Report on an unannounced inspection visit to police custody suites of the

British Transport Police

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

6 – 16 January 2020

Any enquiries regarding this publication should be sent to HM Inspectorate of Prisons at 3rd floor, 10 South Colonnade, Canary Wharf, London, E14 4PU, or hmiprisons.enquiries@hmiprisons.gsi.gov.uk, or
HM Inspectorate of Constabulary and Fire & Rescue Services at 6th Floor, Globe House, 89 Eccleston Square, London SW1V 1PN, or contact@hmic.gsi.gov.uk

This publication is available for download at: http://www.justiceinspectorates.gov.uk/hmiprisons/ or http://www.justiceinspectorates.gov.uk/hmicfrs/

Printed and published by:
Her Majesty's Inspectorate of Prisons
Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services

Contents

Glossary of terms

We try to make our reports as clear as possible, and this short glossary should help to explain some of the specialist terms you may find. If need an explanation of any other terms, please see the longer glossary in our 'Guide for writing inspection reports', available on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

Appropriate adults
Independent individuals who provide support to children and vulnerable adults in custody.

Concordat on Children in Custody
Guidance for police forces and local authorities in England on their responsibilities towards children in custody.

Independent custody visitors
Members of the local community who volunteer to visit police stations unannounced to check on the treatment and welfare of people held in custody.

IS91
An IS91 warrant of detention is served on an immigration detainee when there is no reasonable alternative course of action, e.g. if there is a likelihood they may abscond; their removal from the UK is imminent, etc.

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

PACE Code C Annex M
PACE Code C Annex M details the documents considered essential for the creation and provision of written translations.

Section 2 Mental Health Act
Section 2 Mental Health Act 1983 allows for a person to be admitted to hospital and detained there for a period if assessed they are suffering from a mental disorder and they ought to be detained in the interests of their own health and safety or to protect other persons.

Section 136 Mental Health Act
Section 136 of the Mental Health Act 1983 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.

Fact page

Note: Data supplied by the force.

Force
British Transport Police

Chief Constable
Paul Crowther

Police Authority
British Transport Police Authority

Geographical area
England, Scotland and Wales

Date of last police custody inspection
17 – 20 March 2014

Custody suites	**Cell capacity**
Brewery Road	20 cells

Contingency suites	
Central London	10 cells
Hammersmith	5 cells
Wembley	4 cells
West Ham	4 cells

Annual custody throughput
3,300 detainees in 2019

Custody staffing
1 inspector
12 custody officers
15.5 designated detention officers

Health service provider
Mitie

Executive summary

S1 This report describes the findings following an inspection of British Transport 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 January 2020, 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 British Transport Police (BTP) had one operational custody suite in London at Brewery Road, where detainees arrested in the vicinity were taken, with four contingency suites available if needed. Detainees arrested elsewhere across the country were taken to police custody suites in other force areas.

S4 We last inspected custody facilities in British Transport Police in 2014. This inspection found that of the 21 recommendations made during that previous inspection, 11 had been achieved, three had been partially achieved and six had not been achieved. One recommendation was no longer relevant.

S5 To aid improvement we have made four recommendations to the force (and the British Transport Police Authority) addressing key causes of concern and have highlighted an additional 17 areas for improvement. These are set out in Section 6.

Leadership, accountability and partnerships

S6 British Transport Police had a clear governance structure which provided appropriate accountability for its custody services and facilities. The force was open to external scrutiny and had made good progress against the recommendations made in our last report. We were confident that they would use this inspection to make further improvements. The force had developed a comprehensive action log to improve services which was monitored closely.

S7 However, we did identify areas of concern, some of which had also been present at our previous inspection.

S8 The staffing of custody suites was not satisfactory. There were not always enough custody staff on duty and there was a heavy reliance on overtime to provide adequate staffing levels in the suite. This resulted in less experienced officers delivering custody services and the officer gaolers acting as detention officers had not been well enough trained for the role and were unable to carry out the full range of duties. This did not ensure safe detention and led to inconsistent outcomes for detainees.

S9 The initial training for custody officers and designated detention officers (DDOs) was good, and there had been some additional training on different topics. Continuing professional development training had been inconsistent but the force had recognised this and was introducing changes to improve it.

S10 The force followed *Authorised Professional Practice – Detention and Custody* as set by the College of Policing (https://www.app.college.police.uk/app-content/detention-and-custody-2), and had its own local custody policies to provide staff with additional guidance. However, some of the practices that we observed did not follow either of these policies.

S11 The force had a limited approach to managing performance which was hindered by a lack of information and unreliable data. This prevented them from monitoring key aspects of their service provision effectively.

S12 The quality of records in detention logs was not always good enough and often lacked sufficient detail, particularly on the justification and rationale for some decisions such as use of force and strip searching. There was a quality assurance process for dip sampling custody records and identifying the improvements needed, but this had not yet resulted in consistently good records.

S13 The force was not consistently meeting the requirements of code C of the Police and Criminal Evidence Act 1984 (PACE) codes of practice for the detention, treatment and questioning of persons, particularly for reviews of detention.

S14 Governance and oversight of the use of force in custody were not good enough. Data on the use of force in custody were not reliable, and not all officers completed use of force forms as required. This meant that British Transport Police could not assure itself, the British Transport Police Authority and the public that the use of force in custody was always safe and proportionate.

S15 It was not clear how the force was meeting the public sector equality duty, particularly concerning the use of data to ensure that outcomes for all detainees were fair and equitable.

S16 There was a clear strategic priority to divert children and vulnerable people from custody, which was well understood by staff. Although the force engaged with partners, improvements in outcomes for children and individuals with mental ill health were limited. Few children were moved to local authority accommodation when they should have been. Some detainees requiring mental health assessments waited too long.

Pre-custody: first point of contact

S17 Frontline officers had a good understanding of vulnerability and this was clearly taken account of when deciding if arrest was the most appropriate course of action. Incidents were reported to BTP in a variety of ways and sometimes information received before arriving at an incident was limited. However, officers told us they generally received good information from the call centre and that they had access to good information on their hand-held devices.

S18 Frontline officers only took children to custody as a last resort after exploring all other alternatives.

S19 The pan-London mental health team telephone advice line provided good support to help officers decide whether an individual should be detained under Section 136 of the Mental Health Act or whether alternative solutions were available. However, once detained officers reported long waits with detainees, often in unsuitable environments, before they could attend a health based place of safety for the detainee to be assessed.

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

S20 Custody staff engaged respectfully and courteously with detainees, and the detainees we spoke to said they had been treated well. Good attention was paid to maintaining detainees' privacy and dignity. However, conversations could easily be overheard during booking in, and detainees were not routinely advised that CCTV was recording, including in cells, or that the toilets in their cells were obscured from the direct sight of staff.

S21 The force was generally good at meeting the individual and diverse needs of detainees. Custody staff were competent to meet the needs of female and transgender detainees, those

with disabilities or those observing a faith. There were, however, some delays in interpreters attending for those who spoke little or no English.

S22 The approach to the identification of risk was good but there were some weaknesses in the management of risks. If more than one detainee was waiting to be booked in, there was no triage to identify or prioritise risks. However, the initial risk assessment was thorough. Observation levels usually reflected the risks posed and were generally carried out at the required frequency, but some were not set at the appropriate level including for detainees who were under the influence of drugs and/or alcohol. When rousing checks were set, they were not always conducted appropriately.

S23 Clothes with cords, footwear and jewellery were routinely removed from detainees, which was disproportionate, particularly for those deemed as low risk. Anti-rip clothing was not often used, but when it was the rationale was not always clear. On occasions it appeared to be being used to mitigate risks that could have been better managed with higher levels of observation. All custody staff carried anti-ligature knives and cell call bells were usually answered promptly, which was positive, but the control of cell keys was poor. Handovers were appropriately focused but did not always include all relevant staff and were not recorded on CCTV. Custody officers visited and engaged with detainees following shift changes.

S24 The force met detainees' legal rights in custody well. Arresting officers explained the grounds and necessity for arrest clearly before detention was authorised. There was appropriate oversight by a custody officer when DDOs were booking in. Detainees were advised of their rights and entitlements in custody. Some cases were dealt with quickly and average detention times were similar to other forces inspected recently. However, we found delays in progressing some cases, primarily because investigating officers were not available and interpreters attended late or not at all.

S25 We observed some reviews of detention that were conducted very well and in the best interests of the detainee, with a good focus on welfare. However, the overall approach to PACE reviews was not good enough. We found a number of weaknesses including early reviews and reviews not conducted in person. Records were poor, particularly on the necessity for a telephone review, where detainees, including children, were not spoken to on many occasions. Detainees were often not reminded of their ongoing rights in custody or that a review had taken place.

S26 The approach to ensuring that detainees accessed swift justice was good and there was appropriate oversight of bail procedures and detainees released under investigation. The promotion of complaints procedures was adequate, but we were not satisfied that complaints were always logged or dealt with while the detainee was in custody.

