. These posters did not explain to detainees how to make a complaint while in custody. Information on the complaints process was contained in the rights and entitlements notice, but not all custody officers routinely offered this to detainees to read (see also paragraph 3.39). Leaflets from the IOPC were displayed and available in all the custody suites (although the leaflet displayed at Peterlee was out of date), but the focus of the leaflet was on complaints being reported online. Complaint forms were available in six languages other

than English in all the suites, but none of the custody staff we spoke to were aware of their availability.

3.56 The force did not have a policy in relation to the management of complaints made by a detainee while in custody. Most custody staff told us that they would direct detainees who wished to make a complaint to attend the police station front desk on release. A few staff said that they would make the duty inspector aware of a detainee wishing to make a complaint, and that it would be their decision to decide when the detainee's complaint would be noted. These practices did not assure us that a detainee would be able to make a complaint while they were still in custody, and remained unchanged from the previous inspection.

Area for improvement

3.57 **Complaints should be taken while detainees are still in custody, unless there is a good reason not to do so.** (Repeated recommendation 5.19)

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

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

Physical environment is safe

4.1 The custody estate was dated, and the suites showed many signs of wear. It comprised four full-time designated suites at Bishop Auckland, Darlington, Durham and Peterlee, and two contingency suites at Consett and Spennymoor, which were used infrequently.

4.2 Despite the age of the custody estate, cleanliness across the suites was good. When cells had biological hazards that required a deep clean, they were dealt with promptly and efficiently by an external contractor. There was little graffiti in the cells, and they all had natural light (with the exception of two cells at Durham). However, the temperature in the cells was not always suitable; during the inspection, some suites were too hot, and in some cases ventilation was achieved by leaving doors to the suites and exercise yards open.

4.3 Work had been carried out at Bishop Auckland and Darlington to improve their condition, which included the installation of CCTV in every cell. Some remedial works had also been carried out at Durham and Peterlee, but not to the same extent. However, the estate still lacked facilities; for example, there were no holding rooms, in-cell handwashing basins (except at Darlington), glass-fronted cell doors or accessible cell adaptations (other than an adapted toilet/shower at Darlington and Peterlee).

4.4 CCTV coverage in communal areas and cells varied across the estate. It was available in only four cells at Durham and two cells at Peterlee. At Peterlee and Consett, the positioning of the CCTV monitors at the booking-in desks made it possible for these to be seen by detainees and visitors to the suites, which was inappropriate and did not adequately maintain detainees' dignity or privacy. We identified many blind spots in the CCTV coverage – for example, at booking-in desks and in exercise yards, which meant that insufficient protection was afforded to detainees and staff alike (see also paragraph 4.15).

4.5 Notices advising detainees that CCTV was operating were not displayed in two of the suites, and in the remaining suites these notices were not always prominently displayed, which did not meet the requirements of paragraph 3.11 of PACE code C. When CCTV cameras were positioned in cells, there was no specific signage to promote this, and detainees were not routinely told about it when they were lodged in the cells (see also paragraph 3.5).

4.6 The cell call bells we tested were working, but during the inspection we saw that some call bells were switched off at the booking-in desk to mute them, and staff responses were delayed when they were busy, which compromised detainee safety (see also paragraph 3.28 and area for improvement 3.32).

4.7 Despite the requirement for daily checks of the physical environment, we found that the recording of these was inconsistent, with numerous gaps identified at all the suites. This

meant that the force could not be confident that these were completed comprehensively. All damage and faults were reported to the estates team, and most were fixed promptly.

4.8 During the inspection, we identified many potential ligature points in cells and communal areas across the estate. We provided the force with a comprehensive illustrative report, and work was started to remedy some of these issues during the inspection.

4.9 Custody staff had a reasonable awareness of emergency evacuation procedures, but not all of the staff we spoke to had been involved in a fire drill in the previous 18 months. The data provided showed that drills had been carried out in the previous 12 months at the four full-time suites but failed to identify who had been present and taken part in the drill. Fire evacuation procedures and evacuation plans were not prominently displayed in any of the suites. Fire evacuation grab bags, equipped with handcuffs, fluorescent vests and associated evacuation documentation, were issued to all the suites during the inspection, but the fire evacuation procedures had not been updated to incorporate the use of these.

