Report on an unannounced inspection visit to police custody suites in

# Bedfordshire

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

**7–17 October 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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# Fact page[1]

**Force**
Bedfordshire

**Chief Constable**
Garry Forsyth

**Police and Crime Commissioner**
Kathryn Holloway

**Geographical area**
Bedfordshire

**Date of last police custody inspection**
7-11 April 2014

| **Custody suites** | **Cell capacity** |
|---|---|
| Kempston | 18 cells |
| Luton | 21 cells |

**Annual custody throughput**
8,686 detainees (year to 30.9.19)

**Custody staffing**
Two inspectors
24 sergeants
32 detention officers

**Health service provider**
Castle Rock Group

[1] Data supplied by the force.

# Executive summary

S1 This report describes the findings following an inspection of Bedfordshire Police custody facilities. The inspection was conducted jointly by HM Inspectorate of Prisons (HMIP) and HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) in October 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 Bedfordshire Police in 2014. This inspection found that of the 33 recommendations made during that previous inspection, 13 had been achieved, 11 had been partially achieved and nine had not been achieved.

S4 To aid improvement we have made four 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 Bedfordshire police was part of a well-established tri-force collaboration with Cambridgeshire and Hertfordshire constabularies. Although the strategic lead for custody sat with Hertfordshire, there was sufficient oversight from senior officers in Bedfordshire, and governance structures provided clear accountability for the delivery of custody.

S6 Although we found some positive features, there had been a lack of progress in a number of key areas since our last inspection. During this inspection, we had several causes of concern and highlighted a number of areas for improvement.

S7 There was a clear focus on diverting vulnerable people from custody. Custody staff were well trained and, although sometimes stretched at busy times, were generally of sufficient numbers to meet demand.

S8 The force had adopted *Authorised Professional Practice – Detention and Custody* as set by the College of Policing,[2] and had its own local custody procedures to provide guidance to staff. However, some of the practices we observed did not follow either guidance.

S9 In several areas the force was not consistently meeting the requirements of code C of the Police and Criminal Evidence Act 1984 (PACE) code of practice for the detention, treatment and questioning of persons.

S10 In general, the force managed custody performance well. It collected and monitored a range of data on custody, although there were some gaps, including the use of voluntary attendance[3] and waiting times for Mental Health Act assessments.

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

3 In which suspects involved in minor offences attend a police station by appointment to be interviewed about these, avoiding the need for arrest and subsequent detention.

S11 There was no governance or oversight of the use of force in custody, data on the use of force in custody were not comprehensive, and not all officers completed use of force forms as required. This meant that 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.

S12 The quality of custody records was not good enough and it was not always clear what actions had been taken in the treatment of detainees. They often lacked detail about the provision of food and drinks and other welfare requirements, as well as the reasons and justification for why actions such as the use of force against detainees had been necessary. The quality assurance arrangements did not focus sufficiently on assessing the quality of recording and had failed to identify some of the concerns we found.

S13 The force was not able to demonstrate that it was meeting the public sector equality duty. While there was some good training for staff the force did not have sufficient data on the ethnicity of detainees to show that outcomes were fair and equitable.

S14 The force worked well with partners to improve outcomes for vulnerable detainees and children. It had a clear commitment to improving services for those with mental ill health, and there was good evidence of diversion from custody. However, children charged and refused bail were not moved into local authority accommodation as they should have been.

S15 Adverse incidents were appropriately recorded and reviewed, and organisational learning was implemented as required. The force was open to external scrutiny and responded positively to issues raised by independent custody visitors.

## Pre-custody: first point of contact

S16 Frontline officers had a good understanding of detainee vulnerability and told us they took account of this when deciding whether or not to arrest an individual. A range of alternatives were explored before children were taken to custody.

S17 Frontline officers had good support to deal with individuals with mental ill health, in particular from the mental health triage scheme. This was helping them to avoid detaining these individuals under section 136[4] of the Mental Health Act by finding better health-based solutions. However, when such detentions were necessary, officers reported some long waits with people at health-based places of safety.

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

S18 Custody staff interacted positively with detainees. Although there was a lack of privacy at booking-in desks for detainees to disclose sensitive or confidential information, they were made aware of how their privacy was affected by CCTV monitoring in the suite and cells, and how this was protected when using the toilet in cells.

S19 Custody staff received a range of training to help them better understand and manage the wide range of diverse needs of those coming in to custody, but the arrangements for meeting these varied. There was a good focus on meeting the needs of female detainees and detainees were asked about their faith needs, but there was a lack of all the religious items

[4] Enables a police officer to remove from a public place someone who they believe to be suffering from a mental disorder and in need of immediate care and control, and take them to a place of safety. In exceptional circumstances, and if they are 18 or over, the place of safety may be police custody.

required and they were not always stored respectfully. There were limited facilities for detainees with physical and other disabilities, and there was not always prompt access to interpreting services for those who spoke little or no English.

S20 The approach to identifying risk was good but there were some weaknesses in the management of risk. Initial risk assessments were thorough and resulted in the setting of appropriate levels of observations which were, in the main, adhered to. The rousing of detainees under the influence of alcohol and/or drugs was conducted properly, but rarely by the same staff. Items of detainees' clothing and footwear were removed routinely without an individual risk assessment, which was a disproportionate approach to managing risk. When anti-rip clothing was used the justification for this was not always recorded on the custody record. Cell call bells were barely audible and responses to them were not always prompt. The control of keys was poor, and custody staff and others who unlocked cells did not always carry anti-ligature knives, which posed a potential risk to the safety of detainees. The information exchanged at staff shift handovers was generally good but did not involve all custody staff or health care professionals.

S21 Despite some lengthy waits, most detainees were booked into custody promptly after their arrival. The necessity for arrest was well explained before detention was authorised, and in some cases detention was appropriately refused. There was a focus on progressing cases as soon as possible, and many detainees were released or transferred at the earliest opportunity. We were, however, told of some delays because of waits for appropriate adults (AAs, independent individuals who provide support to children and vulnerable adults in custody), interpreters and Crown Prosecution Service advice, and sometimes in the allocation of investigating officers.

S22 Detainees' rights and entitlements in custody were explained and they were also offered these in writing. Positively, copies of up-to-date codes of practice were readily available and were, in the main, actively offered to detainees. While rights and entitlements were available in a range of languages, custody officers and inspectors did not know about the requirements of PACE code C annex M, covering the availability of documents in translation, or how to access them.

S23 There were many positive aspects to the conduct of PACE reviews of detention. Most reviews were on time and took place face to face. Those we observed were conducted respectfully and in the best interests of the detainee, with a proper focus on their welfare. However, due process was not always followed and some detainees were not advised that their ongoing detention had been authorised. The recording of reviews of detention in custody records was often confusing, and was poor overall. Detainees were rarely reminded in a timely way if reviews had taken place when they were asleep.

S24 The force was focused on completing investigations during the first period of detention. Where this was not possible, decisions to release detainees under investigation or on bail were generally well made and were thoroughly explained to detainees, along with the consequences should they attempt to compromise investigations.

S25 Bail cases were managed and progressed well, but at the time of the inspection over 2,000 people were recorded as released under investigation. This was high and it was not clear how the force was managing these cases to reduce investigation time and minimise the impact on detainees.

S26 Promotion of complaints procedures was limited and not specific to custody. Custody staff were inconsistent in whether and how they would take a complaint, and we were not confident that all would ensure that complaints were recorded and/or dealt with while detainees were in custody.

## In the custody cell, safeguarding and health

S27 The custody estate was ageing, and while Luton had benefited from some refurbishment it still lacked facilities, such as in-cell handwashing. The suite at Kempston was a temporary facility but had been in place for around five years and was showing signs of deterioration. However, there were well-advanced plans to replace this suite.

S28 The custody suites were clean and all cells had some natural light. However, there was a lack of facilities, including no exercise yard at Kempston. The CCTV at both suites had several deficiencies that affected the force's ability to manage the safe delivery of custody services. effectively We found potential ligature points across the estate and provided the force with a comprehensive report illustrating these; it responded positively to this during the inspection.

S29 In our observations and reviews of CCTV footage, we saw staff engaging positively with some challenging detainees to de-escalate situations, potentially avoiding using force on them. In the cases we viewed, incidents involving the use of force had been managed well overall. However, the force did not quality assure individual use of force incidents, which was poor for such an important area of activity.

S30 Some of the arrangements to meet the care and welfare needs of detainees required improvement. While detainees were routinely told about the care they could expect while in custody, and food and drink were regularly offered, other provisions, such as showers, exercise and reading materials, were not. There were not always sufficient supplies of replacement clothing and blankets to ensure detainee comfort and warmth. The detainees we spoke to said they had been treated well but some raised concerns over delays in receiving access to some welfare provision.

S31 Custody officers had a good understanding of safeguarding. The responsibility for making safeguarding referrals to the multi-agency partnership arrangements generally lay with arresting or investigating officers. Investigating officers were expected to identify and take action to mitigate any safeguarding concerns, and were required to share this with custody officers to consider when releasing the detainee.

S32 Children and vulnerable adults did not always receive early support from AAs, and there were long delays before some arrived to support the detainee. Securing AAs promptly had been a concern in our previous inspection and little progress had been made. In this inspection we also had concerns that vulnerable adults were not always identified as needing an AA, despite evidence that one was required. This meant that these detainees were not getting the support they were entitled to.

S33 Children in custody received some good care. All children entering custody were assessed by the youth offending team (YOT) or the liaison and diversion service. Girls were allocated a female member of staff to care for their welfare. However, children were not routinely prioritised for booking in or offered easy-read rights and entitlements material. There was close scrutiny of children held overnight and a strong focus on avoiding overnight detention. Few children were charged and refused bail. However, even though joint working with local authorities had resulted in the provision of four places for children in such cases, none had been moved to these alternatives in the previous year.

S34 A new contractor for physical health services had operated since April 2019. Despite some initial setting-up difficulties, service provision had improved as consistent staffing and governance arrangements became embedded. Staffing was generally sufficient and provided the required level of service cover. The force had good oversight of health delivery and considered a range of performance information, including the quality of the service.

S35 Health care professional support was now largely embedded within suites and the service was valued by custody staff. Detainees were generally seen promptly according to the risk presented. Health care professionals were experienced and competent, and the care provided reflected detainee need.