In the custody cell, safeguarding and health

S27 The conditions in the Brewery Road suite were reasonably good but cleaning arrangements were unsatisfactory. CCTV coverage was limited, some repairs took a long time to address and some areas were cold. We identified a number of potential ligature points in both custody suites, predominantly arising from the design of the toilets and cell doors. When we alerted the force, they responded positively. Custody staff had reasonable knowledge of fire evacuation procedures which had been practised during the year before the inspection.

S28 We saw good examples of staff using de-escalation techniques to mitigate and minimise the use of force on detainees. When force was used, it was generally necessary and proportionate but in some cases that we reviewed some of the techniques used were concerning and the management of situations appeared to lack control. The number of strip searches, including of children, was high compared with other recently inspected forces. The rationale and authorisation for strip searches was not always fully documented to demonstrate that they were justified.

S29 Staff showed a caring approach to detainees and all detainees we spoke to said they had been looked after well. Food and drinks were offered regularly to meet a range of needs. Although some detainees were able to use the exercise yard, some had showers or used the washing facilities or were given reading materials, these were not offered consistently, even to those held overnight or for extended periods in custody.

S30 Custody officers showed a good understanding of how to recognise safeguarding concerns for children and vulnerable adults but custody records did not always indicate how concerns had been addressed. There was also little oversight of referrals made by other officers.

S31 Requests for appropriate adults (AAs) for children were made promptly and in most cases AAs arrived without undue delay. They provided early support and remained or returned for all stages of custody processing. AA provision for vulnerable adults was better than we have seen in many other forces and custody officers made confident decisions on whether a vulnerable adult required an AA. However, in some cases an AA had not been considered when information suggested one might be needed, and AAs for vulnerable adults were not always secured early in detention.

S32 Children were only brought to custody as a last resort and were cared for well during their stay. There was a strong focus on ensuring that their cases were dealt with quickly and avoiding overnight detention where possible. Recent engagement with local partners was not yet embedded and, while few children were charged and refused bail, they were rarely moved to alternative accommodation provided by the local authority as required.

S33 Health care had improved since our last inspection and health care professionals now worked 24 hours a day in the suite. Detainees were usually seen promptly. An appropriate range of medicines and treatments were available including opiate substitution and nicotine replacement therapies. Detainees told us they were satisfied with the care they had received.

S34 Mental health nurses were on site for about 12 hours each day and operated an open referral system which usually enabled detainees to be seen quickly. During the previous 12 months, no individuals had been arrested and detained and taken to custody as a place of safety under Section 136 of the Mental Health Act. However, some detainees in custody waited too long for Mental Health Act assessments and too long for a transfer to hospital if needed. This was not a good outcome for them and the force had occasionally used Section 136 powers to move mentally unwell people from custody to a health based place of safety.

Release and transfer from custody

S35 The focus on ensuring that detainees were released safely had improved. Pre-release risks were assessed well, although not always recorded well. Children and vulnerable detainees were supported to get home safely, including those without the means to do so. Information on support agencies was generally offered. There was limited support for detainees who identified as being homeless.

S36 Arrangements for ensuring that detainees could attend court promptly had improved since the previous inspection, minimising detention times where possible.

Causes of concern and recommendations

S37 Cause of concern: The staffing arrangements for the custody suite were not robust enough to ensure safe detention. Officers on overtime from outside custody were used which meant the suite was sometimes staffed by less experienced staff who were not well enough supported. Training for officer gaolers had not prepared them fully for the role. This led to inconsistent outcomes for detainees.

Recommendation:
The force should ensure that there are sufficient and adequately trained officers on duty in the custody suite to deliver safe detention and meet the needs of detainees in a consistent way.

S38 Cause of concern: The approach of the force to monitoring and managing performance was limited. There were gaps in the data collected for some areas, some data were unreliable and the quality of custody records was not always good enough.

Recommendation:
The force should collect comprehensive information across the range of custody services and use this to manage performance effectively. The quality of custody records should be improved, and quality assurance should ensure that they meet the required standard.

S39 Cause of concern: Governance and oversight of the use of force were not good enough. Data on use of force incidents were not comprehensive or reliable, and not all officers involved in incidents completed use of force forms, as required. Governance arrangements had recently been established but concerns about the reliability of the data limited the effectiveness of any oversight.

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 officers complete use of force forms for any incident they are involved in;**
- **collect and monitor comprehensive and reliable data to underpin the recently introduced governance arrangements.**

S40 Cause of concern: The force did not consistently meet the requirements of PACE code C 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.

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* (www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/police-custody-expectations-2/). These standards are underpinned by international human rights standards and are developed by the two inspectorates, widely consulted on across the sector and regularly reviewed to achieve best custodial practice and drive improvement.

The *Expectations* are grouped under five inspection areas:

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

The inspections also assess compliance with the Police and Criminal Evidence Act 1984 (PACE) codes of practice and the College of Policing's *Authorised Professional Practice - Detention and Custody* (https://www.app.college.police.uk/app-content/detention-and-custody-2/).

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 British Transport Police we analysed a sample of 68 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

Context for British Transport Police

British Transport Police (BTP) police Britain's railways. The force also polices the London Underground, Docklands Light Railway, the Midland Metro tram system, Croydon Tramlink, Tyne and Wear Metro, Glasgow Subway and Emirates airline.

BTP is different from other police forces in that it falls under the remit of the Secretary of State for Transport, and not the Home Secretary (as for forces in England and Wales) or the Cabinet Secretary for Justice (for those in Scotland), and is funded almost entirely by the rail transport industry through police service agreements with the British Transport Police Authority.

The force does not have a resident population. It provides a service across the country to passengers, rail operators and their staff and others who work on or near the railway. It deals with incidents on the railways and their immediate surrounds.

BTP has one operational custody suite in London at Brewery Road N7 and four contingency suites which are available for use, of which only one has been used in the last year. Individuals who are arrested within the area this covers are taken there – for example from Kings Cross, St Pancras and Euston stations. There are arrangements for individuals arrested outside this area to be taken to the nearest custody suite in the local police force area.

The context in which BTP works is different in some ways from other forces we inspect. The custody suite at Brewery Road deals with more detainees from different parts of the country than we would expect to find when we visit other forces' custody suites. This has implications for ensuring the safe release of detainees back to their home address and for engaging with local authorities in whose area detainees live if safeguarding or other concerns require addressing. The force also deals with individuals who are on the rail network with the intent of self-harm or suicide.

This inspection was only concerned with assessing outcomes for detainees held at Brewery Road. BTP detainees held at other custody suites across the country are included as part of their host force inspections.

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 The British Transport Police had a clear structure for the governance of custody. Under the direction of an assistant chief constable, a superintendent was responsible for the delivery of custody, supported by a chief inspector who had operational oversight of the suite. This structure provided clear accountability for safe detention.

1.2 Oversight of custody was undertaken by the force Audit, Risk, Inspection and Compliance Board, chaired by the deputy chief constable, and at monthly meetings chaired by the superintendent. Regular custody meetings were held which focused on discussing operational issues. The force had made good progress against the recommendations made following our last inspection and were keen to improve. Improvements were identified through an 'action tracker log' which was regularly monitored and updated.

1.3 The force had one full-time custody suite at Brewery Road in North London and individuals arrested in the vicinity were taken there. Outside this there were arrangements for detainees to be held in facilities in the 43 Home Office Police force areas across England and Wales.

1.4 However, those arrested in London but further away from the BTP suite could be taken to the custody suite nearest to the arrest point, either the Metropolitan Police Service or the City of London Police facilities. However, some detainees spent a long time travelling to the Brewery Road suite when the facility of another force could have been a closer and more appropriate option. The custody record did not indicate clearly why bringing the detainee to Brewery Road was the best course of action. There was no clear guidance to help officers decide where to take detainees arrested in London, and to show that decisions made were in the detainee's best interest.

1.5 The force relied heavily on overtime to meet required staff levels in the suite. Since our last inspection, the force had reviewed its staffing in custody. Based on demand, the number of inspectors had been reduced from three to one, custody officers from 16 to 12 and designated detention officers (DDOs) from 34 to 15.5. There was a policy which set minimum resource levels for each shift but we were told, and on several occasions observed, that this did not always allow for enough staff on duty. Some actions were not carried out as promptly or consistently as required, including observation visits to detainees and inspection of cells and other parts of the suite (see paragraph 3.27).

1.6 This reliance on overtime resulted in the custody officer role sometimes being fulfilled by officers from other operational areas of the force who had less experience of custody. Police officers also carried out the role of officer gaoler when there were not enough DDOs. These officers could not perform all the duties of a DDO and had not received sufficient training to carry out the role effectively.

1.7 Overall, the staffing arrangements were not satisfactory and did not ensure safe detention. They posed a risk to detainees and the force and led to inconsistent outcomes for detainees. This position had not improved since the last inspection (see cause of concern S37

1.8 Initial training for custody officers and DDOs was good and they received an accredited three-week and two-week in-house training course respectively. Newly trained custody officers should have shadowed more experienced staff before taking up their duties, but many told us that a lack of resources often prevented this.