Area for improvement

4.10 The force should ensure that it adheres to the legal requirements for fire safety.

Safety: use of force

4.11 Data on the use of force in custody were not reliable or accurate. Use of force forms for incidents in custody were not always completed by all the officers involved. We requested the use of force forms for the 12 cases we reviewed but there were none available for four of these cases, and less than half of the forms were available for the others. When force had been used before or during detention, this had not always been recorded on the custody record. In addition, the data collected did not show how many times particular tactics had been used. This meant that the force was unable to show and assess how often force was being used in custody, and the different types of force used, to provide assurance that it was being used appropriately and proportionately. The inaccuracy of the use of force data was part of the wider cause of concern in relation to data collection and performance management (see cause of concern and recommendation S36).

4.12 Most officers working in custody were up to date with their personal safety training, and those who were not were booked onto courses.

4.13 We saw some good examples of de-escalation techniques being used by staff, often in challenging circumstances. Both during our observations in custody suites and in our CCTV review of incidents, we saw operational officers and custody staff alike demonstrating patience and understanding, which potentially avoided using force on detainees.

4.14 We carried out an in-depth review of 12 recent cases in which force had been used against detainees in custody, and cross-referenced them against CCTV footage. Most incidents had been dealt with appropriately and the force used had been fair and proportionate. We referred five cases back to the force for learning: four relating to strip-searching (see below), and one in which we had concerns over the poor technique that had been used to move a detainee into a cell.

4.15 CCTV recordings were kept for up to 30 days, which limited the opportunities for us, but more importantly the force, to review and scrutinise incidents. The quality of the footage was often poor, and there were several blind spots in the suites which prevented effective viewing of incidents (see also paragraph 4.4).

4.16 All use of force incidents in custody should have been reviewed by officers delegated to do so by the custody management team, including viewing the CCTV footage. However, there were not always officers available to do this, so it did not always happen. In addition, there were no arrangements to help to identify where force may have been used but not reported.

4.17 Handcuffs were removed promptly from detainees after their arrival at the booking-in desk. However, when there was a queue for booking in, some detainees, including those who were compliant, waited outside the custody suites in handcuffs for long periods (see also paragraph 3.35).

4.18 Data provided by the force for the year ending 30 June 2019 showed that 631 detainees (5.8%) had been subject to a strip-search in custody. These searches took place in cells. We reviewed strip-searches as part of the 12-case review described above. Although the strip-searching had been justified, and conducted appropriately in all but one of these cases (see below), insufficient attention had been paid to ensuring detainee dignity subsequently. Three detainees had been left naked in the cell after the strip-search, with no effort made to encourage or assist them to dress (see also paragraph 3.2 and area for improvement 3.7).

4.19 The case with insufficient justification involved a 16-year-old boy, who had been strip-searched without an AA in attendance. The rationale for the urgent search had been weak, and retrospectively added to the custody record 10 hours later. There was no record of the AA being informed of this on arrival, or of an explanation being given to the detainee in his presence.

Area for improvement

4.20 The governance and oversight of the use of force in custody should be improved, to provide assurance that it is safe and proportionate to the risk or threat posed. In particular, by:

- **increasing coverage by CCTV cameras in the suites to remove blind spots, and prioritising the way in which footage is retained**
- **quality assuring sufficient use of force incidents in custody to demonstrate that force is used fairly and appropriately.**

Detainee care

4.21 The approach to detainee care was mixed. Although staff interacted courteously and well with detainees, in some areas the needs of detainees were not consistently met, or services consistently provided. This was mainly due to the lack of staff availability (see cause of concern and recommendation S35).

4.22 None of the custody suites had any facilities for drinking water in the cells or for washing hands, except at Darlington (handwashing only), so detainees had to ask for these.

