Report on an unannounced inspection visit to police custody suites in

Northumbria

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

2–13 September 2019

This inspection was assisted by an inspector from the Care Quality Commission (CQC) in assessing health services under our memorandum of understanding.

Glossary of terms

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Force	Northumbria
Chief Constable	Winton Keenen
Police and Crime Commissioner	Kim McGuinness
Geographical area	Northumberland and Tyne & Wear
Date of last police custody inspection	4–12 February 2014

Custody suites	**Cell capacity**
Middle Engine Lane (Northern)	40 cells
Forth Banks (Central)	50 cells
Southwick (Southern)	29 cells
Resilience suites	
Bedlington (Northern)	20 cells
Berwick (Northern)	7 cells
Etal Lane (Central)	25 cells
South Shields (Southern)	12 cells
Stadium of Light	6 cells
St James' Park	5 cells

Annual custody throughput	
1 September 2018 to 31 August 2019	29,549 detainees
Custody staffing	4 inspectors 44 custody officers 101 detention officers
Health service provider	Mitie Care and Custody

[1] Data supplied by the force.

Executive summary

S1 This report describes the findings following an inspection of Northumbria 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 September 2019, as part of their programme of inspections covering every police custody suite in England and Wales.

S2 The inspection assessed the effectiveness of custody services and outcomes for detained people throughout the different stages of detention. It examined the force's approach to custody provision in relation to safe detention and the respectful treatment of detainees, with a particular focus on vulnerable people and children.

S3 We last inspected custody facilities in Northumbria Police in 2014. This inspection found that of the 32 recommendations made during that previous inspection, 11 had been achieved, 11 had been partially achieved and 10 had not been achieved.

S4 To aid improvement we have made three recommendations to the force (and the Police and Crime Commissioner) addressing key causes of concern, and have highlighted an additional 19 areas for improvement. These are set out in Section 6.

Leadership, accountability and partnerships

S5 Northumbria Police had a clear governance structure for custody with meetings at both strategic and operational levels providing effective oversight of the delivery of custody services. Good progress had been made in a number of areas since our previous inspection, especially in the health services provided to detainees.

S6 The force had a good understanding of demand for custody services and had sufficient staff in all its suites to meet this. Resources were moved to manage demand and additional support was available to cover busy periods at the weekends.

S7 The force followed *Authorised Professional Practice – Detention and Custody* as set by the College of Policing,[2] and had its own local custody procedures to provide guidance to staff. However, many of the practices we observed did not follow either guidance.

S8 The force had a good approach to adverse incidents. Incidents were recorded appropriately and reviewed by senior managers with learning shared.

S9 Key aspects of custody were monitored to assess how well custody services were performing, identify trends, inform learning and hold partners and contract providers to account. There were some gaps and inaccuracies in the data collected, but the force was working to address these.

S10 The force had insufficient mechanisms to assure itself, the Police and Crime Commissioner and the public that the use of force in detention and custody was always safe and proportionate. Although the use of force in the incidents we reviewed had generally been proportionate and justified, the force's own governance processes did not include enough cross-reference to CCTV footage to provide this assurance.

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

S11 The force did not always follow the requirements of the Police and Criminal Evidence Act 1984 (PACE) codes of practice for the detention, treatment and questioning of persons. We had a range of concerns, including the way in which detainees were booked into custody and how PACE reviews of detention were carried out.

S12 The quality of recording on detention logs was inconsistent and lacked sufficient detail, and did not reflect the mostly good practice we observed in suites. Insufficient information was recorded and the records were often confusing to follow. Quality assurance through the sampling of records was not robust enough and had not identified the concerns that we found. The quality assurance of recording was a cause of concern.

S13 The force was unable to demonstrate that it was meeting the public sector equality duty in relation to custody. The data on the ethnicity of detainees were not comprehensive, and so the force could not effectively monitor that outcomes for detainees were fair and equitable.

S14 The force was open to external scrutiny and responded positively to issues identified by the independent custody visitors (ICVs).

S15 There was a clear strategic priority to divert children and vulnerable people away from custody and prevent them from entering the criminal justice system. The force worked with partners to provide a range of diversion schemes to help achieve this aim. There was also good partnership working with mental health services to keep individuals with mental ill health out of custody by diverting them into more appropriate health-based solutions.

Pre-custody: first point of contact

S16 Frontline officers had a good understanding of individuals' vulnerability and took account of this when deciding what action to take when dealing with an incident, and whether to arrest an individual or find an alternative solution. Frontline officers only took children into custody as a last resort when all other alternatives had been explored.

S17 The mental health triage scheme provided support to help officers avoid detaining individuals with mental ill health by finding more appropriate health-based solutions. Where individuals were detained under section 136 of the Mental Health Act 1983,[3] officers reported some long delays for mental health assessments at health-based places of safety.