1.9 The force had recognised that operational commitments had affected ongoing continuing professional development for custody staff, and an imminent change in shift patterns was intended to improve this. A recent two-day refresher event on mental health, autism and county lines had been well received by staff.

1.10 The force followed *Authorised Professional Practice (APP)* for custody as set by the College of Policing, together with additional custody guidance where local practices differed. Not all the practices that we observed, however, followed either guidance, for example in relation to some aspects of detainee care.

1.11 Adverse incidents were reported effectively and lessons learned were captured and shared with staff. There had been no deaths in custody in the past six years.

1.12 Oversight of the health contract was sound and the service had improved since our previous inspection.

Area for improvement

1.13 **The force should ensure that all custody staff consistently follow the College of Policing *Authorised Professional Practice – Detention and Custody* and its own local guidance so that detainees receive the appropriate treatment and care.**

Accountability

1.14 The management by the force of the performance of its custody services was hindered by a lack of information and the reliability of some data. There were gaps in the data on custody services collected by the force, for example they were unable to produce data on individuals who attended the station voluntarily rather than under arrest, or easily identify the time taken to transfer immigration detainees to an immigration removal centre after the service of an IS91 warrant (see Glossary of terms) (see paragraph 3.38). Information on mental health detentions and assessments and on children held overnight after charge was also difficult to obtain. Data on the use of force and restraint in custody were unreliable, and it was not always clear whether force had been used on a detainee (see paragraph 4.9

1.15 The superintendent monitored custody performance at a monthly custody meeting (see paragraph 1.2). This included information on waiting and overall detention times, and how well the interpreting service was performing. However, the lack of comprehensive and accurate data prevented effective monitoring of the delivery of key aspects of custody services (see cause of concern S38).

1.16 Mechanisms were not robust enough for the force to assure itself, the British Transport Police Authority and the public that the use of force in detention and custody was always safe and proportionate. Data on incidents in custody suites were unreliable, and there was not enough detail in detention logs to justify why force or restraint had been used in many

cases. Not all officers were completing use of force forms as required by the National Police Chiefs Council. The force had recently implemented a governance and oversight process, which included viewing some incidents on CCTV, to monitor whether all force and restraint used was justified and proportionate. However, it was too early to determine the impact of this process which would in any case be limited until concerns about the reliability of data were addressed (see cause of concern S38 and paragraph 4.9

1.17 The quality of records in detention logs was not good enough and did not always reflect some of the good practice we observed. Some important decisions such as the justification and rationale for the use of restraint or force, strip searches and the removal of clothing were not recorded properly and sometimes not at all (see paragraphs 3.27 and 4.9). There was a quality assurance process for quarterly reviews of custody which included dip sampling of records. This was identifying concerns, including many that we had noted, which were then captured on the comprehensive action tracker and monitored monthly.

1.18 Not all practices that we observed followed the requirements of Code C of the Police and Criminal Evidence Act 1984 (PACE) for the detention, treatment and questioning of persons, in particular the conduct of inspectors' reviews of detention, which in many cases were not good enough (see cause of concern S40 and paragraph 3.46).

1.19 It was not clear how the force was meeting the public sector equality duty. Staff were aware of and tried to meet the individual needs of detainees and some training in the Equality Act 2010 had been carried out. Data on gender and ethnicity were monitored but it was unclear how this was used to ensure that outcomes for all detainees were fair and equitable.

1.20 The force was receptive to feedback and gave good access to external scrutiny to assess and improve its service. For example, it had invited the National Appropriate Adult Network to assess its service provision for appropriate adults (AAs) (see Glossary of terms) and sought peer reviews from other forces.

1.21 There was an active independent custody visitors' (ICVs) scheme (see Glossary of terms), although it was not always clear if issues raised by ICVs were responded to in a timely manner.

Area for improvement

1.22 The force should improve the quality of its custody records and ensure that the reasons or justification for decisions are fully captured.

Partnerships

1.23 The force had a clear priority to divert vulnerable detainees away from custody and staff understood this. Some of the detainees taken to Brewery Road custody suite did not live in the local area which made engagement with partner agencies, especially local authorities, more challenging. The Railway Children charity delivered a scheme to help prevent children from entering the criminal justice system and re-offending and to keep them out of custody. They offered support in the context of BTP's work on the railways (see paragraph 4.5

1.24 The force had only recently engaged in wider partnership arrangements to try and improve outcomes for children in custody in London. It had made arrangements with the local authority responsible for the area where Brewery Road is situated to try and improve access to services. However, at the time of the inspection, joint monitoring of children, particularly

those charged, refused bail and held overnight where the local authority has a statutory duty to provide alternative accommodation, had not started.

1.25 The strategic approach to working with partners to improve outcomes for detainees with mental ill health was limited. Although access to telephone advice had improved with the introduction of the pan-London telephone advice service to support officers on the street, detainees taken to custody waited too long for mental health assessments and too long to be moved, if needed, to a mental health bed in a health-based place of safety. In some cases, delays in obtaining mental health assessments led to officers using Section 136 Mental Health Act powers to move detainees out of custody (see Glossary of terms) (see paragraph 4.72 and area for improvement 4.73

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 The force had guidance on vulnerability and frontline officers had a good understanding of it. They gave examples of factors such as age, mental health and county lines drug dealing. All children were regarded as vulnerable because of their age. Officers clearly took account of vulnerability when deciding whether to arrest a person or find another solution to avoid custody.

2.2 However, officers told us that they did not feel well supported by training, particularly in the complexities of mental health. They said there was a reliance on e-learning and information on the force intranet, rather than training in the classroom. Some officers had attended road shows with external speakers which they felt had prepared them more effectively to deal with vulnerable individuals.

2.3 Frontline officers were called to deal with incidents from a variety of sources. This affected the degree of information they had about the incident and individuals involved, in advance of their attendance. Some incidents were reported by text from the public, or by railway staff by radio, which limited the information available. 999 and 101 calls were transferred from the Metropolitan Police Service call centre to the BTP call centre, creating an intrinsic delay. Officers said that their own call handlers generally provided good quality information, but they were not always able to conduct further enquiries or obtain intelligence because there were not always enough staff on duty. This was mitigated by accessing information from the force computer system on their mobile devices, and enabled them to have enough information to decide what to do.

2.4 The strategy of the force to keep children out of custody was well understood and implemented by frontline officers who received guidance on the options available to achieve this. Officers always tried to return the child home and involve the parents, and to deal with incidents by other means, for example community resolutions or voluntary interviews. They only took children to custody after all other alternatives had been explored, where the seriousness of the offence necessitated it, or where custody was the only means of keeping the child safe.

2.5 The initial support from mental health services to help frontline officers deal with individuals with mental ill health was good. The 24/7 pan-London helpline provided advice and support to help officers decide whether a person needed to be detained under Section 136 of the Mental Health Act 1983, or whether other arrangements could be made such as taking the individual home with an appointment to see a health professional the following day. There was a street triage service in some locations where a mental health professional and a police officer attended incidents to provide direct support and assistance. This service was particularly valued by officers.

2.6 When individuals were detained under Section 136, there were often long waits before a mental health bed was found in a place of safety. It was the responsibility of the mental health

helpline to arrange this, but in the interim officers often waited with detainees in unsuitable environments, such as police vehicles. Ambulances were requested to attend to transport the detainee to the health facility, but if they were not available, police cars were used instead. Officers took some detainees to hospital emergency departments and waited with them for an assessment.

2.7 Individuals who had committed an offence for which they needed to be arrested were taken to custody for any mental health needs to be addressed.

2.8 Detainees were transported to custody in police vans, and sometimes police cars depending on the risk posed. Arrangements were made for detainees who used wheelchairs, for example a taxi adapted for wheelchair use.

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 Custody staff engaged well with detainees and were respectful and courteous and showed empathy towards them. Detainees we spoke to said they had been treated well by custody staff.

3.2 The booking-in desks in the custody suite were at a suitable height to make interactions with detainees less intimidating, particularly for children or other vulnerable detainees. However, the design and structure of the suite limited privacy at the desks. Conversations between custody officers and detainees could easily be overheard which could inhibit detainees from disclosing personal or confidential information. Some detainees, but not all as required by the recent changes to PACE (Police and Criminal Evidence Act), were asked if they wished to speak to an officer in private.

3.3 A separate booking-in room allowed enough privacy for detainees to disclose private or sensitive information, and for conversations to take place in confidence between custody officers and detainees. This facility could also be used when charging or bailing detainees for sensitive offences. The room could be entered discreetly away from the main booking-in desks and was easily accessible for detainees with disabilities.

3.4 Personal or other information about detainees, or when they were visible on CCTV in their cells, could only be viewed by custody officers and staff and not by other people in the suite, which preserved the dignity of detainees. However, we observed two occasions when detainees had their clothes removed and were left in their boxer shorts.

3.5 There were no facilities in the suite to connect telephone calls to the cells, and detainees had to be brought to the booking-in desk areas to make or receive telephone calls, including those with their legal representatives. This compromised their privacy.