S36 The criminal justice liaison and diversion team delivery included triage support and signposting detainees with substance use needs to community-based drug and alcohol services. Luton provided dedicated specialist substance misuse workers offering face-to-face support to detainees as part of a pilot project.

S37 Mental health support was available seven days a week in both suites. This was valued by custody staff and there was a good range of support and pathways, with effective outreach support. However, custody staff did not always record in the custody record their contact with detainees with mental health needs and the services offered, which would have helped them better manage how the detainee was cared for.

S38 No detainees had been taken to custody as a place of safety under section 136 of the Mental Health Act in the previous 12 months. Detainees who needed an assessment under the Act while in custody experienced some delays in both the assessment and onward transport to a health facility, if required. This meant that some mentally unwell people spent longer than necessary in custody.

## Release and transfer from custody

S39 There was a good focus on ensuring that detainees were released safely. Pre-release risk planning was conducted with the detainee, and the arrangements for children and those identified as vulnerable ensured they got home safely. There was assistance to get home for others without the means to do so. Where necessary, relevant agencies were involved to support detainees' release. A range of support leaflets were available and were actively offered to detainees on their release. However, the recording of pre-release risk assessments in custody records was often poor and did not demonstrate some of the good practices we observed.

S40 Person escort records (PERs) contained accurate information but some included loose-leaf documentation, such as risk assessments, rather than recording the relevant information on the PER.

S41 'Virtual' (video-link) courts operated in the force's custody suites. Although these generally worked well, the court usually only accepted detainees up until 2pm, which was early, and sometimes refused them even earlier than that. Custody cases were not always prioritised as they should have been and, if remanded to prison, detainees were not always collected by the escort contractor on the same day. This meant that some detainees spent longer in police custody than necessary, and those remanded after appearing in court did not receive the rights and care they were entitled to as a remand prisoner.

## Causes of concern and recommendations

S42 Cause of concern: Governance and oversight of the use of force were poor. Data on the use of force were not comprehensive or reliable. Incidents were not always recorded, or recorded accurately, on the custody record, and not all officers completed a use of force form following an incident. There was no quality assurance over the use of force, no viewing of incidents on CCTV, and no senior management oversight and governance to demonstrate that when force was used in custody it was proportionate and safe.

**Recommendation**: **The force should assure itself and others that when force is used in custody it is safe and proportionate. It should collect and monitor comprehensive and reliable data, and ensure that all incidents are recorded in sufficient detail and that use of force forms are completed by all officers involved in an incident. It should have robust quality assurance arrangements, including viewing incidents on CCTV, supported by effective oversight at senior officer level.**

S43 Cause of concern: The force did not consistently meet the requirements of code C of the Police and Criminal Evidence Act 1984 (PACE) code of practice for the detention, treatment and questioning of persons.

**Recommendation**: **The force should take immediate action to ensure that all custody procedures comply with legislation and guidance.**

S44 Cause of concern: The quality of custody records was poor. It was difficult to establish the actions that had been taken in all cases, and some information was missing or limited in detail. Quality assurance of the records was not sufficiently robust to identify and address these concerns, and there had been little progress since out previous inspection.

**Recommendation: 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.**

S45 Cause of concern: Consideration was not always given to securing an appropriate adult for vulnerable individuals, despite clear evidence in several cases that one was required. This meant that that these individuals did not receive the support and help they were entitled to. Appropriate adults required for both vulnerable adults and children were not always secured promptly and there were some long delays before they attended, especially at night.

**Recommendation: The force should ensure that detainees who need the support of an appropriate adult because they are vulnerable are identified correctly to receive this support. There should be adequate arrangements to ensure that appropriate adults are secured without delay.**

# 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*.[5] 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*.[6]

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 Bedfordshire Police 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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5 http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/inspection-criteria/
6 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** Bedfordshire Police had a clear governance structure for custody. As part of a well-established formal collaboration with Cambridgeshire and Hertfordshire (under section 22 of the Police Act 1996), the custody function for all three forces sat under the direction of an assistant chief constable (ACC) in Hertfordshire. There was sufficient clarity in the governance arrangements to ensure that the ACC in Bedfordshire was accountable for the actions of staff in the force's own two custody suites and the delivery of custody services. A chief superintendent, supported by a superintendent and chief inspector, had responsibility for the day-to-day operations in custody, and both suites had a full-time inspector fulfilling the role of custody manager.

**1.2** There were effective meeting structures at both strategic and operational level in Bedfordshire and across the tri-force collaboration. The force had several operational delivery groups chaired at ACC level, where issues raised could be taken to the force strategic management board and, if necessary, added to the force risk register.

**1.3** There were also regular meetings with external providers, including the health care contractor, to hold them to account for the services delivered in custody. However, even though senior officers held the IT provider to account, the force custody IT system was not always reliable, and there were lengthy periods when it did not work at all and staff had to use paper records. This happened twice during our inspection. This ongoing situation affected the efficient delivery of custody and posed risks to safe detention.

**1.4** Although the force's governance structures provided a good framework for overseeing the delivery of custody services, there had been a lack of progress since our previous inspection in several key areas. These included the quality and assurance of custody records, and the provision of appropriate adults (AAs). These areas had become causes of concern for this inspection (see causes of concern and recommendations S44 and S45).

**1.5** The custody estate was ageing and lacked some facilities. The force was aware of these shortcomings but had not adequately addressed them. Investment in the Luton custody suite had resulted in some improvements, but conditions and facilities at Kempston were poor. However, plans for a new suite at Kempston were progressing.

**1.6** The force had a good understanding of demand for custody services and had sufficient trained staff to meet this. However, at busy periods there was little resilience to provide additional staffing. This meant that, for example, detainees sometimes had to wait for lengthy periods before they were booked into custody or were not released as soon as possible.

**1.7** There was a commitment to initial and ongoing staff training and staff were appropriately accredited. Attendance at training sessions was well monitored. Initial training was comprehensive and delivered over two weeks. Newly trained custody and detention officers

had a period of shadowing more experienced staff before undertaking their duties, and completed a professional skills portfolio. All staff received two additional days training a year to ensure their continuous professional development. These courses included sessions to raise awareness of the diverse needs of detainees and how to respond to individuals with mental ill health or other vulnerabilities. Staff told us training was good.

**1.8** The force was focused on keeping detainees safe. There had been one death in custody since our previous inspection, which had been investigated by the Independent Office for Police Conduct (IOPC). Adverse incidents in the custody suites were recorded and reviewed properly. Learning from these was shared with staff, and organisational learning fed into training as a result.

**1.9** The force followed *Authorised Professional Practice – Detention and Custody* as set by the College of Policing and had its own local custody procedures document to guide staff. However, many of the practices we observed did not follow either guidance, and we include examples of these throughout this report.

## Area for improvement

**1.10 The force should ensure that its IT system supports the delivery of custody functions and minimises system failures.**

## Accountability

**1.11** The force generally monitored performance well and was able to assess how different custody functions were performing, identify trends and inform learning. Senior managers had access to daily management reports and could see how well custody functions performed across the suites and on a team-by-team basis – such as the timeliness of welfare checks and how long detainees waited to be booked in. However, there were some gaps in data; for example, the force was unable to provide detailed information on detainees who needed an assessment under section 2 of the Mental Health Act, or how long it took to move these detainees to an appropriate health setting. There was also no reliable data about people who attended the stations voluntarily (see footnote 3) to enable the force to assess effectiveness in diverting people from custody.

**1.12** The force had insufficient mechanisms to assure itself, the Police and Crime Commissioner and the public that the use of force in detention and custody was always safe and proportionate. Data on incidents in custody suites were not comprehensive or reliable, not all incidents of force were recorded on custody detention logs, and those that were did not always have sufficient detail to justify why force or restraint had been necessary. Not all staff involved in incidents submitted individual use of force forms, as required by the National Police Chiefs Council. There were no governance and oversight processes, no quality assurance of use of force incidents and no reviews of incidents recorded on CCTV to ensure the techniques used were proportionate and safely deployed. (See cause of concern and recommendation S42.)

**1.13** The force did not always meet the requirements of Code C of the Police and Criminal Evidence Act 1984 (PACE) code of practice for the detention, treatment and questioning of persons. Several examples of this related to the conduct of reviews of detention, including: one case where no review had been carried out as required (PACE section 40); reviews of detainees while they were sleeping that indicated they were carried out in person when the inspector was not in the suite (PACE code C section 15.1); and detainees not told when they woke up that an inspector had conducted a review of their detention, which did not give

them the opportunity to make representations about their continued detention (PACE code C section 15.7). (See cause of concern and recommendation S43.) In addition, custody records and our observations showed that some PACE reviews of detention were carried out by sergeants who were acting or temporary in the rank of inspector. The force ensured that officers performing the duties of the rank above them were authorised to do so by a superintendent.

**1.14** The quality of recording on detention logs was often poor, with little improvement since we had made this a cause of concern in our previous inspection. While the IT system offered the opportunity for free text, which resulted in some detailed entries, many detention log entries were made up of a combination of standard drop-down text alongside narrative added by staff, which made records confusing and difficult to follow - with some entries contradicting each other. It was sometimes difficult to establish what actions had been taken. There was very little recording to show that detainees had been provided with food and drink regularly or had received any other welfare entitlements, or about when AAs were called or arrived, or to justify why actions such as restraint had been necessary. (See cause of concern and recommendation S44)

**1.15** Quality assurance processes were not sufficiently robust. Each of the two custody inspectors were expected to sample 25 records a month, but these checks were not sufficiently focused on the quality of recording and had not identified the concerns we have raised. The quality of the custody records, the limited effectiveness of the quality assurance arrangements and the lack of progress from our previous inspection made this a cause of concern. (See cause of concern and recommendation S44.)

**1.16** The force was unable to demonstrate that it met the public sector equality duty. While staff had received training in identifying and responding to diverse needs, data provided by the force showed that 34% of detainees did not state their ethnicity. We observed that they were often not asked this. This lack of comprehensive data meant the force could not monitor its services to demonstrate that outcomes for detainees were fair and equitable.

**1.17** The force was receptive to feedback and gave access to external scrutiny. There was an effective independent custody visitor (ICV) scheme and we were told that the force responded to issues raised by ICVs promptly. The force also had independent scrutiny groups where members of its communities were invited to review areas of its performance; it had recently extended these discussions to the use of force and restraint in custody.