4.23 A range of microwave meals was stocked, including some vegetarian options, and all were within their use-by dates. Hot drinks, such as tea, coffee and hot chocolate, were also available. Breakfast cereal bars were being trialled for use at Durham and Peterlee. Detailed dietary and religious guidance helped custody staff to understand whether food was suitable for individual detainees' requirements. Our observations at custody suites and review of records showed that meals and drinks were regularly offered and provided. Our CRA for the previous week showed that 80 out of 94 detainees (85%), and all of those held for longer

than 24 hours, had been offered a meal. However, there was no provision for any variation from these meals if the available options were unsuitable, and some custody officers had not considered offering detainees spending long periods in custody a more varied diet, despite having funds available. In one case, we saw a detainee who had been in custody for 32 hours but no other options were offered or provided.

4.24 From our observations, conversations with custody staff, and case reviews, we found that detainees were not regularly offered a shower or exercise, even when held overnight or for extended periods, or when they requested these. In our CRA, only 27 out of 94 detainees (29%) had been offered exercise, and only 20 (21%) offered a shower. Custody staff told us that they were often too busy to fulfil all the requests made.

4.25 There was limited reading material, such as books or magazines, across all the suites; there was little for children and nothing in foreign languages, except at Darlington, where there were a few books aimed at children and one in French. From our observations and from looking at cases, we found that few detainees were offered or provided with any reading material; in our CRA, only 11 out of 94 (12%) had been offered something to read.

4.26 There were sufficient stocks of blankets, suitable mattresses and pillows to ensure that detainees were warm and comfortable.

4.27 All the custody suites held a good supply of toiletries, towels and replacement clothing (grey tracksuit tops and bottoms). There was no replacement underwear for either gender. Footwear (plimsolls) in various sizes, including socks at some custody suites, were available but, these were not routinely provided, leaving detainees barefoot or in their socks (see also paragraph 3.2).

4.28 Toilet paper was not provided routinely or based on a risk assessment, as required by APP guidance, which meant that detainees had to ask for it; this was undignified, and not always fully explained to them. The toilet rolls were kept on cell door handles, peep-hole ledges or on cell corridor floors, which was an unhygienic and an unsatisfactory method of storage.

4.29 Detainees were often escorted to their cells by arresting officers rather than detention officers, so information about the care they could expect to receive was not provided consistently.

Area for improvement

4.30 The force should improve its approach to detainee care by:

- **providing a more varied diet to detainees in custody, particularly those detained for extended periods**
- **increasing detainees' access to showers and exercise, particularly when they are held overnight or for extended periods**
- **increasing the range of reading material, especially for children and those whose first language is not English, and offering this consistently**
- **providing replacement footwear to detainees while they are in their cells and walking around the custody suites**
- **ensuring that toilet rolls are kept hygienically and provided to detainees, in line with *Authorised Professional Practice – Detention and Custody* guidance**

- **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

4.31 Officers and staff we spoke to had a good understanding of the importance of safeguarding and an awareness of how to recognise concerns, supported by training on vulnerability.

4.32 Safeguarding referrals for children and vulnerable adults were made to the force's specialist teams and into the multi-agency working arrangements. Arresting and/or investigating officers were responsible for making referrals, but custody officers were good at identifying when a safeguarding referral was required and asking these officers to complete one. However, custody officers provided little oversight to ensure that referrals had been made as required or to identify the concerns that had been raised. Although we saw a strong focus by custody officers on releasing children and vulnerable adults safely, this additional oversight would have enabled a more informed approach to this and to meeting their needs while in custody.

4.33 There was insufficient focus on securing AAs promptly, to provide early support to detainees. Instead of arranging for AAs to attend as soon as possible, to go through detainees' rights and entitlements and provide support to help them in their journey through custody, AAs often did not arrive until it was time for the detainee to be interviewed. In the cases we observed and the records we reviewed, waiting times for an AA varied considerably. When interviews were arranged quickly, AAs arrived promptly. In other cases, where the investigation took longer, there were long waits; in one case we looked at, a detainee had waited just over 18 hours. The force did not monitor how long detainees waited for AAs, and requests for these and their arrival times were poorly recorded on custody records, making it difficult to assess the reasons for any delays.