3.6 Notices were clearly displayed throughout the custody suite, including all the cells, advising detainees that CCTV recording was taking place. However, we observed that some detainees were not routinely informed that CCTV cameras were monitoring them, particularly when they were taken to their cells by police officers rather than designated detention officers.

3.7 Toilets in cells were obscured on CCTV coverage to protect the privacy and dignity of detainees, but they were not always told about this.

3.8 Detainees were not consistently provided with toilet paper. When it was issued detainees were only given a limited amount and had to request more if they needed it. This was undignified and contrary to APP guidance that the provision of toilet paper should be based

on individual risk assessment (see paragraph 1.10). We saw toilet paper kept on top of the doors to shower cubicles which was unhygienic.

3.9 The design of the shower doors at Brewery Road custody suite provided sufficient privacy for detainees using the showers.

3.10 Footwear was routinely removed from detainees, rather than following a risk assessment. However, they were given plimsolls or slippers which we saw detainees wearing in their cells and on some occasions when walking around the custody suite. This maintained their dignity and provided them with warmth and comfort.

Area for improvement

3.11 The force should improve its approach to the dignity and privacy of detainees by:

- **enabling detainees to speak on the telephone in private, especially to their legal representatives;**
- **informing all detainees that CCTV recording is taking place while they are in their cells and that toilets are obscured from sight;**
- **providing detainees who have had their clothing removed with suitable alternatives.**

Meeting diverse and individual needs

3.12 Overall the force met the individual and diverse needs of detainees well.

3.13 Custody staff had received training in understanding and managing the individual and diverse needs of people coming into custody. The training had included awareness of mental health issues, vulnerability and religious requirements. Custody staff described how they would respectfully address the needs of transgender detainees. However, they said that more classroom-based training would be preferable to e-learning and intranet bulletins.

3.14 Custody officers routinely asked detainees when booking them into custody if they had any religious observance and/or dietary requirements. Detainees were asked to define their ethnicity, but records of this were confusing.

3.15 The force recognised the requirements of a good range of faiths, including religious observance materials for detainees following Christianity, Islam, Hinduism, Judaism, Buddhism and Sikhism. Religious books were appropriately stored in accordance with the different faiths and separated to ensure that the correct items were provided. There were signs in some of the cells depicting the direction for prayers for Muslims.

3.16 The adapted cell at Brewery Lane had a lowered call bell, but it was located near the cell door rather than adjacent to the bed and not easy for someone with mobility difficulties to use. The toilet in the cell was suitable for wheelchair users and there was also an adapted toilet and shower in the medical room with rails to assist detainees with disabilities. At the time of the inspection, this was being used as a storage room for mobility aids.

3.17 Wheelchairs and walking aids were provided for those who needed them. Extra thick mattresses were available for detainees requiring additional lumbar support or extra height to help with mobility difficulties. The exercise yard was easily accessible by wheelchair users.

3.18 Arrangements for supporting detainees with sight or hearing impairments were good. There were sight lines in the cells and rights and entitlements were produced in Braille. There were

hearing loops to help detainees with limited hearing, although there were no sign language DVDs in the custody suite. The force had recently acquired copies of the easy-to-read rights and entitlements booklets for children or individuals who might have difficulty understanding written material.

3.19 There was a focus on meeting the needs of female detainees and notices were clearly displayed in the custody suite. During the booking-in process they were routinely asked if they wished to speak to a female member of staff on any gender-specific issues. However, on occasions no female custody staff were on duty, and a female officer needed to be assigned from elsewhere in the force. Female detainees were routinely offered menstrual care products, of which there was a well-stocked range including disposal bags.

3.20 Custody officers understood their responsibilities to contact embassies or consulates when foreign national detainees requested it and were able to do this without difficulty.

3.21 Telephone interpreting services were available through 'Big Word' using two-way handsets. However, we saw speakerphones being used instead, which compromised the privacy of detainees. Custody officers told us the service was easy to use and worked well when interpreting services were required over the telephone. However, there were sometimes considerable delays when interpreters were required to attend in person for interview purposes which could lead to detainees remaining in custody for longer than necessary (see paragraph 3.37). The force was monitoring the performance of the interpreting service and was aware that it was not meeting the required standards.

3.22 Custody officers were able to access recent rights and entitlements documents in numerous languages, through the relevant website.

Area for improvement

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

- **ensuring that individual rights and entitlements are available in DVD format (sign language) with suitable playback equipment, to assist those with hearing impairments;**
- **ensuring that detainees have timely access to interpreters.**

Risk assessments

3.24 The identification of risk was good but there were some weaknesses in the management of risks.

3.25 Most detainees were booked in promptly (see paragraph 3.34) but during busy periods some were made to wait too long in vehicles and the holding room before their detention was authorised. There was no evidence that detainees were triaged to identify children or vulnerable detainees quickly and prioritise them for booking in.

3.26 Custody officers and DDOs booking detainees into custody focused appropriately on their welfare and identifying risks and vulnerability. They interacted well with detainees to complete standardised risk assessments, responded to individual need and asked appropriate supplementary and probing questions. There was routine cross-referencing to police national

computer warning markers and other information held on the force computer system to inform risk assessments further.

3.27 Initial care plans did not always reflect observations at a level commensurate with presenting risk. In particular, we found a few instances where the observation levels set for detainees who were under the influence of alcohol and/or drugs did not include rousing checks (Level 2 according to the College of Policing *APP*), which posed significant risks. Observation levels were reviewed regularly but custody records did not always indicate sufficient justification for changes (see paragraph 1.5).

3.28 Most checks conducted on detainees were timely, but some were late. These checks were not always carried out by the same member of staff (against *APP* guidance), which could hinder the ready identification of changes in a detainee's behaviour or condition. Where rousing checks were needed for detainees under the influence of alcohol and/or drugs, staff did not always conduct these in accordance with Annex H of PACE Code C (see cause of concern S40).

3.29 Staff were confident and competent to manage the risk associated with suicide and self-harm and all custody staff carried anti-ligature knives which was positive. Most cell call bells were responded to promptly, but we observed a few delays which posed potential risks to detainees needing assistance. There was no call bell in the exercise yard and detainees were often locked in the yard and left unsupervised with no means of contacting custody staff. We raised this with the force who said that they now intended to supervise detainees.

3.30 The management and control of cell keys was poor and had not improved since our previous inspection. Oversight of non-custody staff with access to cell keys was not sufficient and we observed cell keys being routinely handed to them to collect and return detainees to their cells after interview. This diminished the control of the suite by custody staff.

3.31 Clothing with cords, footwear and jewellery were routinely removed from all detainees, with no individual risk assessment, which was a disproportionate response to managing risk, particularly for those considered as low risk. Anti-rip clothing was used infrequently, but records of its use were poor and, when it was used, the rationale was not always clear. On occasions it appeared to be being used to mitigate risks that could have been better managed with higher levels of observation. Most detainees remained on low-level observations even when considered a significant enough risk to have had their clothing removed.

3.32 The quality of staff shift handovers varied. There was an appropriate focus on risk and welfare, but we observed a few handovers where relevant information was not exchanged. Not all custody staff took part in handovers which were not conducted in an area covered by CCTV, contrary to *APP* guidance. Health care professionals were usually on duty but were not involved in the handovers, which was a missed opportunity (see paragraph 4.58). At the start of a new shift, we saw at least one custody officer visiting and engaging with the detainees in their care.

Area for improvement

3.33 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 including rousals;**
- **cell call bells should be answered promptly;**
- **non-custody staff should not have access to cell keys;**

- **detainees' clothing, footwear and jewellery should only be removed following an individual risk assessment;**
- **all custody staff should be involved in shift handovers and these should be recorded on CCTV.**

Individual legal rights

3.34 Waiting times varied between arrest and arrival at the custody suite and between arrival and the authorisation of detention and there were some long delays. We found several cases of delays in detainees arriving at the custody suite and waiting to be booked in, but the custody record did not indicate the reason for this. We observed many detainees who were taken straight to the booking-in desks, but others who waited between 40 minutes and more than an hour to be booked into custody. Some of these were held in vehicles. Frontline officers told us it was not unusual for them to wait a long time with detainees in the holding room or in vehicles with no interaction with custody staff to triage the waiting queue (see paragraph 3.25). Waiting times were monitored by the force and showed an average waiting time at Brewery Road during 2019 of 30 minutes for adults and 36 minutes for children. This was longer than in many forces that we have recently inspected.

3.35 Arresting officers gave a clear explanation to custody officers of the grounds and necessity for arrest in the presence of the detainee. Custody officers explained clearly to detainees the reasons for authorising their detention and these were noted on the custody record. Custody officers told us that they rarely refused detention but were confident to do so if the circumstances warranted it. They provided us with details of such cases. When DDOs booked detainees in, they were appropriately supervised by a custody officer.