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

S18 Custody staff were respectful, courteous and empathetic, and engaged well with detainees, building good rapport with them. However, limited privacy at the booking-in desks restricted the discussion of any confidential or sensitive information.

S19 Custody staff did not routinely tell detainees how their privacy was affected by closed circuit television (CCTV) coverage in the suites and cells, and we found that detainees' dignity was not always protected. We were particularly concerned that the toilets in the cells were not obscured on the CCTV screens in the custody areas, which could be easily viewed by staff. This had a significant adverse impact on detainee dignity and was a cause of concern that we expected the force to correct as a matter of urgency.

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[3] 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.

S20 Custody staff understood and managed well the wide range of needs of people coming into custody. There was an extensive range and sufficient stocks of religious artefacts, appropriate support for people with sight and hearing impairments, and a focus on meeting the needs of female detainees. The arrangements to meet the needs of detainees with mobility issues were more limited. Printed copies of detainee rights and entitlements were available in numerous languages. Professional telephone interpreting arrangements generally worked well, but there were delays when interpreters were required to attend the suite in person; this sometimes led to detainees remaining in custody for longer than necessary.

S21 The approach to identifying and managing risk was good. Initial risk assessments were comprehensive, with observation levels generally set appropriately and conducted on time. Welfare checks were carried out well, including when detainees needed to be roused because they were under the influence of alcohol or drugs. However, when risks were reviewed the reasons for changing any observation levels were not always clear. Items of detainees' clothing that could be used to self-harm were sometimes removed without an individual risk assessment, which was a disproportionate response to managing risk. There was a good exchange of information about detainees at staff shift handovers, but they did not always involve all staff or take place in areas where they would be recorded on CCTV.

S22 Custody officers generally authorised the detention of detainees while they were in the holding rooms after arrival. Although detainees were always advised that their detention had been authorised and told the circumstances of their case, the necessity for their arrest was not always explained to them. This was similar to the findings of our previous inspection.

S23 In the year to August 2019, the average waiting time for detention to be authorised was 20 minutes after the detainee's arrival at the custody suite. Cases were progressed promptly to ensure that detainees could be released or transferred as soon as possible. In our custody record analysis, the average length of detention was 12 hours 17 minutes, significantly better than the comparator of almost 14 hours for forces inspected since March 2016.

S24 Custody officers had a clear focus on ensuring that detainees were released or transferred from custody at the earliest opportunity, but there were delays caused by waits for interpreters, appropriate adults (independent individuals who provide support to children and vulnerable adults in custody), investigating officers, Crown Prosecution Service (CPS) advice and the new Defence Solicitor Call Centre.

S25 The number of immigration detainees brought into custody had decreased over the last three years, but staff reported some recent longer periods of detention.

S26 Detainees were informed on arrival of their main rights, but they were not always given a copy of their rights and entitlements and these were not always readily available in the suites, although custody officers knew how to access them on the Home Office website. However, this situation improved during our inspection. Detainees had reasonable access to legal representation, but no posters advertising the right to free legal advice were displayed in any of the custody suites. There were no up-to-date copies of the current version of PACE code C in any suite, and the versions that were available were not always offered. None of the custody sergeants we spoke with had any knowledge of the requirements to provide translated documents (PACE code C annex M) or how to access these. All of these matters were non-compliant with PACE.

S27 There was a good process for the management and transportation of DNA samples, although there was a backlog at one site and there were no locks on DNA refrigerators. Some evidential samples that should not have been stored in custody were held in additional refrigerators.

S28 The approach to PACE reviews was not good enough. Although we saw inspectors treating detainees courteously and with dignity and respect when carrying out reviews, many PACE reviews were conducted too early, and many reviews took place while detainees were asleep, even when they were being roused regularly. There were very few records that showed that detainees had been advised when they awoke that a review had been conducted. When reviews took place in the detainees' presence, they were not always given the opportunity to make representations before continuing detention was authorised.

S29 Recording of reviews in custody records was often poor, with few details and no attention to detainee welfare. The overall approach was not sufficiently focused on the outcome for the detainee.

S30 In our sample, a high figure of 78% of detainee arrest cases were concluded during their first period in custody. Custody officers acted appropriately in deciding whether to release under investigation or seek authorisation from senior officers to bail detainees with conditions. Bail cases were carefully tracked and expedited. In contrast, the number of live cases for those released under investigation appeared high. It was not clear how the force was acting to reduce investigation time and to minimise the impact that extended periods of bail or release under investigation had on detainees.

S31 There was insufficient information for detainees on how they could make a complaint against the police. Custody staff gave differing accounts of how they would deal with a detainee wishing to make a complaint; we saw detainees voice concern over their treatment but they were not given the opportunity to make a complaint. It was far from clear that a detainee would be able to make a complaint during their time in police custody.