## Areas for improvement

**1.18 The force should address any gaps in its collection of performance information so that it can monitor performance effectively against a comprehensive framework of custody activities.**

**1.19 The force should collect accurate information on the self-defined ethnicity of detainees and use this to monitor custody services to ensure they are delivered fairly.**

## Partnerships

**1.20** There was a clear strategic priority to divert children and vulnerable people away from custody, and officers understood this. A multi-agency gang panel was identifying children at risk of offending and providing support to them and their families. The force also supported

the veterans' charity scheme Project Nova[7] run by RFEA - The Forces Employment Charity and Walking With The Wounded for services personnel. A good liaison and diversion service worked outside of custody to support detainees and help prevent them reoffending. These initiatives demonstrated the force's commitment to working with partners to reduce reoffending, and prevent children and vulnerable people entering the criminal justice system.

**1.21** The force had positive engagement with the three local authorities to improve outcomes for children who were charged and remanded in custody. However, this had not yet led to improved results. Although the overall number of children remanded in custody was low, these children were not moved into alternative local authority accommodation.

**1.22** The force had a clear commitment to improving services for those with mental ill health and there was evidence of diversion from custody. No detainees had been taken to police custody under section 136 of the Mental Health Act (see footnote 4) in the previous 12 months. Officers had access to telephone advice, street triage and mental health nurses in the force control room, which helped ensure that custody was not used as a place of safety.

7 https://www.rfea.org.uk/our-programmes-partnerships/project-nova/

# Section 2. Pre-custody: first point of contact

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

## Assessment at first point of contact

**2.1** Frontline officers had a good understanding of individual vulnerability. They cited a range of factors influencing their assessment of this, such as age and mental health, but also recognised the importance of adopting a case-by-case approach to reflect an individual's circumstances that might make them vulnerable. There was effective support for officers through training, which covered topics such as autism and child sexual exploitation. All children were regarded as vulnerable because of their age, with particular attention given to younger children. It was clear that frontline officers took good account of an individual's vulnerability when deciding whether to arrest them or find an alternative solution.

**2.2** Frontline officers told us that they received good quality and prompt information from the call handlers to help them make their decisions. They said that as call handling and response officer teams operated similar shift patterns, this had been very helpful in building good working relationships. A range of information on the force IT system about individuals coming into contact with the police also highlighted any vulnerabilities and other relevant factors, and officers could access this directly from the scene of the incident. Officers said they had sufficient information to inform their decisions.

**2.3** Children were only taken into custody as a last resort. A range of alternatives were considered, including voluntary interviews and restorative justice options,[8] and officers could also refer children to the youth offending teams (YOTs) for support and interventions to prevent them reoffending. Children were only taken into custody when the nature of their offence made this the required option, or if it was the only way to safeguard them adequately if there was no other place they could be taken to and no immediate alternative solutions through partner agencies.

**2.4** Frontline officers told us they expected to be rigorously challenged by custody officers before the detention of a child would be authorised, and there were often discussions between frontline and custody officers before this to establish the best action. Data provided by the force showed that the number of children entering custody had reduced by 30% in the three years to 31 September 2019.

**2.5** The mental health triage scheme provided good support for frontline officers to deal with individuals with mental ill health (see paragraph 4.67). The scheme, which operated from 1pm to 11pm every day, involved a mental health professional, paramedic and a police officer working from an unmarked police vehicle that attended incidents where possible and provided telephone advice and assistance. Officers told us this was a very valuable service that helped them avoid detaining a person under section 136 of the Mental Health Act by finding a more appropriate health-based solution. Outside the triage scheme's working hours, help for officers was limited, with reliance on telephone advice from mental health

[8] Programmes where offenders consider the consequences of their offending for all parties and can offer an apology or reparation.

services. However, a mental health nurse had recently started working from the call handling centre to provide additional telephone advice between 8am and 4pm.

**2.6** Frontline officers did not use custody as a place of safety for individuals with mental ill health. However, when an individual was detained under section 136 they reported some long waits with them for their mental health assessment at the health-based place of safety. Individuals who had committed an offence for which they needed to be arrested were taken to custody and, if necessary, their mental health needs were addressed there. Any mental health concerns were dealt with before action was taken on the offence for which they had been arrested.

**2.7** Frontline officers transported detainees to custody in their police cars or a police van, depending on the risk posed. Ambulances were generally called to take detainees to health-based places of safety, in line with force policy, but long waits often led to officers using police cars to transfer the detainee to a suitable environment as soon as possible. There were no specific arrangements to transport an individual with disabilities or using a wheelchair, but officers said they would use common sense to avoid custody, or call an ambulance if necessary.

# 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** We observed that custody staff interactions with detainees were positive and engaging, and this was confirmed by the detainees we spoke with. Good staff interactions with detainees were also clearly demonstrated in some of the uses of force in custody that we reviewed on CCTV (see paragraph 4.11), such as in one case where the custody officer engaged with a detainee for approximately two hours to persuade them to engage and comply with the searching process to avoid confrontation.

**3.2** There was insufficient privacy for detainees at booking-in areas. At Kempston, the small space and close proximity of booking-in desks meant there was little possibility for discreet conversations, and this was exacerbated by distractions from nearby custody and non-custody staff. Although the recent installation of privacy screens at Luton had resulted in some improvement, it was still difficult to speak and listen in private when more than one detainee was dealt with. More positively, detainees being booked into custody were routinely assured about their privacy while in their cell, and that although CCTV cameras were present, custody staff could not observe the in-cell toilet when it was in use.

**3.3** We observed some undignified practices for detainees. Detainees often walked around the suites in socks or bare feet as their footwear was automatically removed without staff regularly offering them replacement footwear (see paragraph 3.20 and area for improvement 3.23). We also found that some loose-leaf toilet tissue supplies for detainees were commonly kept on top of dustbins in the cell corridors, which was inappropriate and lacked consideration for detainees' dignity (see paragraph 4.24 and area for improvement 4.28).

**3.4** The recording of detainees' ethnicity was not sufficiently rigorous. In the force's data returns, the ethnicity of 34% of detainees arriving into Bedfordshire custody in the year to September 2019 was classified as 'not stated'. In the cases we looked at and our observations in suites, we found this information was recorded in different ways with no mandatory requirement for custody officers to record a person's self-definition in every case. (See paragraph 1.16 and area for improvement 1.19.)

## Area for improvement

**3.5 Booking-in areas should offer sufficient privacy for conversations with detainees.**

## Meeting diverse and individual needs

**3.6** Custody staff were well prepared to meet the different needs of individual detainees coming into custody. All staff had mandatory equality and diversity training, and custody staff also

received face-to-face refresher training every five weeks to update their professional knowledge. Recent topics had included managing female and transgender detainee needs and addressing detainees' care responsibilities – the latter was not yet covered by the list of standard questions asked of detainees entering custody, although we did see some detainees being asked about this.

**3.7** Arrangements to manage detainees' faith needs were inconsistent. Detainees were asked about their religious worship or dietary needs as part of the standard booking-in process. However, there was a lack of some religious artefacts, with few non-Muslim religious texts. Cell ceilings had Qibla (Mecca) directional markings for Muslim detainees and both suites held supplies of prayer mats and Qur'ans in both Arabic and English, although some were stored untidily without due care and consideration. There was also no guidance for staff on managing detainee faith needs in custody.

**3.8** There was a focus on meeting the needs of female detainees. Staff had received specific training, and female officers usually worked in custody to facilitate immediate access to private consultations or showers where required. Suites stocked a range of sanitary products, which were usually offered to female detainees as part of the standard booking-in process. In one case that we observed during late hours at Kempston, staff persevered in dealing with an uncooperative female, who they eventually calmed and spoke to privately to establish her sanitary product needs. Although products were usually offered, custody records did not always record this.

**3.9** There were insufficient arrangements for detainees with mobility needs. Both suites were largely step-free and had a supply of wheelchairs, and detainees could be permitted to retain their own wheelchairs or other mobility supports in their cells, subject to an individual risk assessment. However, there were no specifically adapted facilities at either suite to offer further support – such as higher cell benches, lowered call bell panels or adapted toilets or showers. Although a few extra-thick mattresses were available, these were sometimes used in place of normal bedding. We saw the effect of this in the case of a detainee with poor mobility and back problems at Kempston who could not use the only available extra-thick mattress as this had already been allocated to another detainee with no physical difficulties.

**3.10** There was a lack of arrangements for detainees with sight and hearing impairments. Although Kempston had visual aid band wall markings in cells to assist detainees, this was not the case at Luton. In addition, although both suites were equipped with hearing loops, staff were not aware of them and there were no British Sign Language DVDs to support detainees with hearing needs who were booked into custody. Rights and entitlement documents in Braille were available but few custody staff who we spoke to were aware of this.

**3.11** Custody staff had easy access to current versions of detainee rights and entitlements documents in foreign languages as required for non-English-speaking detainees. However, they were unfamiliar with the requirements for or means of accessing translated detention documents as per PACE code C annex M (see paragraph 3.33 and cause of concern and recommendation S43). Although post-release support leaflets were also available in several foreign languages, as we would expect, custody staff were again largely unaware of this, indicating they were rarely used (see paragraph 5.3).

**3.12** A professional interpreting service was used. Although some staff reported a good experience of the service, others said there had been problems in securing interpreters both on the telephone and in person for interviews. However, the dual handsets used for telephone interpreting were said to work well.

## Areas for improvement

**3.13 The force should ensure that there is adequate provision for physically disabled or mobility restricted detainees in custody suites. Cells should have appropriate fittings, including easily accessible call bells, and there should be suitable toilets and showers. The suites should stock British Sign Language rights and entitlement DVDs, and ensure that staff are aware of the location of hearing loops and of how to use them.**

**3.14 The force should ensure that interpreters are secured promptly for detainees who require this service.**

## Risk assessments

**3.15** The approach to identifying risk was good but there were some weaknesses in the overall management of risk. Detainees were not always booked in promptly (see paragraph 3.24) and some were made to wait in the holding room, 'air lock' (secure entrance area into the custody suite) and, on occasions, in vehicles outside the custody suites. These detainees were not triaged to identify children or vulnerable detainees quickly or to prioritise them for booking in, unless this was instigated by the arresting/escorting officers.

