positive about the training they received. CDOs were employed by G4S, which the force contracted to provide the service. The training course syllabus for custody officers was shared with G4S, which was responsible for training its own staff, to ensure that training provision was consistent. However, CDOs were less positive than custody officers about their ongoing training, and felt that it was too reliant on e-learning.

1.6 There was a clear process for the recording and reporting of adverse incidents. These were discussed in some detail at a regional health and safety meeting, and learning was identified and shared. There had been no deaths in custody since the previous inspection.

1.7 The force followed *Authorised Professional Practice – Detention and Custody* (APP) for custody, as set by the College of Policing. The EMCJS had also developed custody policies and procedures for all four forces to follow. However, not all practices we observed followed either APP guidance or the joint policies.

1.8 The force was open to feedback and encouraged external scrutiny. There was an effective independent custody visitor (ICV) scheme, and visitors told us that the force was receptive to the issues they raised. In addition, the force had commissioned an external audit of its custody services and was implementing its recommendations.

Areas for improvement

1.9 The force should ensure that custody staff are deployed in the most effective way, to improve outcomes for detainees and prevent them from remaining in custody for longer than necessary. There should be sufficient oversight of staffing levels by senior officers, to ensure that the suites are managed effectively.

1.10 The force should ensure that all custody staff consistently follow the College of Policing *Authorised Professional Practice – Detention and Custody*, and the East Midlands Criminal Justice Services' own guidance, so that detainees receive the appropriate treatment and care.

Accountability

1.11 The force collated comprehensive data in relation to its custody services. This included waiting and detention times, information on children and immigration detainees, levels of strip-searching, and the use of bail and release under investigation. However, there were some gaps – for example, in mental health assessments. Some data were unreliable – mainly in relation to the use of force and restraint in custody (see paragraphs 4.11 and 4.12). This made it difficult for the force to monitor performance effectively in some areas of its custody services.

1.12 The quality of recording on detention logs required improvement. While the records were easier to follow than we often find in other forces we inspect, some information was not captured well enough, and sometimes not recorded at all. For example, this included any safeguarding information for a detainee or action taken as a result (see paragraph 4.27), and the use of force or restraint, together with the justification and rationale for it (see paragraph 4.11).

1.13 The EMCJS regional team conducted a comprehensive quarterly audit of custody records, which identified trends and was used to drive improvement. However, beyond this there was little local quality assurance, and no structured dip-sampling of records was carried out

on a more regular basis to help the force identify where it needed to improve, which could have identified some of the gaps we found.

1.14 Not all practices we observed met the requirements of codes C and G of the Police and Criminal Evidence Act (PACE) codes of practice, notably in relation to the process of booking detainees into custody, and some aspects of inspectors' PACE reviews (see paragraphs 3.37 and 3.48, and cause of concern and recommendation S36). In one case, a detainee had been released without a review of detention taking place, which was a breach of PACE section 40(5).

1.15 The force had insufficient mechanisms to assure itself, the Police and Crime Commissioner and the public that the use of force in relation to detention and custody was always safe and proportionate. The governance and oversight of the use of force were limited, and did not include all use of force incidents that occurred in custody. While some data were available, we found cases where force or restraint had been used in custody but not recorded on the custody record. This meant that the data were not comprehensive, reliable or accurate enough to allow effective scrutiny. Although there was some assessment of incidents by inspectors reviewing a sample of cases, including cross-referencing them on closed-circuit television (CCTV), the under-recording of incidents on custody records resulted in some being missed; moreover, CCTV footage was kept for only up to 30 days, which restricted any review to incidents taking place in the previous month (see also paragraph 4.14). In addition, not all staff completed individual use of force forms, as required by the National Police Chiefs Council (see cause of concern and recommendation S37). The force was aware of these concerns and had already taken steps to improve the recording of use of force.

1.16 The force demonstrated a good commitment to meeting the public-sector equality duty. There were three specific custody-related objectives in its strategic equality action plan, concerning the identification and monitoring of any disproportionality for detainees and the management of transgender detainees. Staff received comprehensive training on their responsibilities under the Equality Act 2010, and senior officers acted as champions for each of the protected characteristics. However, not all detainees were asked to self-define their ethnicity; instead, the custody officer assigned them an ethnicity and added this to the custody record, which could have been inaccurate and limited the force's ability to assess whether outcomes for detainees from different ethnic groups were fair and equitable (see also paragraph 3.14 and area for improvement 3.23).