3.36 Alternatives to custody included community resolutions (applies to the resolution of a less serious offence or antisocial behaviour incident involving an identified offender, through informal agreement between the parties rather than progression through the criminal justice process), conditional cautions (a conditional caution can be issued if the offender admits the offence and accepts the conditions being imposed; if the offender subsequently fails to comply with the conditions they can subsequently be prosecuted) and voluntary attendance (usually for lesser offences, where the suspects attend by appointment at a police station to be interviewed about alleged offences; this avoids the need for arrest and subsequent detention). The force was unable to provide data on the effectiveness of voluntary attendance because it was not monitored (see cause of concern S38 and paragraph 1.13). At Brewery Road, voluntary attendees had to pass through the main booking-in area to be interviewed in the custody suite interview rooms and we observed this when the suite was busy and two detainees were being booked in. The force had recognised that this was contrary to the ethos of the process to divert individuals from police custody and had taken steps to discourage the use of custody for voluntary attendance interviews.

3.37 Custody officers were appropriately focused on ensuring that detainees were released or transferred at the earliest opportunity and, in most cases, this happened. However, investigations were not always progressed in a timely manner which could be attributed to the late or non-attendance of interpreters (see paragraph 3.21) and the absence of investigating officers. This could extend a detainee's stay in police custody.

3.38 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 warrant of detention (see Glossary of terms) (see paragraph 1.14). The force was unable to supply data to support this. There had been a 35% decrease (47 cases) in the number of immigration detainees brought into custody over the previous three years.

3.39 Detainees were clearly advised of their three main rights while in custody during booking in (right to have someone informed of their arrest; right to consult a solicitor and access free independent legal advice and right to consult the PACE codes of practice). A written notice of a detainee's full rights and entitlements was routinely offered to all detainees by custody officers and DDOs, although they did not always accept it (see paragraph 3.54).

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

3.41 All detainees were offered free legal representation and, if they declined, were asked why they did not wish to use the service and their reasons recorded. Posters informing detainees of their right to free legal advice were not displayed in either of the custody suites which did not meet the requirements of paragraph 6.3 of PACE Code C (see cause of concern S40). There were sufficient interview/consultation rooms at both suites for detainees to consult their legal representatives in private. Detainees wishing to speak to legal representatives on the telephone at Brewery Road could not do so in private (paragraph 6.1 of PACE Code C – see cause of concern S40 and paragraph 3.5). Custody staff checked the identity of legal representatives who attended the suite and routinely gave them a summary print-out of the front sheet of their client's custody record.

3.42 We found only one copy of the current PACE codes of practice (see Glossary of terms) in the suite which was insufficient. The codes were not routinely explained or offered to detainees, as they should have been (paragraph 1.2 of PACE Code C – see cause of concern S40).

3.43 Staff knew where to access rights and entitlements in a range of languages (see paragraph 3.22), but not all custody officers were aware of the availability of PACE Code C Annex M (see Glossary of terms) translated documents (see cause of concern S40). We did, however, see a custody officer arrange for an interpreter to provide a written translation of a conditional caution for a detainee who was being released from custody.

3.44 There was a good process for the management and transportation of DNA samples and the freezer was secure, which protected the integrity of stored samples.

Area for improvement

3.45 The force should minimise delays in progressing investigations so that detainees spend no longer than necessary in custody.

PACE reviews

3.46 PACE reviews were undertaken by dedicated custody and operational duty inspectors across the force area. We observed some reviews that were clearly conducted in the best interests of detainees, with a good focus on welfare. However, overall, we identified many significant concerns in the way that PACE reviews were conducted (see cause of concern S40).

3.47 Many reviews were conducted on time but few were conducted with the detainee present. Our custody record analysis (CRA) showed that only 30% of first reviews (17 out of 57) were carried out face to face, which was poor. Some reviews were carried out too early. Our CRA showed that 23% of first reviews (13 out of 57) were carried out early and in one case a detainee was reviewed after only two hours 31 minutes in custody. Inspectors told us

they were under considerable pressure during their shift to balance the conduct of reviews with their other duties.

3.48 A third of first reviews had taken place while the detainee was asleep (18 out of 57) and not always in recognised rest periods. There was some evidence in detention logs that the detainee had been awake shortly before the review had taken place. In most cases where a sleeping review was conducted, detainees were not reminded at the earliest opportunity that a review had taken place. This did not meet the requirements of PACE Code C paragraph 15.7 (see cause of concern S40).

3.49 In 30% of cases (17 out of 57) first reviews were conducted over the telephone but in none of these cases had the inspector spoken to the detainee and it was not always clear if the detainee had been informed of the review. This did not meet the requirements of PACE Code C paragraph 15.10. When conducting a review over the telephone, inspectors did not routinely record their location and why they were unable to attend at the custody suite where the detainee was held. This did not meet the requirements of PACE Code C paragraph 15.14. In our case audits, we found an email from an inspector responsible for conducting two reviews of detention who merely advised the custody officer that the reviews had been completed. No information appeared on the custody record or the email which was particularly poor and did not meet the requirements of PACE Code C paragraph 15.9 (see cause of concern S40).

3.50 In our CRA, we found three cases where reviews of children had been conducted remotely over the telephone, but there was no evidence that the children had been spoken to by the inspector. Although not contrary to PACE, such practices fail to take into account the specific needs of children in custody.

3.51 Custody records of reviews were frequently poor and lacking in detail (see paragraph 1.4). The focus of the reviews appeared to be process driven rather than ensuring that continued detention of detainees was necessary and their welfare needs were met.

Access to swift justice

3.52 The approach to ensuring swift justice was good. When custody officers found insufficient evidence to charge detainees, good decisions were made to release them under investigation (RUI) or seek authorisation to bail them through the appropriate channels. We observed detainees subject to RUI who were appropriately advised by custody officers of the outcome if they tried to compromise the investigation. To reinforce this, they were given a comprehensive document which explained the types of offence they would commit should they approach witnesses or interfere with the course of justice. A weekly review process for individuals under RUI ensured that cases were progressed in a timely manner. The force also monitored and managed these numbers nationally.

3.53 The progress of bail cases was closely monitored by the bail manager, who sent timely reminders to officers responsible for the case to ensure that outstanding enquiries were pursued, and applicable bail periods adhered to. At the time of our inspection, there were only 76 active bail cases at the Brewery Road suite dating from after April 2017 and only 49 detainees that were RUI. These figures were low and reflected good management.

Complaints

3.54 Information on the complaints process was clearly visible, displayed adjacent to the booking-in desks, and included in the rights and entitlements booklets given to detainees. Some

leaflets from the Independent Office for Police Conduct were available in the custody suite but there were also out-of-date leaflets from the former Independent Police Complaints Commission. The force did not have a policy on the management of complaints made by a detainee while in custody and its general complaints policy did not have a specific section on this. The force acknowledged that the policy was out of date and required review.

3.55 Custody officers had differing views on how to deal with a detainee wishing to make a complaint. Some said that they would notify the duty inspector depending on their availability. Others said they would tell the detainee to make their complaint after being released. We observed a detainee wishing to make a complaint being told by the custody officer that an inspector would be notified. This did not happen and when we looked at the custody record a few days later there was no reference to an inspector taking the complaint or what advice had been given to the detainee.

3.56 Data supplied by the force showed very few complaints for custody (seven of the 349 complaints throughout the force recorded over the previous six months) which, along with the differing practices described above, did not provide confidence that a detainee would be able to make a complaint while in custody.

Area for improvement

3.57 The force should strengthen its management of complaints to ensure that detainees can make complaints while 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 The British Transport Police custody estate had reduced significantly since the 2014 inspection from four full-time suites and two contingency suites to one full-time suite at Brewery Road and four contingency suites at Central London, Hammersmith, Wembley and West Ham. We inspected the suites at Brewery Road and Central London which were the only two to have been used in the previous 12 months. We found potential ligature points in both suites, predominantly because of the design of toilets and the fit of doors. We gave the force a comprehensive illustrative report during the inspection, which received a positive response.

4.2 Conditions in the two suites were reasonably good. There was very little graffiti but the cells at Brewery Road were only superficially clean, with ingrained dirt in the corners. At this suite DDOs and officer gaolers were responsible for cleaning the cells, which was unsatisfactory. Cleaners only attended to the cells when there were biological hazards. All cells had access to natural light but the temperature at Brewery Road varied, with the cells warm and the holding room and interview rooms very cold. Apart from two cells at Central London, all cells had toilets and those at Brewery Road had handwashing basins in the cells.

4.3 Call bells that we tested were functioning.

4.4 There were CCTV cameras across the custody estate but at Brewery Road there were many gaps in the CCTV coverage, some of the images were grainy and there was no audio facility, which failed to protect detainees and staff. Brewery Road had sufficient notices advising detainees that CCTV was operating in the suite and cells. At Central London, there were notices in each cell, but not enough notices were prominently displayed in communal areas. This did not meet the requirements of PACE Code C paragraph 3.11 (see cause of concern S40).

4.5 Daily checks of the physical environment, including cells and communal areas, were conducted by DDOs against a pre-determined checklist which ensured consistency. These checks were recorded to show that they had been completed, although we found a significant number of occasions when checks had not been recorded. Any damage or faults were recorded locally and reported by telephone to a central helpdesk. In most cases, minor faults were responded to promptly but staff told us that some repairs could take a considerable time to be completed.