In the custody cell, safeguarding and health

S32 Conditions and cleanliness in the three full-time suites were good overall, with minimal graffiti. Southwick was older than the other two, and lacked some amenities. All cells had natural light and the temperature was mostly suitable. CCTV was installed across the custody estate, including in all cells, but the lack of audio coverage in key areas, together with poor audibility where there was coverage, limited its effectiveness. There were potential ligature points across all the suites we inspected (including the resilience suites), mainly due to the design of toilets and some benches. We provided the force with a comprehensive illustrative report detailing these.

S33 Most resilience suites were not ready to be used at short notice because they were in poor condition and not properly stocked to meet detainees' needs.

S34 Cell call bells were in working order but in one suite the audio capability had been turned off, which posed significant risks.

S35 Detention officers (DOs) carried out daily cell checks but there were some gaps, and some defects had not been noted in the checks. Basic defects were put right within a reasonable period but there were some delays in more major repairs.

S36 Staff were reasonably familiar with fire evacuation procedures but not all teams had had a fire drill in the previous 18 months, representing no improvement since our previous inspection.

S37 We saw staff dealing with challenging detainees patiently, and they de-escalated some difficult situations well. Not all staff were up to date with their officer safety training; a few were over four months out of date.

S38 We examined 15 cases involving the use of force in depth. In seven of these no forms at all had been submitted, and in most of the others not all staff had submitted the required individual forms to justify why they needed to use force. Detention log entries did not always make clear that force was used, and some of those that did had insufficient information to justify its use or identify the techniques employed.

S39 We had difficulties in reviewing our sample of use of force cases on CCTV because of deficiencies in audio coverage (see paragraph S31). The incidents were generally managed well and most showed that force was only used against detainees as a last resort. We referred seven cases to the force for review where we had questions about the techniques used and the dignity of detainees once their clothing was removed.

S40 Handcuffs were not applied routinely and when they were, they were removed quickly from compliant detainees on arrival at the custody suites, which was positive.

S41 The level of strip searching of detainees was comparable to other forces according to the force's data, although our sample of cases showed a lower proportion. However, strip searches and the removal of clothing to prevent self-harm, with or without force, were not always properly justified and recorded.

S42 The standard of care that detainees received was mixed and was not always good enough. While food and drinks were provided regularly, few showers were offered, access to exercise was limited and few detainees were given something to read. The blankets given to detainees were of poor quality and thin.

S43 Staff had a good understanding of how to identify and address safeguarding concerns. Custody officers were well focused on securing appropriate adults (AAs) as soon as possible so that detainees could be read their rights and entitlements in the AA's presence and receive early support. AAs for children had arrived promptly in many of the cases we looked at. Securing AAs for vulnerable adults was more difficult, with some long waits; in some cases an AA could not be secured before the detainee was due to be released. Despite information that vulnerable adults should have had access to an AA, custody staff did not always consider securing one, which meant these detainees might not receive the support to which they were entitled.

S44 Children were cared for well in custody and there was a clear focus on minimising the time they spent there. In many cases we saw, children were dealt with and released promptly. Senior officers had good oversight of children entering custody, but joint monitoring with local authority partners was not strong enough to assess the outcomes achieved and the improvements needed. Very few children were charged and refused bail, but although custody officers asked for alternative local authority accommodation children were rarely moved there.

S45 Physical health care provision had improved significantly since the last inspection. Health care professionals were now present at all times in each of the three full-time suites and provided a responsive service. Quality assurance and clinical governance arrangements were good, with adequate training and support for health staff. Clinical areas were clean and generally complied with infection prevention standards. However, detainees were not seen in private as health consultations took place with custody staff observing at the door.

S46 Health care professionals were experienced, well trained and had the appropriate competencies to provide effective support. Custody staff and detainees valued their support. The quality of electronic clinical records was very good, and staff could, with the detainee's consent, readily access NHS information to see their current medication.

S47 Medicines management arrangements were robust and detainees could access prescribed medication, including community-prescribed opiate substitution treatment. Detainees experiencing drug or alcohol withdrawal could obtain symptomatic relief. However, detainees had no access to nicotine replacement therapy.

S48 A dedicated drug and alcohol worker saw detainees face-to-face at the Forth Bank suite, and this was valued. Liaison and diversion staff offered support in other suites, signposting detainees to community services. Naloxone (a drug used to counteract opiate overdose) was available in all custody suites.

S49 Mental health liaison and diversion services were very good, and valued by custody staff and detainees. The embedded service operated seven days a week and included an impressive range of outreach and innovative post-release, follow-up work. The service had recently expanded to provide a promising all-age service, with liaison and diversion staff able to see detained children in custody.

S50 Custody had not been used to detain anyone under section 136 of the Mental Health Act in the previous 12 months, and there had been no lengthy waits to transfer people detained under the act to mental health beds.