1.17 Staff had received training in unconscious bias, and this had been extended to ICVs and external partners. The force invited external quality assurance of incidents involving the use of force and strip-searching in custody from members of its community, to provide some external scrutiny over whether it was applying these coercive powers in a fair and transparent way to all detainees.

Areas for improvement

1.18 The force should strengthen its approach to performance management by addressing the gaps in its performance information and ensuring that all its data is reliable.

1.19 The force should improve the quality of its custody records by ensuring that all necessary information is fully recorded, including the rationale and justification for any decisions made.

information held was potentially inaccurate, which would have had an impact on how well it could be used to assess fair treatment for all detainees (see also paragraph 1.16).

3.15 Custody officers had received specific training and were well prepared to understand and manage the various individual and diverse needs of those coming into custody. This included understanding the impact of adverse childhood experiences, mental ill health, autism, dyslexia, attention-deficit hyperactivity, different religious requirements and diverse cultures, and recognising the needs of transgender detainees. Custody officers told us that some of the training had been classroom based, which had been beneficial in developing their awareness and preventing misconceptions. However, CDOs had received little training on these issues, and felt that they were not provided with the same opportunities as custody officers.

3.16 The facilities for detainees with poor mobility or sight impairments were limited and varied across the suites. Euston Street was the designated site for detainees with disabilities with wheelchair access, hearing loops and toilet facilities. However, none of the suites had cells with specific adaptations for detainees with mobility impairments, such as lowered call bells, or contrasting colour bands to help visually impaired detainees. There were no wheelchairs or walking aids at Keyham Lane, and no toilets for detainees with disabilities, or showers that could easily be accessed at Keyham Lane or Beaumont Leys. Extra thick mattresses were available at Euston Street but not at the other two suites – although the force told us they would double up mattresses. The exercise yard at Euston Street was the only one that could be used by those in wheelchairs, as Keyham Lane and Beaumont Leys both had a step leading to the yard. However, we observed custody staff meeting the needs of a child with mobility difficulties by buying a blow-up bed for use in his cell.

3.17 There was some emphasis on meeting the needs of female detainees. Leaflets were available, informing them that they could speak to a female member of staff about any gender-specific issues, and they were routinely offered menstrual care products, of which there was a well-stocked range, including disposal bags. However, not all custody officers offered these detainees the opportunity to speak to a female member of staff. In practice, this was difficult to achieve, as when there were no female custody staff working, and a female officer was assigned from elsewhere in the force, they were not always readily available to attend the suite if needed.

3.18 The force recognised the requirements of a wide range of faiths. This included religious observance materials for those following Christianity, Islam, Hinduism, Judaism, Buddhism and Sikhism – although not all of these were available at Keyham Lane. The religious books and other artefacts were all appropriately stored. In most of the cells, there were signs depicting the direction for prayers for those following Islam. During booking-in, we saw custody officers asking detainees if they had any religious observance and/or dietary requirements.

3.19 At all of the suites, there were support arrangements for detainees with sight or hearing impairments, including rights and entitlements in Braille, hearing loops to help detainees with limited hearing, and printed versions of rights and entitlements documents to assist those with dyslexia. There were a few versions of the easy-read format of rights and entitlements information but these were only available at Keyham Lane, and there were no sign language DVDs at any of the custody suites. However, we saw a sign language interpreter attending a custody suite for one detainee.

3.20 Custody officers were able to access up-to-date rights and entitlements documents in numerous languages, through the relevant website.

3.21 The force had contracted interpreting services through two separate providers – a telephone and an in-person service. At Euston Street, two-way handsets were used for

telephone interpreting but at the other two suites we saw speakerphones being used, which sometimes compromised the privacy of detainees. The in-person interpreters attended when detainees were interviewed. Custody officers told us that both of the services were easy to use and generally worked well, with no notable or recurring issues.

3.22 Custody staff had a good understanding of their responsibility to inform foreign national detainees' home nation embassy or consulate of the detainee's arrest, where required or requested, and could contact them without difficulty.