**3.16** Custody officers focused on the welfare of detainees and identifying risks and vulnerability factors. They interacted well with detainees to complete standard risk assessments, responded to individual need, and mostly asked appropriate supplementary and probing questions. There was routine cross-referencing to Police National Computer warning markers and historical information held on the custody record system, and all arresting/escorting officers were asked if they had any relevant information to inform risk assessments further.

**3.17** Initial observation levels in detainees' care plans generally reflected the risk posed, but in the custody records we reviewed there was not always sufficient justification recorded for any changes implemented (see paragraph 1.15 and cause of concern and recommendation S44). Observations were mainly adhered to. Where rousing of detainees under the influence of alcohol and/or drugs was identified, staff conducted these checks in accordance with annex H of PACE code C. However, these checks were not always carried out by the same member of staff, which meant that changes in a detainee's behaviour or condition might not always be readily identified, and which was contrary to *Authorised Professional Practice* guidance. We also found evidence in custody records of staff recording a series of cell checks in each detainee's custody record after they had visited them, rather than individual entries, which was poor practice. This ceased during the inspection following our feedback to the force.

**3.18** We expect that when a detainee's risk assessment indicates a heightened level of risk and they are to be observed at level 3 (constant observation via CCTV) or at level 4 (physical supervision in close proximity) that the custody officer fully briefs the officers conducting these about their role and the risks presented by the detainee. We observed that this was not always the case, particularly for level 3 CCTV monitoring where detention officers routinely swapped this role without custody officer intervention, which was also contrary to force policy. Although officers told us that they generally received a briefing on carrying out level 4 duties, they frequently remained in this post for lengthy periods without any breaks. In one case we reviewed, one officer was in post for over five hours without a break, which was too long.

**3.19** The management and control of cell keys was poor. There was insufficient oversight of non-custody staff access to cell keys; we routinely saw them lodging detainees in their cell after booking in and being handed cell keys to collect and return detainees to their cells after interview. This diminished the control that custody staff maintained in the custody suite. Most detention officers and custody officers did not carry anti-ligature knives, and these were not always readily available elsewhere in the suite and none were attached to the cell keys; this compromised detainee safety and was poor practice.

**3.20** Clothing with cords and footwear were routinely removed from all detainees, without an individual risk assessment, which was a disproportionate response to managing risks and had not changed since our previous inspection. We saw little use of anti-rip clothing, but staff advised us it was used on occasion, particularly when a detainee did not or was unable to engage in the risk assessment process or if there were concerns about self-harm. The recording of the use of anti-rip clothing was poor, and we were not assured that its use was always justified. Following the removal of clothing, most detainees remained on low-level observations even when deemed a significant enough risk to have had their clothing removed.

**3.21** Cell call bells were barely audible and were not always answered promptly (see paragraph 4.3 and area for improvement 4.8). We observed some delays of up to six minutes, which posed potential risks to detainees who required assistance.

**3.22** The quality of staff shifts handovers varied but those we observed had a sufficient focus on detainee risk and welfare. However, they did not always include all relevant staff and were generally done between one incoming custody and one outgoing custody officer. There was no collective handover between all the incoming and outgoing custody staff to ensure discussion of all aspects of the detainees, and we only saw one handover where a custody officer later ensured that all the incoming detention officers were individually briefed. At the start of a new shift, we saw at least one custody officer visiting the detainees in their care but some made no effort to introduce themselves to detainees or have any meaningful interaction with them, and most exchanges were conducted through the cell hatches. Health care professionals were not involved in handovers, which was a missed opportunity to gather further information. These practices remained unchanged since our previous inspection.

## Area for improvement

**3.23 The approach to managing risk should be improved. In particular:**

- **all custody staff should carry anti-ligature knives in the custody suites at all times**
- **detainees' clothing and footwear should only be removed on the basis of an individual risk assessment**
- **anti-rip clothing should only be used as a last resort and should be fully justified in the custody record**
- **cell call bells should be answered promptly**
- **all custody staff should be involved collectively in shift handovers.**

## Individual legal rights

**3.24** Waiting times between the arrival of detainees at custody suites and authorisation of their detention was variable. We saw many detainees taken straight through to the booking-in desks, but we also observed occasions where some detainees waited between 40 minutes and over two hours to be booked into custody, some held in vehicles. Frontline response officers told us it was not unusual for them to wait a long time with detainees in the holding rooms, air locks and in vehicles without any interaction with custody staff to triage the waiting queue (see paragraph 3.15). Waiting times monitored by the force showed an average of 19 minutes for adults and 20 minutes for children in the year to 30 September 2019. Our own analysis of custody records showed an average waiting time of 25 minutes between arrival and detention authorisation.

**3.25** Arresting officers 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 the reasons for authorising their detention so that detainees understood them, and recorded them clearly on the custody record. Custody officers told us they rarely refused detention but they were confident to do so if the circumstances did not justify it, and they provided us with details of such cases. We found a few cases in our custody record analysis where detention was appropriately refused.

**3.26** Alternatives to custody were available through restorative justice processes, cautions and voluntary attendance.[9] Facilities for interviewing voluntary attendees were available outside the custody suites but the force was unable to supply any reliable data to show if this alternative was used effectively (see paragraph 1.11).

**3.27** Our expectation is that detainees will have their cases progressed quickly so that they remain in custody for the minimum time possible. Custody officers had a clear focus on ensuring that detainees were released or transferred at the earliest opportunity, and in most cases this happened. However, we were told and observed that investigations were not always progressed promptly; delays could be attributed due to the non-availability of appropriate adults (AAs) (see paragraph 4.33), waiting for the attendance of interpreters or Crown Prosecution Service (CPS) advice, and on occasions the allocation of investigating officers, all of which could lengthen a detainee's stay in custody.

**3.28** Custody officers reported a good relationship with Home Office Immigration Enforcement officers and told us that most immigration detainees were moved on within 24 hours of an IS91 (authority to detain notification) warrant being served on them, but there were sometimes longer delays. The force had seen a 10% decrease (25 cases) in the number of immigration detainees brought into custody over the last three years.

**3.29** During booking in, detainees were clearly advised of their three main rights while in custody (to have someone informed of their arrest, consult a solicitor and access free independent legal advice, and consult the PACE codes of practice). Custody officers routinely offered all detainees a written notice setting out their full rights and entitlements although they did not always accept it (see paragraph 3.43).

**3.30** Detainees were told that they could inform someone of their arrest, which staff facilitated and they sometimes allowed the detainee to speak to their nominated representative while still at the booking-in desk.

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[9] In restorative justice programmes, offenders consider the consequences of their offending for all parties and can offer an apology or reparation. A caution, which is not a criminal conviction, can be given to anyone aged 10 or over for minor crimes provided the offender admits the offence and agrees to be cautioned. The offender can be arrested and charged if they do not agree to the caution. Under voluntary attendance, suspects involved in minor offences attend a police station by appointment for interview, avoiding the need for arrest and subsequent detention.

**3.31** All detainees were offered free legal representation. If they declined, they were asked the reasons why and these were recorded. There were sufficient interview/consultation rooms in both the custody suites to allow detainees to consult their legal representatives in private. Staff told us that access to interview rooms was often restricted during office hours when the virtual (video-link) court was sitting, as one room was set aside for its use. Detainees could speak to legal representatives by telephone in private in their cells using a portable handset. Legal representatives were readily given a summary printout of their client's custody record front sheet on arrival at the custody suites. Multilingual posters informing detainees of their right to free legal advice were displayed at Kempston but only in the holding room and not the main booking-in area, and only part of these were displayed at Luton (half the languages were missing), which did not meet the requirements of PACE code C paragraph 6.3. (See cause of concern and recommendation S43.)

**3.32** Detainees were told during booking in that they could read the PACE codes of practice, which were readily available, and most custody officers fully explained these and actively offered them to detainees. We saw several detainees who accepted this offer and were given the current version.

**3.33** Although staff knew where to access rights and entitlements in a range of foreign languages, no custody officers or custody inspectors who we spoke to were aware of the availability of PACE code C annex M translated documents. This meant that non-English speaking detainees could not be provided with a range of written translated documents about their detention in their own language, as required (see paragraph 3.11 and cause of concern and recommendation S43).

**3.34** There was a good process for the management and transport of DNA samples, but we found some old elimination DNA and evidential samples in fridges and freezers at both suites, which should not have been stored in the custody environment. Freezers in the custody suites had locks but were insecure, which did not protect the integrity of stored samples.

## PACE reviews

**3.35** Many PACE reviews were conducted on time, and the majority were conducted face to face with the detainee. In our custody record analysis, we found that 83% of first reviews were conducted on time and the remainder were early, but it was not always recorded why an early review was required (see cause of concern and recommendation S44). Our analysis also showed that none of a sample of 68 first reviews and 32 second reviews required were conducted over the telephone, which was positive.

**3.36** Reviews that we observed were undertaken by dedicated custody inspectors and operational duty inspectors across the force area, and they treated detainees courteously and with dignity and respect. These reviews had a proper focus on the best interests of the detainee and their welfare, but due process was not always followed - some detainees were not advised that their continued detention had been further authorised. Reviews were often poorly recorded on custody records, with some lacking detail or mention of detainee welfare, and there was some reliance on pre-completed text supplied by the computer system, rather than tailoring records to reflect the individual circumstances of the detainee (see cause of concern and recommendation S44).

**3.37** In our case audits and observations, most reviews that had taken place while the detainee was asleep were overnight. However, most detainees were not informed that a review had taken place as soon as possible after they were awake, which did not meet the requirements of PACE code C paragraph 15.7. We also observed a few reviews of sleeping detainees that indicated that they were carried out in person when the inspector conducting these was not

present in the custody suite, which did not meet the requirements of PACE code C paragraph 15.1 (see cause of concern and recommendation S43).

**3.38** In our custody record analysis, we identified one case in which a review of a detainee's detention was required but was not carried out. There was a limited record of why this was not completed when it was due, and there was nothing further recorded about why it was still outstanding when the detainee was released on bail three hours later. This was a breach of PACE section 40(5) (see cause of concern and recommendation S44).

**3.39** We found that where the force was using sergeants to perform acting and temporary duties above their substantive rank to carry out PACE reviews and other PACE requirements, this had been authorised by a senior officer.

## Access to swift justice

**3.40** The force was focused on completing investigations during the first period of detention to avoid releasing detainees subject to further investigation. Our analysis of custody records identified that 60 out of 94 detainees (64%) had their cases concluded during the first period in custody, which was a good outcome for them.