4.34 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. When this was not suitable or possible, officers generally had easy access to AAs when required. Although there were differences in provision from the two local authorities covering the force area, AAs were obtained either from their own staff or through the contracted national service provider – The Appropriate Adult Scheme (TAAS). They were available 24 hours a day, seven days a week, as needed. Officers told us that AAs from TAAS arrived promptly after request, and monitoring of the service by the force showed this to be the case.

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

4.36 We observed some AAs receiving a verbal explanation of their role, and in one case a guidance sheet was issued. However, this did not happen routinely.

4.37 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 designated cells. Custody staff knew that all girls should be assigned a female officer to look after their welfare, and this had happened in a case we looked at. Custody staff told us that parents

would not be allowed to stay with their children in a custody room or cell, although we saw a parent being allowed to stay in an interview room with their child while a decision was made about case disposal. All of the suites had rooms available for AAs to speak privately with a detainee, and we saw these being used.

4.38 However, the force had few arrangements to provide children with specific support. No easy-to-read rights and entitlements documents were available (see also paragraph 3.14 and area for improvement 3.19), although a laminated guide to custody for children was sometimes handed to them. There was no force expectation for custody health care professionals or liaison and diversion service teams to see all children entering custody, to carry out welfare checks or assess their needs. Custody officers made referrals as they thought necessary, but in some cases we looked at, the child had not been seen by a health care practitioner when the circumstances seemed to merit this.

4.39 Custody officers focused well on minimising the time that children spent in custody and avoiding overnight detention by bailing or releasing children under investigation. In the custody records we looked at where this had happened, the children had been dealt with promptly and returned home.

4.40 The force monitored all children entering custody. Every custody record involving the detention of a child was monitored. Custody officers were required to provide the justification for any child held overnight. These cases were given greater scrutiny, and feedback was given to custody officers where appropriate.

4.41 Although there was no formal joint monitoring of children in custody with local authority partners, there had been co-working to enable children who had been charged and refused bail to be moved from custody to local authority accommodation. Local authorities have a statutory duty to provide appropriate alternative accommodation in these circumstances. The force and its local authority partners had all signed up to the Concordat on Children in Custody; processes, with escalation procedures, were being worked to; and there had been some recent improvement in the position. Information provided by the force for the year up to 30 June 2019 showed that, of the 12 children who had been charged and refused bail in the previous year, eight had needed to be moved to local authority accommodation, of whom four had been moved – two to secure and two to appropriate accommodation (see also paragraph 1.26).

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 help to manage their needs while in custody and their safe release.

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

- **requesting them early into a detainee's detention, so that support is provided as quickly as possible**
- **recording and monitoring request and arrival times, so that the time that 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 ensure that it consistently identifies when children need to be seen by health care professionals in custody, and refer them accordingly.

Governance of health care

4.45 Total Healthcare had delivered physical healthcare services for many years and had a longstanding relationship with the force. Tees, Esk & Wear Valley NHS Foundation Trust (TEWV) provided the liaison and diversion team, which delivered an all vulnerabilities health model as part of a newly established partnership with Spectrum Health and Humankind that had been directly commissioned by NHS England (see also paragraph 4.57 and section on mental health).

4.46 There was close collaboration and mostly effective partnership working between health care providers and the police. The police had recently challenged the input provided by Total Healthcare. Staffing was sometimes stretched in delivering a service across the four suites, as forensic medical examiners (FMEs) had historically been utilised mainly on an on-call basis. The force had addressed this issue by increasing the visibility of FMEs and the length of time that they routinely spent in the custody suites. The latter was due to increase further, which we judged to be a pragmatic solution to delivering effective operational services. Despite these reported constraints, we found that most detainees received an appropriate and timely level of support.

4.47 Health provision was considered at regular performance meetings with the police. They included discussion of the strategic development of detainee care, and these meetings had recently increased in frequency. We judged that clinical leadership and the operational oversight of physical health services needed strengthening. The matron for the service had other important responsibilities, which were understandably being prioritised. Appraisals took place, but one-to-one managerial and clinical supervision was more limited, although some opportunities for peer review were afforded. Clinical governance systems needed greater emphasis, to ensure that practice was subject to regular clinical audit, medicine stock was fully accounted for, and resuscitation equipment was consistently monitored. The electronic clinical records system was good and enabled practitioners to access, with consent, the national clinical information system, to review current treatment issues.