Area for improvement

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

- **ensuring that there is suitable provision for detainees with disabilities, including extra thick mattresses and access to an adapted toilet, at all suites;**
- **ensuring that wheelchairs and other walking aids are available at all the custody suites;**
- **ensuring that detainees are asked to self-define their ethnicity when being booked into custody, and that it is accurately recorded;**
- **ensuring that a female member of staff is readily available when allocated as a single point of contact for female detainees, and carries out the role effectively;**
- **ensuring that there is a consistent supply of religious books at all custody suites;**
- **ensuring that individual rights and entitlements information is available in DVD format (sign language), with suitable playback equipment, to help those with hearing impairments, and in easy-read format for children or those who find reading difficult, at all the custody suites;**
- **ensuring that two-way handsets are available, to enable interpreting services to provide confidentiality, for detainees at Keyham Lane and Beaumont Leys custody suites.**

Risk assessments

3.24 The approach to identifying risks was generally good but there were some weaknesses in their ongoing management.

3.25 On arrival, most detainees were booked in quickly. They did not wait in vehicles outside the custody site but some experienced long waits in holding rooms, sometimes because of local booking-in practices (see paragraph 3.35). There was little management of queues to manage risks or to prioritise children or vulnerable detainees for booking-in.

3.26 Custody officers focused appropriately on the welfare of detainees, and identifying risks and vulnerability factors. They interacted positively with detainees to complete the risk assessment template, responded patiently to individual need, and asked relevant

Area for improvement

4.25 The force should improve its care for detainees by:

- **increasing the range of reading material available, especially for children and those whose first language is not English, and offering this routinely;**
- **increasing detainees' access to showers and exercise, particularly when they are held overnight or for extended periods.**

Safeguarding

4.26 The officers we spoke to had a good understanding of how to identify vulnerability and safeguarding concerns, and their responsibilities in addressing these. They received training on safeguarding children and vulnerable adults; this included training in the role of the custody officer in identifying concerns and raising these with investigating officers so that they could be dealt with.

4.27 Arresting and investigating officers were responsible for making safeguarding referrals to the force's specialist team and telling custody officers of any risks or concerns that might affect the detainee's care in custody or on release. We saw some good examples of officers providing this type of information, with custody officers directing any necessary further action. Custody officers could also find more details by looking at the referral forms and other information held on the custody computer system. However, safeguarding information, and any action taken, was not always recorded on custody records – including how vulnerable adults and children would get home when released from custody (see paragraph 1.12 and area for concern 1.19).

4.28 In general, children and vulnerable adults received prompt support from appropriate adults (AAs). Custody officers requested AAs early on in detention, although would delay requests if a detainee was under the influence of alcohol or drugs, or it was in their best interests to have a period of sleep. AAs were expected to attend as early as practicable, to help detainees understand their rights and entitlements while in custody, and then to remain or return for all other aspects of custody processing when their presence was required.

4.29 Family members or carers were sought as AAs in the first instance, and arresting officers sometimes asked them to attend at the time of the arrest. When they were not able to attend, or it was not appropriate for them to act as AA – for example, if they had been a witness to the incident – AAs for vulnerable adults were obtained through The Appropriate Adult Service (TAAS), and for children through the Youth Offending Service (YOS) during the day and TAAS at night. AAs from TAAS arrived promptly, in line with contractual arrangements, but custody officers told us that the service from YOS was less responsive and not as reliable, sometimes leading to children having long waits before receiving support from an AA.

4.30 The force did not monitor how long children or vulnerable adults waited before receiving support from an AA, and request times were not always recorded on the custody record. AA provision was included in discussions with partners about children in custody, and was also considered as part of the quarterly audits (see paragraph 1.13) carried out on a sample of cases, which provided some insight into how the AA arrangements worked in practice. In most of the cases we looked at and observed, children and vulnerable adults had both received early support.