**3.41** We observed that where custody officers identified insufficient evidence to charge detainees, decisions to release them under investigation or to seek authorisation from senior officers to bail them through the appropriate channels were generally well considered. Detainees released under investigation (RUI) or on police bail with conditions were given a thorough explanation of what this involved, told of the consequences should they attempt to compromise their investigations and issued with the relevant paperwork.

**3.42** The progress of bail cases was monitored by officers' supervisors, and were further scrutinised at a force performance meeting. At the time of our inspection, there were 134 active bail cases. In contrast however, there were over 2,000 active RUI cases, of which 1,794 were over 28 days old. Although these cases were reviewed monthly by supervisors, it was not clear that they were properly disposed of, or that RUI was effectively managed to reduce investigation time and minimise the impact of extended periods of RUI on detainees.

## Complaints

**3.43** Information on the complaints process was displayed in both suites but was not prominent or the content immediately apparent, they were only available in English and those displayed at Kempston were in a poor condition. These notices were generic and did not explain how detainees could make a complaint while in custody. Although there was information on the complaints process in the rights and entitlements documentation routinely offered to all detainees during their booking in, these were not always accepted (see paragraph 3.29). Many custody staff told us they would notify the custody or duty inspector if a detainee wished to make a complaint but this depended on the nature of the complaint, while others said they would direct the individual to dial 101 or attend the police station front desk on release. Neither suite had any leaflets for detainees about the Independent Office for Police Conduct (IOPC).

**3.44** Force data showed that in the six months to 30 September 2019, 21 complaints were received from individuals about custody-related incidents, which was low. In one of the cases we audited, a detainee wished to make a complaint about rough treatment during their arrest but were advised that this was not possible while their case was being investigated. This detainee was subsequently released under investigation and nothing further was

recorded in the custody record about their wish to make a complaint. These practices remained unchanged from our previous inspection, and did not assure us that a detainee would be able to make a complaint while they were still in police custody.

## Area for improvement

**3.45 Complaints procedures should be well promoted, and detainee complaints should be taken while they are still in custody.**

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

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

## Physical environment is safe

**4.1** Since the previous inspection in 2014, the custody suite at Bedford and the stand-by suite at Dunstable had been closed, leaving the force with two full-time designated suites at Luton and Kempston. The Luton suite was ageing but had benefited from some refurbishment, although it still lacked some facilities, such as in-cell handwashing. We were told that the suite at Kempston was a temporary facility, but it had been in position for around five years and was showing signs of decline, such as peeling paint in the shower room. This suite, due to its temporary nature, also lacked several facilities - there was no exercise yard, no privacy screening at the booking-in desks and no in-cell handwashing. Neither suite had any adaptations to cater for detainees with physical disabilities (see paragraphs 3.9 and 3.10). We found a few potential ligature points in both suites and provided the force with a comprehensive illustrative report detailing these, which it responded to positively during our inspection.

**4.2** Despite the lack of facilities, cleanliness across the two suites was good with very little graffiti. All cells had some natural light. The temperature varied in different parts of the suites, although it could be controlled to an extent at Kempston. Specialist cleaners deep cleaned cells that had biological hazards, and were prompt in attending.

**4.3** The cell call bells that we tested were functioning but were barely audible in both suites, which posed significant risks (see paragraph 3.21).

**4.4** Kempston had a few notices advising detainees that CCTV was operating in the suite but there was only one sign displayed at Luton, which did not meet the requirements of PACE code C paragraph 3.11 (see cause of concern and recommendation S43). There were CCTV cameras across the custody estate and in all the cells, but no specific signs to promote the latter. However, detainees were routinely advised of the CCTVs during their booking in (see paragraph 3.2).

**4.5** The CCTV arrangements had several deficiencies. At Luton, half the cells did not link to monitors in the rear office and so CCTV could not be monitored in real time, and at the time of inspection the CCTV monitors at the booking-in desks were not functioning; we were told the system was regularly out of action. We had difficulties in viewing use of force incidents at Luton because of problems with the system (see paragraph 4.16). At Kempston, there were some blind spots and gaps in the CCTV monitoring, including the availability of audio, and the positioning of monitors immediately to the rear of the booking-in desks was not ideal for level 3 CCTV constant monitoring as this was a busy area. The limitations of the CCTV affected the force's ability to manage the safe delivery of custody services effectively.

**4.6** Detention officers or custody officers were supposed to conduct daily checks of the cells and interview rooms against a checklist. However, the checklist was very basic, there was an inconsistent approach to carrying the checks out and a substantial number of gaps where they had not been completed. Any defects or faults were recorded locally and reported online to a central department, and were generally responded to and addressed promptly, but staff told us some repairs could take a considerable time if they required an external contractor.

**4.7** Custody staff had reasonable awareness of emergency evacuation procedures and how and where to evacuate detainees in an emergency. However, while all staff told us they had been involved in regular fire scenario exercises in the previous six to 12 months, none had been on a physical evacuation drill to ensure the evacuation procedures worked in practice. Force data showed that there had been four scenario exercises at both suites in the previous six months to cover all the teams, but they did not always identify the staff who had been present, what the scenario had been, and often failed to identify any learning points or the actions taken when learning points were identified. There were sufficient sets of handcuffs in the custody suites to evacuate the cells safely if required.

## Areas for improvement

**4.8 Cell call bells should be loud enough to be audible.**

**4.9 The force should ensure that the CCTV at both suites effectively supports the safe delivery of custody services.**

**4.10 The force should adhere to legal requirements for fire regulations.**

## Safety: use of force

**4.11** We saw good examples of staff using de-escalation techniques, often in challenging circumstances. In our CCTV review of incidents and observations in the custody suites, both operational and custody officers demonstrated patience and understanding, which potentially avoided using force on detainees.

**4.12** All custody staff were up to date with their personal safety training. The force provided personal safety refresher training for all custody staff monthly, and all custody staff were recertified twice a year.

**4.13** We reviewed CCTV footage and custody records of 15 recent cases where force had been used against detainees in custody. We were unable to view one case because of CCTV issues and we referred this to the force to quality assure. All the incidents had been dealt with appropriately and the force used had been proportionate. We referred five cases back to the force for learning; this was not due to concerns over the actual force used – indeed one case was a good example that we suggested could be shared wider with officers to support learning. These cases related to officer safety awareness, detainee dignity or how risk was managed when officers were searching detainees or seizing property.

**4.14** Information on the use of force in custody was neither accurate or comprehensive. The use of force in custody was not always fully or accurately recorded on the custody record, and use of force forms for incidents were not always completed by all the officers involved. The data on the use of force provided for our inspection were incomplete and did not include information for all the use of force tactics deployed. This meant that the force was unable to show that when force was used it was appropriate and proportionate.

**4.15** There was little quality assurance of the use of force in custody to demonstrate that officers used it in a safe and proportionate way. Although custody inspectors were required to quality assure custody records monthly, this did not include reviewing any use of force incidents, and there was no review of incidents recorded on CCTV. This lack of assurance over such an important area of activity, and the lack of comprehensive and accurate information on the use of force, were a cause of concern (see cause of concern and recommendation S42).

**4.16** It was difficult for us to view use of force incidents at Luton as staff told us that the CCTV system there suffered regular faults and was not always fully operational (see paragraph 4.5), Although we were able to make other arrangements to view most of the use of force incidents that we had identified, the limitations of the CCTV system posed risks to detainees, staff and the force. The force was aware of these problems and was acting to address them.

**4.17** Handcuffs were usually 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, had to wait outside the custody suites in handcuffs for long periods.

**4.18** Force data showed that 8.2% of detainees (706) had been strip searched in the year to 30 September 2019. Of these, 42 were children (6.4%), which was high and merited further investigation by the force. The strip searches that we observed during our review of CCTV had been carried out well with the dignity of the detainee maintained, but in the records we looked at there was not always sufficient justification for strip searching.

## Detainee care

**4.19** Custody officers used a stock briefing script as part of the core booking-in process, which informed detainees about provision for their welfare provisions and other important information, such as meal times and how to use cell call bells and toilets. It also prompted the custody officer to check if the detainee required anything at that time. We saw this frequently happening, which was not something that we always see. This often led to immediate requests and offers to facilitate provision of meals, drinks and reading materials early on, and made clear that detainees were entitled to make such requests during their detention. We also saw detainees receiving showers, including most of those due to attend (or appear by video) at court.

**4.20** Despite this, some detainees we spoke to said they had waited a long time for offers of welfare provision or not been offered these at all. Our case audits and custody record analysis also highlighted some additional concerns about whether welfare provision was regularly facilitated. Written custody records often lacked detail about welfare issues, and we found long gaps with no records that food and drink had been given. Only four of the 94 custody records that we analysed recorded any offer of reading material, only five recorded offers of outside exercise, and food and drink were recorded as offered to only 66 detainees (70%). Our observations indicated that the practice was better than what was recorded, but the limited recording made it difficult for the force to show the level of care offered to detainees. (See cause of concern and recommendation S44.)

**4.21** Food and drink supplies were good, and as well as sandwiches there was a wide selection of microwave meals covering many dietary needs, with helpful guidance for staff about their ingredients and suitability. Staff told us they would arrange to obtain specific food required for health or dietary reasons. Weekly checks ensured that food remained in date. Staff were not rigid in following meal times and provided food as required. However, water was only available by request with no drinking water in cells.

**4.22** Disposal of food waste was ineffective, and empty containers and other debris often accumulated in cells instead of being taken away as quickly as possible. At Kempston we found uncollected waste in several occupied cells, including four discarded meal trays on the floor of one cell, leaving an unpleasant smell. This inattention to detainee dignity and care was contrary to both force policy and *Authorised Professional Practice* guidance.

**4.23** Both sites had limited supplies of reading materials for detainees, mainly ageing books and magazines, with few items for children or in common foreign languages. This was despite the force's own custody operating procedure which required local custody inspectors to ensure that these were in place.

**4.24** Custody staff assured us that toilet paper was issued to all detainees automatically without individual risk assessment, in accordance with *Authorised Professional Practice*. We saw this happening sometimes, but not always. This was largely due to arresting officers rather than custody staff escorting detainees to cells (see paragraph 3.19), and so detainees did not receive the same information or provision as they would have done. Toilet paper was also stored unhygienically (see paragraph 3.3).