4.48 There were policies to report and manage incidents, and an independent health complaints process was advertised in the suites, although rarely used by detainees. Total Healthcare looked to rotate custody care practitioners (CCPs) into their urgent care environments, so that individual clinical competencies were maintained, and opportunities to undertake mandatory and professional training were well established.

4.49 Treatment rooms were generally spacious and clean, and mostly complied with infection prevention standards. Consultations took place in private, unless risk factors indicated otherwise.

4.50 A standard emergency bag containing essential medical equipment was held in each clinical room. The contents we saw were generally appropriate and included a defibrillator, but monitoring and checking arrangements were unclear. All of the custody staff we spoke to had received appropriate first-aid training, which included basic life support training.

Area for improvement

4.51 Managerial oversight and clinical governance arrangements should ensure effective support and supervision of custody care practitioners, and routinely monitor clinical standards and medical equipment.

Patient care

4.52 The health care professionals we met were professional and competent, and records indicated an appropriate level of training for CCPs. They generally saw detainees within an hour of being requested, with actual responses linked to identified detainee need. The support provided, particularly by CCPs, was valued by custody staff and detainees. Some custody staff indicated that FME support was good, but they experienced occasional difficulties in attendance, although we were unable to verify this in performance reports. The clinical records we sampled were of good quality, and accurately captured professional contacts and also any ongoing health need, with key risks being appropriately noted on the police records system.

4.53 CCPs did not consistently wear clinical uniform and often had identification badges in police lanyards. This could have resulted in detainees misunderstanding the remit and independence of health care professionals in custody, which might have had an impact on disclosure, potentially leaving detainees at risk.

4.54 Detainees received prescription medication, including access to community-prescribed opiate substitution treatment. Those experiencing withdrawal could obtain symptomatic relief, including access to nicotine replacement therapy, although the latter was only available once a detainee had been in custody for over 12 hours, which took no account of individual dependency and habits.

4.55 The monitoring of medicines was inconsistent, with medicine stocks not subject to individual counts of potentially tradable medicines such as diazepam and dihydrocodeine. There was no evidence of a local medicine audit, and reconciliation arrangements were unclear.

Area for improvement

4.56 Medicines management arrangements should ensure that medicine stocks are fully accounted for, with clear audit trails of medicine disposal and reconciliation established.

Substance misuse

4.57 At the time of the inspection, there were no dedicated substance misuse workers to offer face-to-face support to detainees with drug and alcohol problems, although custody officers and health care professionals provided advice and active signposting. A new all vulnerabilities health model (due to be fully operational by September 2019) was expected to deliver this type of support (see also section on mental health). Humankind was part of the partnership arrangement to deliver this model, and some of these specialist staff were now in post. Humankind offered direct alcohol and drug services in the community and had good local networks with other agencies. Although it was too early to make a judgement, the service model looked to be a positive development to support detainees with drug and alcohol problems.

4.58 Naloxone (a drug used to counteract opiate overdose) was available for trained custody officers to administer to detainees, which was a positive development since the previous inspection. In addition, detainees could be supplied with sterile injecting equipment to replace used gear.

Area for improvement

4.59 Detainees with drug and alcohol problems should receive specialist support while in custody.

Mental health

4.60 The TEWV mental health criminal justice liaison and diversion service (CJLDS) was currently providing a reasonable level of support to detainees, seven days a week. An all vulnerabilities health model, operating from 6.30am to 8pm, seven days a week (based on the national commissioning strategy), was being introduced, with a view to enhancing the support provided to detainees (see also paragraph 4.57).

4.61 The implementation phase of the new health model was being steered and risk managed by a strategic partnership group. As a result of gaps in the envisaged staff profile, the CJLDS was prioritising detainees presenting with the highest risk, which meant that more moderate and lower-level support was not readily available. Spectrum Health Care and Humankind were part of this partnership and, once in post, these services were expected to meet demand. Currently, detainees who potentially fell into this category were offered follow-up support and an appointment following their release from custody, so that resources could be directed to seeing higher-risk detainees while in custody.