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 Since the previous inspection, there had been an improved focus on ensuring that detainees were released safely. Custody officers engaged well with detainees to complete pre-release risk assessments (PRRAs), and made appropriate use of initial risk assessments and care plans to ensure that all identified risks had been addressed or managed before release. Particular attention was given to managing the safe release of children and vulnerable detainees. When necessary, relevant agencies, such as HCPs, were often involved to support the release of the detainee. However, in our observations, PRRA templates were generally completed after detainees had been released and often did not fully reflect what we had seen. In our case audits and review of PRRAs, we also found that records lacked detail. For example, release arrangements had not been recorded routinely and did not always demonstrate how a detainee planned to travel home after release (see also paragraph 4.27).

5.2 Detainees without the means to travel home following release could be given travel warrants for trains and petty cash for bus journeys, both of which were easily accessible to custody officers. When these options were not appropriate – for example, if detainees were deemed to be vulnerable, or during the night when public transport was not available – custody officers told us that they would ask police officers to take detainees home. However, officers were not always available, owing to other operational commitments, so this arrangement could not be relied on.

5.3 On release, most detainees were given a support leaflet with useful telephone numbers, but this was only available in English.

5.4 Enhanced safeguarding arrangements were in place for individuals arrested under suspicion of committing some higher-risk offences, and were the responsibility of the investigating officers dealing with them, but not all custody officers knew whether, or satisfied themselves that, this happened before release.

5.5 Person escort records (PERs) were well completed and contained accurate and relevant information. However, we saw PERs with medical information in unsealed envelopes, which did not ensure confidentiality. Moreover, additional loose-leaf documentation, such as charge sheets, continued to be inserted into some PERS, despite our previous recommendation against doing this.

Area for improvement

5.6 The force should ensure that medical information for person escort records is kept confidentially, and stop the practice of inserting loose-leaf documentation.

Courts

5.7 Detainees who were required and ready to appear in court after being held overnight were processed in a timely manner and were not held in police custody for longer than necessary. However, those arrested on warrant during the day had to be brought to the police custody suites as the local remand court, Leicester Magistrates' Court, would not accept them directly.

5.8 Custody staff told us that the court would not accept additional detainees, after the initial collection, after 2pm but they were often refused much earlier. While we saw some detainees being accepted by the court before 2pm, we saw several (and were told about more) who were refused, including sometimes very early in the day. This resulted in them not being presented before the first available court and therefore remaining in police custody for longer than necessary. This was a similar position to that found during the previous inspection.

Area for improvement

5.9 **Senior police managers should work with the HM Courts and Tribunals Service, so that detainees are presented to the first available court and do not spend longer than necessary in police custody.** (Repeated recommendation 5.23)

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

Causes of concern and recommendations

6.1 Cause of concern: The force did not consistently meet the requirements of PACE codes C and G 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. (S36)

6.2 Cause of concern: The governance and oversight of the use of force were limited. Not all incidents involving the use of force in custody had been recorded, making the data unreliable and preventing effective scrutiny. Although the force reviewed some cases to assess how incidents were dealt with, the effectiveness of this was also limited by the unreliable data. Not all staff followed National Police Chiefs Council guidance in completing individual use of force forms.

Recommendation: The force should assure itself and others that when force is used in custody, it is safe and proportionate. It should:

- **ensure that all use of force incidents are properly recorded on the custody record, so that there is comprehensive, reliable and accurate data to inform the governance arrangements;**
- **strengthen the review of individual incidents by ensuring that there is an accurate pool of cases from which to draw these, and that closed-circuit television is readily available for viewing them;**
- **ensure that all officers complete use of force forms for any incident they are involved in.** (S37)

Areas for improvement

Leadership, accountability and partnerships

6.3 The force should ensure that custody staff are deployed in the most effective way, to improve outcomes for detainees and prevent them from remaining in custody for longer than necessary. There should be sufficient oversight of staffing levels by senior officers, to ensure that the suites are managed effectively. (1.9)

6.4 The force should ensure that all custody staff consistently follow the College of Policing *Authorised Professional Practice – Detention and Custody*, and the East Midlands Criminal Justice Services' own guidance, so that detainees receive the appropriate treatment and care. (1.10)

6.5 The force should strengthen its approach to performance management by addressing the gaps in its performance information and ensuring that all its data is reliable. (1.18)

6.6 The force should improve the quality of its custody records by ensuring that all necessary information is fully recorded, including the rationale and justification for any decisions made. (1.19)