**4.25** There was insufficient suitable alternative clothing for detainees. Although there were plentiful supplies of tracksuit bottoms in all sizes at both suites, jumpers were not available, and, as at the previous inspection, the force still used inappropriate loose medical 'scrub'-style tops rather than standard T-shirts. Kempston also had low stocks of these items and we were told that when these ran out, detainees were given anti-rip clothing instead, which was also unsuitable. Replacement footwear was available but not regularly offered or provided, even though detainees' own footwear was routinely removed leaving them to walk around in socks or bare feet on cold floors (see paragraphs 3.3 and 3.20).

**4.26** The suites had limited supplies of blankets for detainees and provided just one per person. We observed a detainee refused an additional blanket at Kempston after he complained of being cold. Although staff said that some cell areas could be temperature controlled, this was not possible for individual cells, and on our night time visit the temperatures in cell areas were cold. The lack of suitable clothing, blankets and warmth in cells did not provide detainees with sufficient comfort and dignity in custody.

**4.27** Kempston had no exercise yard and so detainees held there did not have access to their entitlement to 'brief, daily outdoor exercise where practicable' (*Authorised Professional Practice*). In our case audits, we found one example of good practice where a child held for longer than 24 hours was moved from Kempston to Luton to allow access to the facility there. However, it was not clear if this would happen in all such instances, particularly for adults, and seemed unlikely to apply for those held at Kempston for shorter periods.

## Area for improvement

**4.28 The force should strengthen its approach to detainee care by:**

- **ensuring that custody staff remove all food and drink waste from cells immediately after use, in accordance with *Authorised Professional Practice* guidance**
- **storing toilet paper hygienically and respectfully, and providing it to all detainees on their arrival into custody, subject to individual risk assessment**

- **issuing detainees with adequate replacement clothing and footwear in all instances where personal items are removed, to provide sufficient dignity and comfort**

- **ensuring that custody suites stock a sufficient supply of blankets to issue to detainees**

- **providing detainees with access to their daily entitlement of outside exercise, including making suitable arrangements at Kempston.**

## Safeguarding

**4.29** Custody officers had a good understanding of safeguarding and how to recognise concerns, supported by training on vulnerabilities. The arresting or investigating officers had responsibility for making safeguarding referrals for both children and vulnerable adults to the multiagency partnership arrangements. They flagged any issues they identified with custody officers to help them take care of the detainee in custody and support their safe release.

**4.30** This approach was strengthened through the requirement for all investigating officers to complete an 'officer declaration form' on the custody record to show whether any safeguarding concerns had been identified for the detainee, victim, witnesses or the public, and the actions they had put in place to offset these. Custody officers were also required to complete a similar declaration to show they had taken account of this information before a detainee was released. However, not all the custody records we looked at included these declarations. (See cause of concern and recommendation S44.)

**4.31** Custody officers who had concerns about a detainee involved the health care professional and/or the liaison and diversion service (LADS) to obtain further information and advice. The LADS triaged all adult detainees entering custody and sought to engage with any who had mental ill health or were vulnerable, as well as all females. In the daytime, youth offending teams (YOTs) reviewed all children entering custody, and picked up those who had been detained overnight the next day. The LADS workers visited children from 5pm to 9pm to carry out a welfare check and address any immediate concerns.

**4.32** Children and vulnerable adults, in particular, did not always receive early support from appropriate adults (AAs, independent individuals who provide support to children and vulnerable adults in custody). Although the custody officers we spoke to were aware of their responsibility to secure an AA as soon as practicable - to provide early support for a child or vulnerable adult and help them understand their rights and entitlements while in custody - this did not always happen in practice.

**4.33** Family members or carers were sought in the first instance to attend as AAs. Custody officers said they would issue guidance for AAs and describe the role to those not familiar with it. Arresting officers told us they often tried to arrange an AA to attend at the time of the arrest to minimise delays following the detainee's arrival in custody. When family members were not available or it was not appropriate to use them, AAs were sought through local authority social services departments or YOTs, and out of hours through Central Bedfordshire's emergency duty team (EDT) - which facilitated the service on behalf of all three local authorities in the force area. The effectiveness of these arrangements varied. Custody officers reported that social services AAs requested in the daytime generally arrived without too much delay – although some would only attend when the detainee was ready for interview, which could be several hours into detention. However, they told us that at night it was difficult to secure an AA through the EDT and that often one could not be provided until the following day (see paragraph 3.27).

**4.34** In our review of custody records, AAs sometimes attended promptly, with some present from the detainee's arrival into custody, whereas other detainees waited several hours to receive any support. Custody officers told us that if an AA was unlikely to arrive for some time, they would try to get them to speak to the detainee by telephone to offer some early assurance and support. However, we did not find any cases where this had happened. In one custody record, a child waited approximately 14 hours before an AA from YOT arrived, and there was no record of any efforts to secure one until 12 hours into the child's detention.

**4.35** The force did not monitor how long detainees waited before receiving support from an AA or if requests were made promptly. Recording of AA request and arrival times was poor, making it difficult to identify the reasons for any delays or to enable monitoring. It was also not usually clear whether the AA attending was a family member or from external agencies, and so could discuss provision of the service with partners.

**4.36** Custody officers often asked arresting or investigating officers to make the practical arrangements to secure an AA. However, in the custody records we looked at there was little evidence of any custody officer oversight to ensure that these arrangements were progressed effectively.

**4.37** Our review of custody records and observations in suites showed that vulnerable adults were not always identified as needing an AA, despite some clear evidence that one was required. Although the custody officers we spoke to could describe the factors they should take into account when deciding whether an adult detainee needed an AA, in practice not all vulnerable adults received the support they were entitled to. There appeared to be no consideration given for an AA in several cases we looked at. In others, a detainee's need for an AA was not identified until later on into detention, sometimes following a health care or LADS assessment. In one case we observed, although the health care professional advised custody staff that an AA was needed, the detainee had already been fingerprinted and photographed without an AA present to explain these processes. The force did not monitor how many adult detainees received the support of an AA to help understand and assure itself that vulnerable individuals received the required support while in custody.

**4.38** In our previous inspection, we recommended that the force improve the provision of the AA service. The force had recognised that AA provision was not satisfactory and had been working with partners to improve the position. A pilot scheme was due to be set up to help inform the development of an improved AA service. Despite this, there had been little further progress, and on this inspection we had additional concerns about the lack of AA support for vulnerable adults. This was a cause of concern that we expected the force to address with urgency. (See cause of concern and recommendation S45.)

**4.39** Children in custody received some good care. They were generally placed in designated cells away from adult detainees, girls were assigned a designated female officer to look after their welfare, and children were screened and assessed by the YOTs, with visits if needed. Force policy required all children to be seen by the health care professional, although this had not happened in the all the cases we looked at. Children were released into the care of a responsible adult in all the cases we saw.

**4.40** However, children were not routinely considered and prioritised for booking into custody. Although there were easy-read child-friendly rights and entitlements materials readily available in the suites, these were not given to a child we saw in custody, and there was little evidence of this happening recorded in custody records. Children could make and receive telephone calls from family but there were no visit rooms for relatives to see children. We were told that interview rooms could be used instead but we saw no evidence of this in the custody records we looked at.

**4.41** Once children were booked into custody there was a strong focus on dealing with them as quickly as possible to minimise their time spent there. Custody officers provided examples of children who had been dealt with swiftly and where overnight detention was avoided by releasing them under investigation or bailing them. This approach was also evident in some of the records we looked at. However, custody officers told us that some children remained in custody for longer periods because there was no other place with sufficient safeguards to ensure the child's (or others') safety. They said this was particularly the case for looked-after children and those who frequently went missing.

**4.42** The force closely monitored all children held overnight at both operational and strategic levels. Custody officers provided information to custody inspectors every morning on each child held overnight, and the justification for this. Inspectors reviewed the cases to assure that detention was justified and whether the child had been (or was being) dealt with as quickly as possible. Daily information on these children was also provided to the chief inspector, the chief superintendent and the superintendent overseeing custody. Monthly information on children held overnight, along with other information such as the length of detention for children, was part of the force's performance management data, which gave senior officers oversight of children in Bedfordshire's custody.

**4.43** There was also joint monitoring of children with partners through the Children and Young Persons Board, chaired by a chief superintendent. The board reviewed children held overnight as well as considering, for example, the wider diversion of children away from custody and the criminal justice system.

**4.44** Despite this strong focus on monitoring children held overnight, there had been little progress in ensuring that children charged and refused bail were moved to alternative local authority accommodation, as required by statute. Force information showed that 28 children were charged and refused bail in the year to the end of September 2019. The force had requested secure or non-secure accommodation for 27 of these children but none were moved; this was a poor outcome. The force and its three local authority partners had all signed up to the Home Office concordat on children in custody, and joint working had led to the provision of four dedicated beds with specially trained foster carers. However, social services had deemed that the children referred so far for this accommodation had been too great a risk for a placement into foster care, and so these beds had not yet been used.

## Area for improvement

**4.45 The force should continue to work with its partners to ensure that children charged and refused bail are not held in custody but transferred to other secure or appropriate accommodation.**

## Governance of health care

**4.46** Castle Rock Group medical services had been responsible for the delivery of physical health services in the custody suites since April 2019. Mental health liaison and diversion services were delivered by East London NHS Foundation Trust.

**4.47** Oversight of health delivery by the police was good, with regular challenge through the contract review meetings. Data submission was qualitative and performance information covered an appropriate range and depth of activity, including key areas of detainee care such as response times.

**4.48** Despite some initial difficulties with implementation of the new contract, service provision had stabilised and there was now consistent staffing that included a mix of nurses and paramedics providing health care professional (HCP) cover, supported by forensic medical examiners (FMEs) operating geographically.

**4.49** There was a full range of clinical policies, including a clear framework to report and manage incidents. Staff had to validate online that they had seen policies and other clinical information, including learning materials that had been forwarded to them. In addition, an independent health complaints process was advertised, although it had not been used to date.

**4.50** HCPs were embedded in both suites and mostly mirrored the shifts of custody staff, which facilitated consistency and close working relationships. FMEs were on call to provide telephone advice and attend suites if required. There were no HCP vacancies and any short-term staff absence was covered through a pool of regular bank staff or overtime use, although very occasionally HCPs had covered the two suites.