4.62 Out-of-hours mental health support for detainees was provided by Total Healthcare appropriately. Custody staff valued the support provided by the CJLDS, and custody staff understood the impact that psychological distress could have on the health and well-being of detainees. Detainees were referred based on the completed risk assessment and presentation in custody. The CJLDS reviewed all referrals via an initial case screening, and a team conference call prioritised workload. Training and supervision for mental health staff were good, and local relationships with the police were constructive.

4.63 A mental health professional based in the control room provided effective and much valued triage support to frontline officers (see also paragraph 2.6). Assessments for detention under the Mental Health Act 1983 were generally undertaken promptly, with few reports of any long delays in the transfer of detainees to hospital. However, the force did not monitor how long detainees waited for these assessments or any subsequent waits for a mental health bed. The CJLDS could make direct referrals for an assessment, and FMEs were commonly included in this process, but their individual involvement varied considerably.

4.64 Only one detainee had been held in custody as a place of safety under section 136 of the Mental Health Act (see footnote 2) during the previous 12 months, and this had involved an exceptional set of circumstances.

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 There was good attention to ensuring that detainees were released safely. Pre-release risk assessments (PRRAs) were usually completed with the detainee present, and generally reflected the initial risk assessment, complemented by information obtained during their period in custody. The quality of recording on the PRRAs varied, with some custody officers not completing the exit assessment template in the presence of the detainee, preferring to have a conversation with them instead and updating the assessment once the detainee had left the custody suite, using a generic cut-and-paste entry. Some custody officers also completed the threat, harm, risk, investigation, vulnerability and engagement (THRIVE) risk assessment tool, although these also varied in standard and individual detail, with cut-and-paste entries routinely added (see also paragraph 1.15).

5.2 The PRRA template was comprehensive and focused on identifying, reducing and mitigating any potential risks identified during and before release from custody. Vulnerability and safeguarding issues were communicated to relevant agencies and support organisations. Particular attention was given to managing the release of children and vulnerable detainees, to ensure that they got home safely. Travel warrants and money, from a petty cash fund, were available, and given to detainees without means, to help them to pay for transport home.

5.3 Information leaflets on support organisations were available for issue to detainees on release. However, these were not automatically offered, but provided only if the custody officer assessed it as relevant to the individual. Other than those relating to human trafficking, these support leaflets were available only in English.

5.4 Person escort records (PERs) for detainees being transferred to another agency were completed by detention officers and contained accurate, relevant and current information. The contents of the PERs were discussed with escorting officers before the detainee left the custody suite, to ensure clarity and that all potential risks to detainees were understood.

Courts

5.5 Court acceptance times were regularly set too early, at 2pm. In addition, unlike in some other forces, detainees on a 'fail to appear' warrant were not permitted to be taken directly to the court. This meant that some detainees were not presented before the first available court, and therefore spent too long in police custody unnecessarily.

Area for improvement

5.6 The force should liaise with HM Courts & Tribunals Service to ensure that early court acceptance times do not result in detainees staying in police custody for an unnecessarily long time.

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

Causes of concern and recommendations

6.1 Cause of concern: There were not always sufficient staff in the custody suites to carry out all the custody processes and meet the needs of detainees promptly. This hindered the effective operation of custody and led to adverse outcomes for some detainees. There was little supervision in the suites to oversee custody services and ensure the safe and respectful treatment of detainees.

Recommendation: The force should ensure that there are sufficient staff in place, who are adequately supervised to deliver the safe and respectful treatment of detainees. This should allow for detainees' needs to be met promptly and for custody processes to be completed effectively and efficiently. (S35)

6.2 Cause of concern: The performance management of custody was limited. There were gaps in data, including those relating to the use of force, and the accuracy of some data could not be guaranteed. Key areas of performance were not routinely monitored to assess how well custody services were delivered, identify where improvements were needed and monitor outcomes from any improvement actions taken.

Recommendation: The force should effectively monitor the performance of custody services, based on comprehensive and accurate data, and use this to assess performance and identify and act on areas requiring improvement. (S36)

6.3 Cause of concern: Reviews of detention did not consistently meet PACE or the requirements of code C of its codes of practice. They were poorly conducted and recorded.