4.6 Custody staff had a reasonable awareness of the fire evacuation procedures, but this was not the case with some of the officer gaolers. Data showed that fire evacuation drills had been carried out for all shifts in the previous year, but they failed to identify learning points or actions taken to address learning points. A fire evacuation plan was not prominently

displayed in either of the suites. There were enough sets of handcuffs in both suites to evacuate the cells safely if required.

Areas for improvement

4.7 The CCTV system should be improved to cover all areas of the suites adequately and provide better quality footage with audio facility.

4.8 All staff working in custody should be aware of the fire evacuation procedures.

Safety: use of force

4.9 Information on the use of force was not reliable or comprehensive. It was not always entered on the custody record and not all officers involved in incidents submitted a use of force form. It was, therefore, difficult to assess whether force had been used on detainees in custody, and if it was always appropriate and proportionate. Data for 2019 provided by the force on the use of restraint equipment in custody showed 81 instances, 55 of which involved spit hoods. We do not normally find spit hoods used in the controlled environment of custody which did not give us confidence that these data were accurate and able to show that the use of restraint equipment in custody was being appropriately used (see cause of concern S38).

4.10 However, our review of CCTV involving use of force incidents and our observations showed that when force was used it was generally proportionate and necessary. We saw operational and custody staff engaging well with detainees and demonstrating patience and respect. We saw good examples of staff de-escalating challenging situations with detainees to minimise the use of force.

4.11 We reviewed the custody records and CCTV footage of 13 cases in which force had been used on detainees in custody. We referred three cases back to the force for review and learning. Our concerns related to the length of time one detainee had been restrained with his arms raised behind his back, whether the use of force and the searches of the detainee were necessary and proportionate, and the ineffective management of a detainee during a cell search which escalated the incident (resulting in the detainee assaulting an officer).

4.12 The remaining 10 cases had generally been dealt with well, although in some cases the management of the incident and the techniques used did not enable sufficient control over the detainee. When reviewing its use of force incidents BTP should include this concern as part of its scrutiny.

4.13 We observed detainees who arrived in custody in handcuffs usually having these removed promptly. The policy of the force required that when detainees arrived handcuffed, the method of handcuff application, the serial number of the handcuffs and whether injuries had been caused should be entered on the custody record. This did not always happen and it was not clear from custody records whether there was sufficient oversight by custody officers to ensure that the use of handcuffs was appropriate and necessary.

4.14 Most custody officers and designated detention officers were up to date with their personal safety training. Three were not, but arrangements were in place for them to attend the relevant training courses.

4.15 Data provided by the force for 2019 showed that 15% of adult detainees and 12% of children had been strip searched. This seemed high, and our own custody record analysis (CRA)

showed that the BTP had a higher percentage of strip searches than many other police forces inspected since March 2016. The force followed *Authorised Professional Practice* when authorising and conducting the strip searching of detainees but the custody records did not always fully document the rationale and authorisation for strip searches to show that they were always justified.

4.16 The force had recently introduced monitoring and quality assurance of the use of force in custody, which included viewing some incidents on CCTV. At the time of inspection, it was too early for these arrangements to determine if officers were using force on detainees in a safe and proportionate way (see paragraph 1.16).

Area for improvement

4.17 The force should monitor and analyse its use of strip searches to provide assurance that, when these are carried out, they are necessary and fully justified.

Detainee care

4.18 Custody staff showed a strong, caring ethos in looking after detainees. Detainees told us that they had been well cared for with regular offers of meals and drinks by custody staff who were helpful and considerate towards them.

4.19 There were sufficient stocks of food and drinks, consisting of microwaveable meals, including vegetarian, gluten free and halal options, and cornflakes, fresh milk, tea and coffee. All were within their use by dates. Our CRA, case audits and observations showed that meals and drinks were regularly offered and provided. Ninety per cent of detainees had been offered a meal, and 100% of detainees held for more than 24 hours. Custody staff told us that other meals could be provided to meet specific requirements, or to offer variety to detainees kept in custody for significant periods by buying food or allowing food to be brought in by friends or relatives. We were given examples of this.

4.20 Reading material, such as books or magazines, was limited, including children's books, and there were only two books in foreign languages, one in Hindi and the other in Romanian. Reading material was not routinely offered or provided. Our CRA showed that only 13% of detainees were offered reading material, which did not reflect *APP* guidance.

4.21 Blankets were made of anti-rip material which did not provide comfort. No other options were available to afford a greater degree of comfort to detainees posing minimal risks.

4.22 There were ample supplies of toiletries, towels and replacement clothing, including underwear and footwear for detainees of both genders.

4.23 Our observations and discussions with staff indicated that detainees were not regularly offered showers or exercise, even those in custody overnight or for extended periods. This did not reflect *APP* guidance. Our CRA showed that 13% were offered a shower and only one of the five people held for more than 24 hours. Only 10% of detainees were offered exercise, and only two of the five held for more than 24 hours.

Area for improvement

4.24 The force should improve its care for detainees by:

- **providing blankets that give warmth and comfort for detainees who pose minimal risks;**
- **increasing the range of reading material, 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

4.25 Officers and staff had a good understanding of how to identify safeguarding concerns for children and vulnerable adults. A comprehensive safeguarding strategy reflected safeguarding issues on the rail network. This was being reviewed and updated at the time of our inspection and provided a good framework for officers.

4.26 Custody officers had limited oversight of safeguarding concerns or arrangements made for detainees brought into custody. It was the responsibility of arresting or investigating officers to make safeguarding referrals for children and vulnerable adults, but although custody officers could access this information, in practice they were only aware of the issues identified if these officers told them.

4.27 Safeguarding referrals were reviewed by a central safeguarding team. Actions taken following reviews and contact details of partner agencies were recorded and accessible to all officers. However, custody officers did not routinely access this information to inform their own risk assessments.

4.28 Although custody officers were alert to recognising safeguarding concerns while detainees were in custody and ensured that children were always released home safely to the care of a responsible adult, it was not always clear how any concerns had been addressed. Custody records were inconsistent: in some cases safeguarding arrangements were clearly in place, in others there was very little detail even though the custody record indicated safeguarding concerns that needed to be addressed (see cause of concern S38).

4.29 There was a good focus on securing appropriate adults (AAs) for children as soon as practicable. Requests were made promptly, usually while the child was being booked into custody, and the AA was asked to attend to provide early support. If a parent or family member could not be contacted or was not able to attend, an AA was requested from the independent AA scheme. If a delay in arriving was likely, custody officers tried to contact the AA by telephone for the initial rights and entitlements to be read and for the AA to speak to the child in advance. In most of the cases, the AA (family or independent) arrived with no undue delay, regardless of the time of day or night. They remained or returned for all aspects of custody processing.

4.30 Custody officers were confident to decide whether a vulnerable adult required an AA, based on the risk assessment and any information held on the detainee. They sought advice from the health care professional if needed. In most cases that we looked at and observed, AAs

had been requested when needed. In two cases which suggested that an AA might be needed, there was no evidence that this had been considered.

4.31 AAs for vulnerable adults were not always secured early in their detention. Sometimes it was not immediately apparent that one was needed, but often AAs were asked to attend for the interview, which could be several hours into detention, rather than earlier to offer support and to re-read the rights and entitlements. The force did not monitor how long detainees waited before an AA arrived to assess how well their needs were being met. However, overall AA provision for vulnerable adults was better than we have seen in many other forces.

4.32 Guidance on the role of an AA was available in the suite.

4.33 Children were well cared for in custody. They were placed in cells in the female wing where possible which was generally quieter, and we were told by custody staff that, if appropriate, they could stay in an interview room with their parent or AA. We observed this on one occasion.

4.34 Girls were routinely assigned a female officer to look after their welfare needs, and all children were visited by the mental health nurse, where possible during their working hours. The nurse liaised with and made referrals to other agencies so that support could be provided and safeguarding concerns addressed. Children were not routinely seen by the health care professionals but they attended if requested, particularly at night when the mental health nurse was not on duty. Easy read rights and entitlements had been recently acquired (see paragraph 3.18).

4.35 Good support was available for children leaving custody. A partnership arrangement with the Railway Children organisation provided outreach youth workers to offer a range of support to children (see paragraph 1.23). The force also ran educational programmes for children who had trespassed on the railway to make them aware of the dangers involved. Children identified as being involved in county lines drug dealing were notified to the pan-London 'Rescue and Response' team operated by the Metropolitan Police Service.

4.36 Children were only brought to custody as a last resort. Frontline officers sometimes contacted custody to discuss the case before they brought a child into custody, which ensured that other options were fully explored. In the cases that we looked at, the seriousness of the offence or the safety risks posed to children, especially those suspected of involvement in county lines drug dealing, indicated that custody was the appropriate option.

4.37 When children were brought into custody they were generally dealt with as quickly as possible, with a focus on avoiding overnight stays. Investigations were carried out promptly, including overnight and, if these could not be completed within a reasonable time, custody officers considered using bail or release under investigation if there was a safe place for the child to be taken to. In many of the cases that we looked at the child's time in custody had been kept to a minimum.