**4.51** Contract response times of between 30 and 120 minutes were linked to clinical and forensic priorities. In our custody records analysis, response times were a mean of 95 minutes, ranging from two minutes up to one outlying case taking seven hours 25 minutes. Response time performance in the previous three months had improved, with on average 94% of cases seen within the agreed timescales.

**4.52** There was compliance with mandatory health staff training and staff had reasonable access to professional development opportunities. There were still some staffing issues from the previous provider but managerial arrangements were clear, and Castle Rock had introduced an enhanced practitioner role to provide more sustained clinical leadership, supervision and in-house staff development. Recruitment for these posts was still under way but the approach was a positive one that would enhance quality assurance.

**4.53** The clinical rooms were clean and uncluttered but small, with Kempston being particularly cramped. Physical environments did not wholly comply with infection prevention standards: Luton had no in-room sink and taps; Formica counter tops were used as work surfaces; and there were no separate areas for forensic sampling. However, clinical equipment was appropriate and all stock was in-date.

**4.54** Both clinical rooms had an emergency resuscitation bag that contained all essential kit and medications and an automated external defibrillator, which were checked regularly. All HCPs were trained to immediate life support level. Custody staff had received appropriate first aid training and those we spoke with could provide basic life support to detainees, and we saw this in practice during our inspection.

## Area for improvement

**4.55 Clinical rooms should comply with relevant standards of infection control and contemporary standards for forensic sampling.**

## Patient care

**4.56** All custody ranks and the few detainees we spoke to clearly valued the embedded HCP support within suites. HCPs came from a wide variety of clinical backgrounds; those we met possessed significant experience and clearly had the competencies to provide effective detainee care.

**4.57** Custody staff made appropriate referrals to HCPs based on risk assessment, or at the request of the detainee, with good working relationships evident. Professional interpreting services for non-English speaking detainees were available if required. Patient records were handwritten but a single electronic recording system was due to be introduced. The patient records we sampled were qualitative and captured all key clinical matters. Castle Rock staff recorded significant risk issues and medication requirements in the detainee's custody record.

**4.58** The medicines management practices we observed were good, with an appropriate range of patient group directions (authorising appropriate HCPs to supply and administer prescription-only medicine) to facilitate effective detainee care. Custody staff could access a small range of over-the-counter medicines that were held securely in a separate lockable cabinet in the health care treatment rooms. A proportionate range of stock medicines, including controlled drugs, were available, safely stored and fully accounted for, with effective stock checks and reconciliation arrangements in place. Custody staff could also obtain prescriptions for detainees once validated by HCPs, and individual prescriptions were held securely with detainees' personal property.

**4.59** Symptomatic relief for drug and alcohol withdrawal was provided. We saw evidence of opiate substitution treatment being continued for detainees in custody when prescribed and deemed clinically appropriate. This included access to nicotine replacement therapy.

## Substance misuse

**4.60** The mental health criminal justice liaison and diversion team (CJLDT) delivered an 'all-vulnerabilities' service, intended to support detainees exposed to a range of difficult psychological and social circumstances (see paragraph 4.63). This included triage support and signposting to community services for detainees with drug and alcohol problems. At the Luton suite, Change Grow Live (CGL) also provided active face-to-face support to detainees with substance misuse problems through two dedicated practitioners working Monday to Friday as part of a pilot project; this enabled good support and effective reengagement for all referred detainees. CGL worked alongside the CJLDT and routinely provided additional support to detainees through direct community outreach work. There was no parallel provision in the Kempston suite, and this inequity resulted in a less responsive service for detainees.

**4.61** Detainees were also targeted for drug testing at Luton based on their offence and other risk factors, which could trigger referral into community treatment. On leaving custody, all detainees were given information that included details of community substance misuse services, but there was no immediate access to sterile injecting equipment.

## Area for improvement

**4.62 Both custody suites should offer equitable support for detainees with drug and alcohol problems.**

## Mental health

**4.63** The CJLDT delivered all-age, all-vulnerabilities support in both suites seven days a week, from 8am to 9pm on weekdays and up to 8pm at weekends. The service had been put out to tender and the outcome of this process was due. There were no significant vacancies; staffing

was multidisciplinary and reflected the range of support on offer, with plans to remodel the service profile further, including the use of peer mentors.

**4.64** The team's work was well valued by custody staff, and collaborative work included a rolling programme of training to the police. The input for detainees was good and there was an impressive number of established pathways and practical measures that facilitated ongoing community support. This included the use of support time and recovery workers to accompany detainees to non-health-related appointments, such as housing departments, as well as clinical appointments.

**4.65** Governance arrangements were well established. Quarterly performance reports were considered at the partnership boards. Appraisal and clinical supervision arrangements were in place, and staff had good access to training and professional development. Clinical records were good but not all chronological contacts or key milestones were noted. This meant that risks were not always flagged to custody staff, which could affect detainee care.

**4.66** There were no data to show the time taken for assessments of individuals for detention under the Mental Health Act (see paragraph 1.11). Our custody records analysis and case audits showed a few delays, which resulted in some detainees spending too long in custody before they were transferred to a mental health facility under section 2 of the Act. This was particularly the case out of hours, when CRG FMEs assumed responsibility for detainees requiring specialist mental health support. Information provided by the force showed that in nine cases it had not been apparent that a mental health assessment was required when the detainee entered custody because, for example, they were under the influence of alcohol or drugs. However, when the need for this was subsequently identified during the person's detention, a mental health assessment could not be arranged before they were due to be released (that is, within 24 hours, as required by PACE). This resulted in the force detaining the person under section 136 of the Mental Health Act while they were in custody, so that they could be taken to a health-based place of safety for an assessment.

**4.67** A joint street triage scheme operated by the police, ambulance and mental health practitioners was regarded as a significant asset in diverting vulnerable people away from custody. In the previous year, no individuals had been detained and taken to custody as a place of safety under section 136 of the Mental Health Act, which was positive.

## Areas for improvement

**4.68 Staff should note all significant risks and milestones on the detainee's custody record.**

**4.69 The force should monitor the time taken to facilitate and arrange transfer of detainees under section 2 of the Mental Health Act, and escalate to NHS England all episodes where detainees have needed to be moved out of custody to an appropriate place of safety under section 136 of the Act.**

# 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 a good focus on ensuring that detainees were released safely. We observed that in some cases pre-release risk planning was considered from the moment a detainee was booked in and at staff shift handovers, which was positive. Custody officers spoke to all detainees and completed pre-release risk assessments before their release, including those being transferred to court or other custodial settings. There was a clear focus on addressing vulnerability and safeguarding and, where necessary, relevant partner agencies, such as health care professionals or the liaison and diversion service, were involved to support the detainee's release. We saw custody officers using the custody records to establish what had taken place during the detainee's time in custody and what they could do to ensure they were released safely. However, recording on pre-release risk assessments and the custody record was poor. Entries on custody records were often cursory and, although they addressed how the individual was travelling home, they often did not refer to how risks or concerns identified at booking in or during the detainee's time in custody had been addressed. (See cause of concern and recommendation S44.)

**5.2** All detainees were asked if they had the means to get home after release. Children and vulnerable detainees were routinely taken home by police officers or released into the care of a parent or responsible adult. We saw police take home some detainees without money or means of transport, and they facilitated telephone calls to taxi firms and friends and family to make transport arrangements. Although travel warrants were available for detainees who did not live locally, these were not held in the custody suites and had to be requested through the control room inspector.

**5.3** Staff routinely gave detainees being released an information leaflet with contact details of national support agencies, and explained this to them. Detainees attending court were also given the leaflet, which was positive. This leaflet issued was in English but most custody staff were unaware that it was also available in nine other languages. There was also a range of other support leaflets provided by charities and other services, but custody staff knowledge of these was also variable and consequently they may not have been issued to detainees who would have benefited from them. The liaison and diversion service also had access to a wide range of support information leaflets for detainees, and they sometimes gave these to the custody officer to hand to detainees with their property on release.

**5.4** The quality of information in the person escort records (PERs) we sampled was good. Detainee risk markers, including violence and risk of self-harm, were clearly identified and dated. However, there was an over-reliance on attaching loose-leaf forms - including risk assessments, details of medical assessments and any medications administered - rather than record this information in the PER, which should have been the definitive risk information/management document.

## Area for improvement

**5.5 All relevant information to ensure the safe transfer of a detainee should be recorded in their person escort record.**

## Courts

**5.6** Detainees held for court appeared at Luton Magistrates' Court, either through attendance or via video link. Detainees transferred to court - mainly children and vulnerable adults - were collected promptly in the morning, and the arrangements for transporting them to court worked effectively. However, detainees waiting for their video-link ('virtual') court appearance were occasionally held in police custody for longer than necessary. The scheduling of virtual courts was not shared with custody staff in advance and police custody cases were not always prioritised, as they should have been. We observed a few detainees who were ready for their video-link court appearance as early as 10am but who were still in police cells in the late afternoon.

**5.7** Custody staff told us that the court had a 2pm deadline for accepting additional detainees during the day, regardless of whether they were due to appear in person or via the virtual court; this was too early. We saw staff at Kempston try to get one detainee accepted by the virtual court but this was refused at 12.45, resulting in him not appearing before the first available court, as he was held in custody overnight to appear the following day. We were told that detainees were sometimes remanded or sentenced to prison by the virtual court later in the day and so were held in police custody for longer than necessary, and in some cases overnight. In our custody record analysis, one female detainee was remanded by the virtual court at 16.56 and not picked up for transfer to prison until 6.46 the following day, more than 26 hours later, which was unacceptable. Such delays jeopardised the detainee's well-being and put unnecessary and avoidable pressure on police custody staff. If this detainee had attended a court in person she would have been transported to prison that day, and received her rights and been cared for as a remand prisoner.

## Area for improvement

**5.8 The force should engage with HMCTS to minimise the time detainees wait for virtual court appearances, with cases prioritised appropriately. Detainees remanded to prison should be transported there without undue delay.**

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

## Causes of concern and recommendations

**6.1** Cause of concern: Governance and oversight of the use of force were poor. Data on the use of force were not comprehensive or reliable. Incidents were not always recorded, or recorded accurately, on the custody record, and not all officers completed a use of force form following an incident. There was no quality assurance over the use of force, no viewing of incidents on CCTV, and no senior management oversight and governance to demonstrate that when force was used in custody it was proportionate and safe.