Recommendation: The force should take immediate action to ensure that all custody procedures comply with legislation and guidance, and that officers implement them consistently. The way in which reviews are conducted, and the standard and recording of them, should be improved. (S37)

Areas for improvement

Leadership, accountability and partnerships

6.4 The force should agree and implement clear plans for the future of the custody estate, with clear timescales for delivering these so that all detainees are held in a suitable environment and can have their needs appropriately met. (1.11)

6.5 The force should ensure that 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. (1.21)

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

6.6 Custody staff should ensure that detainees who are strip-searched are left appropriately clothed. (3.7)

6.7 Detainees should be able to make telephone calls, especially those to legal representatives, in sufficient privacy. (3.8)

6.8 The force should ensure that detainees are made aware of how their privacy is affected by closed-circuit television (CCTV) coverage in the suite, including the cells it covers and in particular that toilets are obscured from view. Notices advising detainees that CCTV is in operation throughout the custody suite should be clearly and prominently displayed in all custody suites. (3.9)

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

- having a sufficient range of religious observance material to enable all detainees to observe their faith, should they so wish, while in custody
- having arrangements to help detainees with mobility impairments manage in their cell, and for them to shower and use the toilet with sufficient privacy and dignity
- helping detainees with comprehension difficulties to receive and understand information, including on their rights and entitlements, in a format that is appropriate to their individual needs
- ensuring that detainees have timely access to interpreters and are not kept in custody for longer than necessary while waiting for them to attend. (3.19)

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

- the same custody staff should conduct observation checks and record them in sufficient detail in detention logs
- cell call bells should be answered promptly, only muted with the custody officer's authority and properly recorded in the detention log
- all custody staff should carry anti-ligature knives
- detainees' clothing, footwear and jewellery should be removed only if the individual risk assessment suggests that this is necessary. (3.32)

6.11 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. (3.45)

6.12 Complaints should be taken while detainees are still in custody, unless there is a good reason not to do so. (3.57, repeated recommendation 5.19)

In the custody cell, safeguarding and health care

6.13 The force should ensure that it adheres to the legal requirements for fire safety. (4.10)

6.14 The governance and oversight of the use of force in custody should be improved, to provide assurance that it is safe and proportionate to the risk or threat posed. In particular, by:

- increasing coverage by CCTV cameras in the suites to remove blind spots, and prioritising the way in which footage is retained
- quality assuring sufficient use of force incidents in custody to demonstrate that force is used fairly and appropriately. (4.20)

6.15 The force should improve its approach to detainee care by:

- providing a more varied diet to detainees in custody, particularly those detained for extended periods
- increasing detainees' access to showers and exercise, particularly when they are held overnight or for extended periods
- increasing the range of reading material, especially for children and those whose first language is not English, and offering this consistently
- providing replacement footwear to detainees while they are in their cells and walking around the custody suites
- ensuring that toilet rolls are kept hygienically and provided to detainees, in line with *Authorised Professional Practice – Detention and Custody* guidance
- 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. (4.30)

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

6.17 The force should strengthen its approach to securing appropriate adults (AAs) for children and vulnerable adults by:

- requesting them early into a detainee's detention, so that support is provided as quickly as possible
- recording and monitoring request and arrival times, so that the time that 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)

6.18 The force should ensure that it consistently identifies when children need to be seen by health care professionals in custody, and refer them accordingly. (4.44)

6.19 Managerial oversight and clinical governance arrangements should ensure effective support and supervision of custody care practitioners, and routinely monitor clinical standards and medical equipment. (4.51)

6.20 Medicines management arrangements should ensure that medicine stocks are fully accounted for, with clear audit trails of medicine disposal and reconciliation established. (4.56)

6.21 Detainees with drug and alcohol problems should receive specialist support while in custody. (4.59)

Release and transfer from custody

6.22 The force should liaise with HM Courts & Tribunals Service to ensure that early court acceptance times do not result in detainees staying in police custody for an unnecessarily long time. (5.6)

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 recommendations

Levels of custody-trained staff should be sufficient to ensure the safety and wellbeing of detainees, staff and visitors. (2.24)	**Not achieved**