4.38 The force had recently engaged with its partners to try and improve outcomes for children in custody. Arrangements had been put in place with the London Borough of Islington which covered the Brewery Road suite to act as a gateway to other local authorities for children in custody who lived outside the area. In this way, safeguarding concerns could be flagged and alternative accommodation requested if necessary. BTP had a particular problem in dealing with many different local authorities to determine where responsibility for the child lay because of the non-resident nature of many detainees. At the time of our inspection these arrangements were not embedded but it was a positive initiative to improve outcomes for children.

4.39 The custody inspector had recently started to attend the Review of Children in Custody meetings of the pan-London Local Safeguarding Children Board (LSCB). A range of issues concerning children were discussed, including the provision of alternative accommodation for children charged and refused bail.

4.40 During 2019, 18 children were charged and refused bail. Six requests were made to local authorities, who have statutory responsibility to provide alternative accommodation. Only one child had been moved, which was poor. An escalation process in line with the Concordat on Children in Custody (see Glossary of terms) was in place but no accommodation was available and little was achieved.

4.41 It was not clear why only six requests had been made because the force did not have ready access to information on children charged and refused bail which could only be obtained by looking at each custody record. Without this information the force could not monitor the outcomes achieved and use the information with its partners to improve outcomes for children.

Areas for improvement

4.42 The force should ensure that safeguarding concerns are adequately addressed and clearly captured on custody records.

4.43 The force should seek to secure appropriate adults for vulnerable adults as soon as practicable so that they benefit from support early in their detention.

4.44 The force should 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

4.45 BTP commissioned Mitie (Forensic Medical Services) to deliver general medical services. Oversight of the contract, including monthly performance reports and quarterly minuted meetings, was robust. Joint working between health and custody staff was very good.

4.46 Governance systems were effective. There had been no serious incidents, clinical errors or complaints in the last 12 months. Learning from adverse events was disseminated across Mitie services to improve practices.

4.47 Paramedic-led health care professionals (HCPs) were embedded 24 hours a day at Brewery Road, a marked improvement since our last inspection. HCPs also covered the contingency custody suite when it was open, but this was infrequent. Health staff vacancies had caused difficulties in 2019 but a recently revised approach to recruitment had started to deliver competent staff. Mitie doctors (forensic medical examiners) were available but rarely called. Mitie staff credential checking, induction, training and supervision systems were effective.

4.48 Clinical records were now electronic, using SystmOne, which improved security, storage and retrieval of information. Records we sampled were informative and professional. There was access to interpreting services as required.

4.49 The designated medical room was large, clean, complied with infection prevention standards and was suitable for forensic sampling. Clinical supplies were in date and stored tidily, and clinical waste was dealt with appropriately.

4.50 We observed the medical room door left open on occasion, while patients were assessed, but we did not see individual risk assessments indicating potential threats. We also observed one occasion where a mental health nurse (MHN) was assessing a patient with the HCP in the medical room but was not involved with the assessment, with the potential to compromise confidentiality.

4.51 Custody staff were prepared for medical emergencies. Resuscitation equipment was kept in the medical room and an automated external defibrillator was sited at the custody desk. Equipment was checked daily.

4.52 Forensic sampling kits were available, stored securely and in date.

Area for improvement

4.53 The health providers at Brewery Road should develop and implement a protocol to ensure privacy and confidentiality of patients in the medical room.

Patient care

4.54 Detainees being booked in were asked by custody staff if they needed to see an HCP, and some were referred by staff. About 104 consultations occurred each month with approximately 39% of detainees receiving medical assessments. Our CRA showed the mean waiting time to see an HCP of 49 minutes, and more than 95% had been seen within target (60 minutes) since April 2019, which was impressive. We observed waiting times of around 20 minutes.

4.55 Consultations were conducted professionally and empathetically. We observed the HCP and MHN jointly assessing a patient followed by a joint verbal report to the police, which the police said happened frequently. Joint assessments avoided repeat questioning of the patient and were more time efficient for the police and health staff.

4.56 Clinical practices were methodical and evidence based, although our CRA indicated that some detainees who appeared under the influence of alcohol and/or drugs were not referred to the HCP for several hours, delaying clinical triage. This could lead to underlying problems such as head injuries not being identified at an early stage of detention. However, the lead HCP was confident that custody staff would report unusual signs and symptoms, and Mitie intended to introduce an early warning system for health assessments in 2020. Detainees we spoke to indicated satisfaction with their care.

4.57 Handovers to custody staff were thorough and summaries were recorded on the Niche police records management system. Custody staff confirmed that they were given adequate information about the detainees' health status and risks, together with fitness to detain and interview.

4.58 We did not observe HCPs attending custody staff shift handovers which provided useful information of potential use in health assessments (see paragraph 3.32).

4.59 Detainees being released were given information as necessary to continue their care. Some GPs, with consent, could access SystmOne from the community to find details of their patient's care while in police custody, ensuring continuity of care.

4.60 Medicines belonging to detainees were initially stored securely with their property.

4.61 HCPs used patient group directions (authorising appropriate health care professionals to supply and administer prescription-only medicine) to prescribe and administer a relevant range of medications for use by patients in custody. Patients' own medicines could be continued following verification with the prescriber. This included opiate substitution therapy which had not been available at the last inspection.

4.62 Custody officers were able to give over-the-counter pain relief after consultation with the HCP, which enabled prompt responses to common health issues. All administrations of medicines were recorded on Niche, creating a full record.

4.63 Stock control of medicines and monitoring of controlled drugs were strong, with running balances maintained in auditable logs which were checked daily. All medicines, including controlled drugs, were kept in locked metal cabinets and access was restricted to HCPs via a wall key safe in the medical room.

4.64 We observed detainees taking their prescribed medicines with them on release or to court, including opiate substitution therapy, which enabled continuity of care (see paragraph 5.7).

Notable practice

4.65 *Joint assessment of patients by the health care professional and mental health nurse enabled improved communications between health professionals, reduced demands on the patient, and were more efficient for the police.*

Substance misuse

4.66 As in 2014 detainees were not able to see a substance misuse worker. However, discussions were at an advanced stage for the provision of a visiting service. Detainees who disclosed substance misuse problems or showed withdrawal from drugs or alcohol were screened using validated alcohol and opiate withdrawal screening tools. Symptomatic relief of withdrawal was available, as was nicotine replacement therapy.

Mental health

4.67 A liaison and diversion service delivered by Barnet, Enfield and Haringey NHS Trust had been introduced since we last inspected. MHNs were embedded in custody for 12 hours each day and were co-located with the HCPs.

4.68 Custody staff told us they had received some instruction in identifying when to refer detainees with potential mental health problems, but few had received recent training, and fewer said that the training was adequate.

4.69 Detainees could self-refer to the MHN or be referred by the HCP or custody staff. Detainees were seen promptly, though our CRA revealed one sizeable delay due to an unavoidable staffing problem. The service was busy with about 400 contacts a month since July 2019.

4.70 Custody had not been used as a place of safety for people who were detained under Section 136 of the Mental Health Act (MHA) in the previous 12 months.

4.71 During the six months to December 2019, 170 referrals for assessment of detainees under the MHA had been made, nearly one a day, which had resulted in 29 uses of Section 2 MHA

(see Glossary of terms) since May 2019. This demonstrated the serious nature of the health problems experienced by detainees which the police had to manage. Applications were coordinated by Islington Council and were said to be reasonably timely during the working day, but often delayed out of hours. Evidence we gathered reflected that there were sometimes significant delays in carrying out MHA assessments and then in onward transportation to an appropriate place of safety or health facility if required. There was no formal monitoring of response times by emergency duty teams and no formal meeting at which the police could discuss strategic issues with mental health services partners.

4.72 Section 136 of the MHA had been used on five occasions in custody since May 2019 to expedite the movement to hospital of detainees who were either awaiting an MHA assessment or had been sectioned and were awaiting a bed. This action was generally only taken when it was not possible to carry out an assessment or move the detainee to a mental health bed during the first 24 hours of detention and the PACE detention time was running out. The use of Section 136 powers in this way was poor practice which resulted in longer detention times for individuals who were mentally unwell (see paragraph 1.25).

Area for improvement

4.73 The force should improve outcomes for individuals with mental ill health by:

- **delivering mental health awareness training to all custody staff to enable them to identify detainee behaviours that warrant referral for mental health assessment;**
- **working strategically with partners to minimise waiting times for mental health beds so that detainees in custody are assessed promptly and, if detained under Section 136, taken to a place of safety without further delay;**
- **monitoring the time taken to facilitate and arrange transfer of detainees under section 2 of the Mental Health Act and escalating to NHS England all episodes where detainees have had 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 an improved focus on ensuring that detainees were released safely. Particular attention was given to managing the safe release of children and vulnerable detainees. Where necessary relevant agencies, for example health care professionals, were involved to support the release of the detainee. Pre-release risk assessments (PRRAs) were completed with the detainee in most cases and custody officers engaged well and made appropriate use of the initial risk assessment to establish how the individual was feeling and ensure they were released safely. However, our case audits and review of PRRAs showed that some records lacked sufficient detail and did not reflect what we had observed.