**Recommendation**: The force should assure itself and others that when force is used in custody it is safe and proportionate. It should collect and monitor comprehensive and reliable data, and ensure that all incidents are recorded in sufficient detail and that use of force forms are completed by all officers involved in an incident. It should have robust quality assurance arrangements, including viewing incidents on CCTV, supported by effective oversight at senior officer level. (S42)

**6.2** Cause of concern: The force did not consistently meet the requirements of code C of the Police and Criminal Evidence Act 1984 (PACE) code of practice for the detention, treatment and questioning of persons.

**Recommendation**: The force should take immediate action to ensure that all custody procedures comply with legislation and guidance. (S43)

**6.3** Cause of concern: The quality of custody records was poor. It was difficult to establish the actions that had been taken in all cases, and some information was missing or limited in detail. Quality assurance of the records was not sufficiently robust to identify and address these concerns, and there had been little progress since out previous inspection.

**Recommendation**: 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. (S44)

**6.4** Cause of concern: Consideration was not always given to securing an appropriate adult for vulnerable individuals, despite clear evidence in several cases that one was required. This meant that that these individuals did not receive the support and help they were entitled to. Appropriate adults required for both vulnerable adults and children were not always secured promptly and there were some long delays before they attended, especially at night.

**Recommendation**: The force should ensure that detainees who need the support of an appropriate adult because they are vulnerable are identified correctly to receive this support. There should be adequate arrangements to ensure that appropriate adults are secured without delay. (S45)

# Areas for improvement

## Leadership, accountability and partnerships

**6.5** The force should ensure that its IT system supports the delivery of custody functions and minimises system failures. (1.10)

**6.6** The force should address any gaps in its collection of performance information so that it can monitor performance effectively against a comprehensive framework of custody activities. (1.18)

**6.7** The force should collect accurate information on the self-defined ethnicity of detainees and use this to monitor custody services to ensure they are delivered fairly. (1.19)

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

**6.8** Booking-in areas should offer sufficient privacy for conversations with detainees. (3.5)

**6.9** The force should ensure that there is adequate provision for physically disabled or mobility restricted detainees in custody suites. Cells should have appropriate fittings, including easily accessible call bells, and there should be suitable toilets and showers. The suites should stock British Sign Language rights and entitlement DVDs, and ensure that staff are aware of the location of hearing loops and how to use them. (3.13)

**6.10** The force should ensure that interpreters are secured promptly for detainees who require this service. (3.14)

**6.11** The approach to managing risk should be improved. In particular:

- all custody staff should carry anti-ligature knives in the custody suites at all times
- detainees' clothing and footwear should only be removed on the basis of an individual risk assessment
- anti-rip clothing should only be used as a last resort and should be fully justified in the custody record
- cell call bells should be answered promptly
- all custody staff should be involved collectively in shift handovers. (3.23)

**6.12** Complaints procedures should be well promoted, and detainee complaints should be taken while they are still in custody. (3.45)

## In the custody cell, safeguarding and health care

**6.13** Cell call bells should be loud enough to be audible. (4.8)

**6.14** The force should ensure that the CCTV at both suites effectively supports the safe delivery of custody services. (4.9)

**6.15** The force should adhere to legal requirements for fire regulations. (4.10)

**6.16** The force should strengthen its approach to detainee care by:

- ensuring that custody staff remove all food and drink waste from cells immediately after use, in accordance with Authorised Professional Practice guidance
- storing toilet paper hygienically and respectfully, and providing it to all detainees on their arrival into custody, subject to individual risk assessment
- issuing detainees with adequate replacement clothing and footwear in all instances where personal items are removed, to provide sufficient dignity and comfort
- ensuring that custody suites stock a sufficient supply of blankets to issue to detainees
- providing detainees with access to their daily entitlement of outside exercise, including making suitable arrangements at Kempston. (4.28)

**6.17** The force should continue to work with its partners to ensure that children charged and refused bail are not held in custody but transferred to other secure or appropriate accommodation. (4.45)

**6.18** Clinical rooms should comply with relevant standards of infection control and contemporary standards for forensic sampling. (4.55).

**6.19** Both custody suites should offer equitable support for detainees with drug and alcohol problems. (4.62)

**6.20** Staff should note all significant risks and milestones on the detainee's custody record. (4.68)

**6.21** The force should monitor the time taken to facilitate and arrange transfer of detainees under section 2 of the Mental Health Act, and escalate to NHS England all episodes where detainees have needed to be moved out of custody to an appropriate place of safety under section 136 of the Act. (4.69)

## Release and transfer from custody

**6.22** All relevant information to ensure the safe transfer of a detainee should be recorded in their person escort record. (5.5)

**6.23** The force should engage with HMCTS to minimise the time detainees wait for virtual court appearances, with cases prioritised appropriately. Detainees remanded to prison should be transported there without undue delay. (5.8)

# 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

| | |
|---|---|
| Quality assurance processes, leading to improved outcomes for detainees, should include sampling of custody records, checking against closed-circuit television (CCTV) recordings, person escort records and staff handovers. (2.25) | **Partially achieved** |
| There should be sufficient staff in custody at all times to ensure the safety and well-being of detainees. (2.27) | **Partially achieved** |
| The police force should ensure that learning from adverse incidents has clear ownership and is overseen at a strategic level to ensure that there is effective collation, monitoring of trends and identifying areas for improvement. There should be an effective process for communicating this learning to frontline staff. (2.28) | **Achieved** |

### Recommendations

| | |
|---|---|
| There should be robust arrangements to collect, evaluate and monitor data relating to the treatment of those in custody to improve outcomes and safety for detainees. (3.8) | **Partially achieved** |
| Custody-specific refresher training should be delivered regularly to ensure staff respond appropriately to the welfare and safety of detainees in their care. (3.15) | **Achieved** |

## Treatment and conditions

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

### Main recommendation

| | |
|---|---|
| The police custody estate should be clean, safe and free of ligature points, and staff should be trained to identify these issues or manage and mitigate the presenting risks. (2.26) | **Partially achieved** |

### Recommendations

| | |
|---|---|
| Booking-in areas should provide sufficient privacy to allow effective communication between staff and detainees. (4.10) | **Not achieved** |
| All holding rooms should be suitable for purpose. (4.11) | **Achieved** |
| Some cells should be adapted for use by detainees with physical disabilities. (4.12) | **Not achieved** |
| Detainees' shoes and cords should not be routinely removed. (4.25) | **Not achieved** |
| All custody staff should be involved in the same shift handover and incoming staff should introduce themselves to detainee. (4.26) | **Not achieved** |
| Pre-release risk assessment questions should encourage a discussion with detainees. (4.27) | **Achieved** |
| Information about support agencies should be available in languages in addition to English. (4.28) | **Achieved** |
| The CCTV monitors should clearly identify which cells are being displayed. (4.29) | **Achieved** |
| Bedfordshire Police Service should collate use of force data from custody and examine it for trends in accordance with the Association of Chief Police Officers policy and College of Policing guidance. (4.36) | **Not achieved** |
| Detainees should not be observed being strip-searched. (4.37) | **Achieved** |
| The shower areas in the custody suites should be clean, repaired and safe for detainees to use. (4.44) | **Partially achieved** |
| Custody sergeants should ensure that non-custodial staff do not visit detainees in cells unsupervised. (4.45) | **Not achieved** |
| Emergency practice evacuations should take place regularly, and be recorded. (4.46) | **Partially achieved** |
| Replacement clothing that maintains detainees' dignity should be provided. (4.57) | **Partially achieved** |
| All detainees held overnight and those who require one should be offered a shower and should be able to take it with an appropriate degree of privacy. (4.58) | **Achieved** |
| Detainees, particularly those held for more than 24 hours, should be offered exercise. (4.59) | **Partially achieved** |

## Individual rights

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

### Main recommendations

| | |
|---|---|
| The force should facilitate the provision of appropriate adults for vulnerable people in custody. (2.29) | **Not achieved** |
| The force should facilitate the provision of PACE beds for children in custody to prevent them from being held in police custody overnight. (2.30) | **Partially achieved** |

### Recommendations

| | |
|---|---|
| Police officers should be encouraged to make more use of alternatives to custody processes where appropriate, such as voluntary attendance at the police station. (5.12) | **Achieved** |

| | |
|---|---|
| Bedfordshire Police should ensure that there are no unnecessary delays in progressing detainees' cases due to the lack of availability of staff from the prisoner handling units. (5.13) | **Partially achieved** |
| Double handset telephones should be provided in all suites to facilitate telephone interpreting. (5.14) | **Achieved** |
| Senior police managers should engage with HM Courts and Tribunal Service to ensure that detainees are not held in police custody for longer than necessary. (5.23) | **Partially achieved** |
| Detainees should be able to make a complaint about their care and treatment before they leave custody. (5.27) | **Not achieved** |

# Health care

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

## Recommendations

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| Clinical rooms should comply with relevant standards of infection control and contemporary standards for forensic sampling. (6.9) | **Not achieved** |
| Nurses should ensure that they are in compliance with their professional standards of medicines management when using patient group directions to administer medicines. (6.10) | **Achieved** |
| Detainees should be able to continue with prescribed medications for any clinical condition, including opiate substitution therapy. (6.16) | **Achieved** |
| Detainees under section 136 of the Mental Health Act 1983 should not enter police custody unless there are exceptional circumstances. (6.26) | **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*.[10]

## 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.[11] 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.[12]

## Case audits

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

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

[11] 95% confidence interval with a sampling error of 7%.

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

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

## Observations in custody suites

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

## Interviews with key staff

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

## Focus groups

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

## Feedback to force

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

# Appendix III: Inspection team

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|---|---|
| Kellie Reeve | HMI Prisons team leader |
| Fiona Shearlaw | HMI Prisons inspector |
| Norma Collicott | HMI Constabulary and Fire & Rescue Services inspection lead |
| Marc Callaghan | HMI Constabulary and Fire & Rescue Services inspection officer |
| Anthony Davies | HMI Constabulary and Fire & Rescue Services inspection officer |
| Patricia Nixon | HMI Constabulary and Fire & Rescue Services inspection officer |
| Steve Eley | HMI Prisons health services inspector |
| Dayni Johnson | Care Quality Commission inspector |
| Helen Ranns | HMI Prisons researcher |
| Joe Simmonds | HMI Prisons researcher |