Recommendations

Through partnership working at a strategic level, action should be taken to address the lack of local authority accommodation for children and young people refused bail at police stations. (3.16)	**Partially achieved**
Relevant and appropriate management information should be collected and used to plan, monitor and identify trends and interventions in custody, and to improve outcomes for the force and detainees. (3.17)	**Not achieved**

Treatment and conditions

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

Main recommendations

Pre-release risk assessments (PRRA) should be detailed, meaningful and based on an ongoing assessment of the 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, including information leaflets about support agencies. Custody sergeants should be further briefed about the purpose and procedures for PRRAs. (2.25)	**Achieved**

Recommendations

Booking-in desks should allow effective and private communication between detainees, staff and their legal representatives. (4.9)	**Partially achieved**
Durham Constabulary should develop procedures that ensure custody staff consider and respond to the distinct needs of women, children and young people, and disabled people in custody. (4.10)	**Partially achieved**
Every suite should have some cells with bed plinths that are of conventional bed height and a hearing loop should be available in all custody suites. (4.11)	**Achieved**
Risk assessments should be completed at the earliest possible opportunity and include warning markers on the PNC before the risk assessments is completed. (4.26)	**Achieved**
Custody sergeants and detention officers should receive their handovers together, in an area cleared of other staff and detainees. (4.27)	**Achieved**
Custody staff conducting constant supervision via closed-circuit television should not be engaged in other tasks and significant events and interactions should be recorded. (4.28)	**Partially achieved**
Detainees should not be handcuffed in cells. (4.32)	**Achieved**
All detainees held overnight, or who require one, should be offered a shower, which they should be able to take in private. (4.47)	**Not achieved**
Pillows should be provided to all detainees. (4.48)	**Achieved**
Unless there is a forensic reason to do so, replacement clothes rather than paper suits should be given to detainees to wear when their own clothes are removed. (4.49)	**Achieved**
A range of reading materials should be available and routinely offered, including books and magazines suitable for young people and for those whose first language is not English. (4.50)	**Not achieved**

Individual rights

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

Recommendations

Appropriate adults should be available for vulnerable people out of normal office hours so that they are not further disadvantaged by delays or prolonged stays in custody. (5.5)	**Achieved**
Complaints should be taken while detainees are still in custody, unless there is a good reason not to do so. (5.19)	**Not achieved** (recommendation repeated 3.57)

Health care

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

Main recommendations

Section 136 detainees should not come into custody as a place of safety. Durham police should engage with partners to ensure better access to section 136 facilities, in line with the expectations of the national Mental Health Crisis Care Concordat. (2.26)	**Achieved**
Durham police should ensure people arrested with mental health concerns are diverted to the correct medical or clinical services at the earliest opportunity and mentally ill people should not be unnecessarily subjected to the criminal justice process. (2.27)	**Achieved**

Recommendations

IT systems should be available to allow health care staff access to the local hospital database. (6.11)	**Achieved**
Clinical staff should perform shift handovers in suitable work premises. (6.12)	**Achieved**
Clinical examination rooms should comply with the infection control standards. (6.13)	**Achieved**
All instances of care that would be relevant to custody staff should be reflected in the custody record. (6.19)	**Achieved**
Injecting drug users released into the community should be offered clean needles by drug workers. (6.21)	**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*.[12]

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.[13] 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.[14]

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

13 95% confidence interval with a sampling error of 7%.

14 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

Martin Kettle	HMI Prisons team leader
John Allen	HMI Prisons inspector
Fiona Shearlaw	HMI Prisons inspector
Patricia Nixon	HMI Constabulary and Fire & Rescue Services inspection lead
Marc Callaghan	HMI Constabulary and Fire & Rescue Services inspection officer
Viv Cutbill	HMI Constabulary and Fire & Rescue Services inspection officer
Vijay Singh	HMI Constabulary and Fire & Rescue Services inspection officer
Steve Eley	HMI Prisons health services inspector
Shaun Thomson	HMI Prisons health services inspector
Kathleen Byrne	Care Quality Commission inspector
Joe Simmonds	HMI Prisons researcher