6.7 The force should strengthen its approach to the quality assurance of custody services by having its own structured dip-sampling arrangements, to help identify where improvements are needed. (1.20)

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

6.8 The force should improve its approach to detainee dignity and privacy by:

- having arrangements to allow private or sensitive information to be disclosed in a confidential environment;
- ensuring that all detainees are routinely asked if they wish to speak to a member of staff in confidence, to discuss any personal or confidential issues, as required by PACE code C3.5(c);
- ensuring that personal information (detention summary sheets) is appropriately stored, to maintain detainee confidentiality;
- ensuring that all detainees are told that closed-circuit television (CCTV) recording and monitoring are taking place, with toilets obscured from view, and clearly displaying notices in all the cells and corridors;
- ensuring that detainees can shower in sufficient privacy at all custody suites;
- providing replacement footwear for detainees to use in cells;
- ensuring that clothing and footwear removed from detainees is stored appropriately. (3.12)

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

- ensuring that there is suitable provision for detainees with disabilities, including extra thick mattresses and access to an adapted toilet, at all suites;
- ensuring that wheelchairs and other walking aids are available at all the custody suites;
- ensuring that detainees are asked to self-define their ethnicity when being booked into custody, and that it is accurately recorded;
- ensuring that a female member of staff is readily available when allocated as a single point of contact for female detainees, and carries out the role effectively;
- ensuring that there is a consistent supply of religious books at all custody suites;
- ensuring that individual rights and entitlements information is available in DVD format (sign language), with suitable playback equipment, to help those with hearing impairments, and in easy-read format for children or those who find reading difficult, at all the custody suites;

- ensuring that two-way handsets are available, to enable interpreting services to provide confidentiality, for detainees at Keyham Lane and Beaumont Leys custody suites. (3.23)

6.10 The approach to managing some elements of risk should be improved. In particular:

- All detainees should be placed on appropriate observation levels, including those under the influence of alcohol and/or drugs, who should be placed on observation levels that include rousals;
- Detainees' clothing and footwear should only be removed on the basis of an individual risk assessment;
- Officers conducting CCTV or close proximity observations of detainees should be appropriately briefed;
- There should be effective control over the management of custody keys;
- All custody staff should be involved collectively in shift handovers. (3.33)

6.11 The force should ensure that detainees have access to swift justice by monitoring cases effectively and giving officers enough time to complete outstanding enquiries. (3.55)

6.12 The force should strengthen its approach to dealing with complaints from detainees by promoting the complaints procedure, so that detainees know how to make complaints while in custody. (3.58)

In the custody cell, safeguarding and health care

6.13 The temperature in the suites and cells should be regulated appropriately. (4.8)

6.14 All cell benches should be of an adequate height. (4.9)

6.15 The force should ensure that all legal requirements concerning fire safety are adhered to. (4.10)

6.16 The force should improve its care for detainees by:

- increasing the range of reading material available, especially for children and those whose first language is not English, and offering this routinely;
- increasing detainees' access to showers and exercise, particularly when they are held overnight or for extended periods. (4.25)

6.17 The force should continue to work with local authority partners to avoid the overnight detention of children in custody, by transferring them to suitable alternative accommodation. (4.39)

6.18 On an individual assessed basis, nicotine replacement should be offered to smokers. (4.45, repeated recommendation 6.16)

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* (available on our website at: www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/police-custody-expectations-2/).

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 (95% confidence interval with a sampling error of 7%). 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. 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.

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

Observations in custody suites

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

Interviews with key staff

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

Focus groups

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

Feedback to force

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

Appendix III: Inspection team

Kellie Reeve	HMI Prisons team leader
Fiona Shearlaw	HMI Prisons inspector
Norma Collicott	HMI Constabulary and Fire & Rescue Services inspection lead
Patricia Nixon	HMI Constabulary and Fire & Rescue Services inspection officer
Marc Callaghan	HMI Constabulary and Fire & Rescue Services inspection officer
Vijay Singh	HMI Constabulary and Fire & Rescue Services inspection officer
Steve Eley	HMI Prisons health and social care inspector
Kathleen Byrne	Care Quality Commission inspector
Joe Simmonds	HMI Prisons researcher
Helen Ranns	HMI Prisons researcher