5.2 Travel warrants and letters to facilitate travel on the underground were available to assist detainees without the means to get home safely. We observed these being readily issued, which was an improvement since our previous inspection. When these options were not available, custody staff told us they asked police officers to take children and vulnerable adults home, and we saw this happening.

5.3 Information on support agencies was issued to most detainees, but was only available in English. There was access to a limited range of support leaflets in the suite. We saw one detainee with no fixed address being released from custody to spend the night in the front office and were told this was not an isolated incident. While this showed concern and care for the detainee, it was not ideal and suggested that links with support agencies in the area should be strengthened.

5.4 Person escort records (PERs) that we checked were completed to a good standard. Additional loose-leaf documentation, including risk assessments, health examinations and charge sheets, were inserted in to the PERs which was not appropriate.

Area for improvement

5.5 All relevant details relating to a detainee's risk or medical concerns should be recorded in the person escort record.

Courts

5.6 Most detainees attending court were transferred early in the morning. Flexible arrangements with the local courts, via police liaison officers, prevented detainees from being held in police custody for longer than necessary. This was an improved position since our previous inspection.

5.7 We observed one detainee being transferred to court with medication in his property, which had been prescribed by the custody suite health care professional. This was a positive initiative (see paragraph 4.64).

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

Causes of concern and recommendations

6.1 Cause of concern:
The staffing arrangements for the custody suite were not robust enough to ensure safe detention. Officers on overtime from outside custody were used which meant the suite was sometimes staffed by less experienced staff who were not well enough supported. Training for officer gaolers had not prepared them fully for the role. This led to inconsistent outcomes for detainees.

Recommendation:
The force should ensure that there are sufficient and adequately trained officers on duty in the custody suite to deliver safe detention and meet the needs of detainees in a consistent way. (S37)

6.2 Cause of concern:
The approach of the force to monitoring and managing performance was limited. There were gaps in the data collected for some areas, some data were unreliable and the quality of custody records was not always good enough.

Recommendation:
The force should collect comprehensive information across the range of custody services and use this to manage performance effectively. The quality of custody records should be improved, and quality assurance should ensure that they meet the required standard. (S38)

6.3 Cause of concern:
Governance and oversight of the use of force were not good enough. Data on use of force incidents were not comprehensive or reliable, and not all officers involved in incidents completed use of force forms, as required. Governance arrangements had recently been established but concerns about the reliability of the data limited the effectiveness of any oversight.

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 officers complete use of force forms for any incident they are involved in;**
- **collect and monitor comprehensive and reliable data to underpin the recently introduced governance arrangements.** (S39)

6.4 Cause of concern:
The force did not consistently meet the requirements of PACE code C 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. (S40)

Areas for improvement

Leadership, accountability and partnerships

6.5 The force should ensure that all custody staff consistently follow the College of Policing *Authorised Professional Practice – Detention and Custody* and its own local guidance so that detainees receive the appropriate treatment and care. (1.13)

6.6 The force should improve the quality of its custody records and ensure that the reasons or justification for decisions are fully captured. (1.22)

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

6.7 The force should improve its approach to the dignity and privacy of detainees by:

- enabling detainees to speak on the telephone in private, especially to their legal representatives;
- informing all detainees that CCTV recording is taking place while they are in their cells and that toilets are obscured from sight;
- providing detainees who have had their clothing removed with suitable alternatives. (3.11)

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

- ensuring that individual rights and entitlements are available in DVD format (sign language) with suitable playback equipment, to assist those with hearing impairments;

- ensuring that detainees have timely access to interpreters. (3.23)

6.9 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 including rousals;
- cell call bells should be answered promptly;
- non-custody staff should not have access to cell keys;
- detainees' clothing, footwear and jewellery should only be removed following an individual risk assessment;
- all custody staff should be involved in shift handovers and these should be recorded on CCTV. (3.33)

6.10 The force should minimise delays in progressing investigations so that detainees spend no longer than necessary in custody. (3.45)

6.11 The force should strengthen its management of complaints to ensure that detainees can make complaints while still in custody. (3.57)

In the custody cell, safeguarding and health care

6.12 The CCTV system should be improved to cover all areas of the suites adequately and provide better quality footage with audio facility. (4.7)

6.13 All staff working in custody should be aware of the fire evacuation procedures. (4.8)

6.14 The force should monitor and analyse its use of strip searches to provide assurance that, when these are carried out, they are necessary and fully justified. (4.17)

6.15 The force should improve its care for detainees by:

- providing blankets that give warmth and comfort for detainees who pose minimal risks;
- increasing the range of reading material, 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. (4.24)

6.16 The force should ensure that safeguarding concerns are adequately addressed and clearly captured on custody records. (4.42)

6.17 The force should seek to secure appropriate adults for vulnerable adults as soon as practicable so that they benefit from support early in their detention. (4.43)

6.18 The force should 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. (4.44)

6.19 The health providers at Brewery Road should develop and implement a protocol to ensure privacy and confidentiality of patients in the medical room. (4.53)

6.20 The force should improve outcomes for individuals with mental ill health by:

- delivering mental health awareness training to all custody staff to enable them to identify detainee behaviours that warrant referral for mental health assessment;
- working strategically with partners to minimise waiting times for mental health beds so that detainees in custody are assessed promptly and, if detained under Section 136, taken to a place of safety without further delay;
- monitoring the time taken to facilitate and arrange transfer of detainees under section 2 of the Mental Health Act and escalating to NHS England all episodes where detainees have had to be moved out of custody to an appropriate place of safety under Section 136 of the Act. (4.73)

Release and transfer from custody

6.21 All relevant details relating to a detainee's risk or medical concerns should be recorded in the person escort record. (5.5)

Example of notable practice

6.22 Joint assessment of patients by the health care professional and mental health nurse enabled improved communications between health professionals, reduced demands on the patient, and were more efficient for the police. (4.65)

Section 7. Appendices

Appendix I: Progress on recommendations from the last report

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

Main recommendations

7.1 Pre-release risk assessments should be detailed, meaningful and based on an ongoing assessment of detainees' needs while in custody; the custody record should reflect the detainee's position on release and any action that needs to be taken. (2.23)
Achieved

7.2 Custody sergeants should ensure detention is appropriate and lasts no longer than is necessary. (2.24)
Partially achieved

7.3 Procedures for contacting face-to-face interpreters should be reviewed to ensure that they are appropriately vetted individuals and suitably qualified. The interpreters list should be up to date. (2.25)
Achieved

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.

Recommendations

7.4 Staffing levels should be reviewed to ensure that sufficient custody staff are on duty at all times to meet demand. (3.17)
Not achieved

7.5 Police constables who are used as gaolers should receive training in the role before working in custody. (3.18)
Not achieved

7.6 The lack of local authority accommodation for children and young people refused bail at police stations should be resolved at a strategic level with local authority partners. (3.19)
Not achieved

Treatment and conditions

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

Recommendations

7.7 Detainees should be taken to the police station nearest to the place of arrest to avoid long escort times to a BTP custody suite. (4.8)
No longer relevant

7.8 The cell call bell should be relocated so that detainees with disabilities can use it from a seated position. (4.9)
Not achieved

7.9 Women should be asked if they would like to speak to a female officer and this should be facilitated. (4.10)
Achieved

7.10 Non-custody staff should not have access to cell keys and visits to cells should be undertaken only by custody staff, or, if necessary, accompanying other staff. (4.20)
Not achieved

7.11 Travel warrants should be available at all the custody suites. (4.21)
Achieved

7.12 Detainees should be offered sufficient food and drink. (4.39)
Achieved

7.13 An appropriate exercise yard should be provided so that detainees, particularly those who are held for more than 24 hours, can be offered exercise. (4.40)
Not achieved

Individual rights

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

Recommendations

7.14 Appropriate adults should be available at all times for young people and vulnerable adults. (5.12)
Achieved

7.15 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)
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

7.16 Safe staffing levels should ensure that all detainees are assessed by properly trained and skilled staff who are familiar with the four suites. (6.9)
Achieved

7.17 Staff, including agency staff, should receive management supervision and training to ensure they understand their duty of care to detainees and their professional responsibility to communicate appropriately with detainees. (6.16)
Achieved

7.18 All detainees at risk of medical emergency, for example undetected head injury, should be assessed by a health care professional. (6.17)
Achieved

7.19 Detainees should be able to have their prescribed opiate substitution while in custody. (6.21)
Achieved

7.20 Links with local drug and alcohol services should provide detainees with the opportunity to manage their addictions and receive continuity of care while in custody. (6.23)
Partially achieved

7.21 All custody staff should have mental health awareness training to improve their understanding of the distinction between behavioural traits, for example personality disorders, and mental illness so that they deal with detainees appropriately. (6.30)
Partially 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* (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 to 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
Paul Tarbuck	HMI Prisons health and social care inspector
Joe Simmonds	HMI Prisons researcher
Helen Ranns	HMI Prisons researcher