Release and transfer from custody

S51 Custody officers completed pre-release risk assessments (PRRAs) with the detainee, and showed a good focus on vulnerability and ensuring that detainees were safely released from custody. However, the recording of PRRAs was poor. Relevant agencies were often involved in supporting the release of detainees. A range of support leaflets was available, although we did not often see these given out.

S52 Person escort records for detainees being transferred to another agency or to court contained accurate and relevant information. Detainees held because they were required to appear at the next court hearing were processed promptly and not generally held in police custody for longer than necessary.

Causes of concern and recommendations

S53 Cause of concern: The force did not consistently meet the requirements of the Police and Criminal Evidence Act codes of practice for the detention, treatment and questioning of persons.

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

S54 Cause of concern: The recording on custody records was inconsistent and lacked sufficient detail. Not enough information was recorded to show the reasons why certain decisions had been taken or the sequence of actions relating to the detainee. Quality assurance arrangements were not sufficiently robust.

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

S55 Cause of concern: Staff in the custody area could view detainees using the toilet in their cell because these areas were not obscured on the CCTV screen. This had a significant adverse impact for the dignity of detainees.

Recommendation: The force should take immediate steps to ensure that toilets in cells are obscured on CCTV screens to provide sufficient privacy to detainees.

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*.[4] 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 an 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*.[5]

The methodology for carrying out the inspections is based on: a review of a force's strategies, policies and procedures; an analysis of force data; interviews with staff; observations in suites, including discussions with detainees; and an examination of case records. We also conduct a documentary analysis of custody records based on a representative sample of the custody records across all the suites in the force area open in the week before the inspection was announced. For the Northumbria force we analysed a sample of 146 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.

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4 http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/inspection-criteria/
5 https://www.app.college.police.uk/app-content/detention-and-custody-2/

Section 1. Leadership, accountability and partnerships

Expected outcomes:
There is a strategic focus on custody, including arrangements for diverting the most vulnerable from custody. There are arrangements to ensure custody-specific policies and procedures protect the wellbeing of detainees.

Leadership

1.1 Northumbria Police had a clear governance structure for custody. Under the direction of an assistant chief constable (ACC), a superintendent and chief inspector had overall responsibility for the custody function. They were supported by four inspectors and specialist staff trained to deliver custody services. This structure provided clear accountability for the safe delivery of custody.

1.2 Meeting structures at both strategic and operational levels provided effective oversight of the delivery of custody services and how they were performing. The force had several operational delivery groups chaired at ACC level, with the investigations operational delivery group overseeing custody and feeding any key issues into the force strategic management board and, if necessary, adding to the force risk register for ongoing monitoring. The force had made progress since our last inspections, most significantly in the provision of the health services to detainees.

1.3 The custody suites were in generally good condition, although Southwick was dated and lacked some amenities. However, some contingency suites were not in a condition or properly stocked to meet detainee needs if they had to be opened at short notice (see paragraph 4.1).

1.4 The force had a good understanding of demand for custody services and had sufficient staff in all its suites to meet this. There were 44 custody officers and 101 detention officers, supported by a pool of custody-trained officers from elsewhere in the force to fill in where there were staff shortages or absences. Some detention officers were specifically employed as 'key workers' to provide additional cover over the busy period at the weekends. Inspectors had the authority to move resources on a shift-by-shift basis, providing a flexible approach to managing demand.

1.5 There was a good commitment to initial and ongoing training, and staff were appropriately accredited. Initial training was comprehensive and delivered over three weeks. Newly trained custody officers and detention officers were then given a period of shadowing more experienced staff before undertaking their duties. All staff received two additional days training a year to ensure their continuous professional development. These training days covered a variety of topics; they included sessions to raise awareness of the diverse needs of detainees, and to equip staff with the knowledge of how to respond to individuals with mental ill health or other vulnerabilities.

1.6 The force followed *Authorised Professional Practice – Detention and Custody* as set by the College of Policing (see footnote 2), and had its own local custody procedures to provide guidance to staff. However, many of the practices we observed did not follow either guidance.

1.7 The force was focused on keeping detainees safe and had a good approach to adverse incidents. Incidents that occurred in custody were appropriately recorded and reviewed by senior managers, and learning was shared with staff and used to inform wider organisational learning and feed into training.

1.8 There had been two deaths in custody since the previous inspection (in 2015 and 2016). The Independent Office for Police Conduct (IOPC) had investigated and closed these cases.

1.9 The force effectively monitored the health care services to detainees. There were regular meetings with the health contractor to oversee delivery of the service, which had greatly improved since our last inspection. There was also good oversight over some other services that affected detainees, for example with the local courts and the local authorities providing appropriate adult services.

Area for improvement

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

Accountability

1.11 The collation of performance data for custody had greatly improved since our last inspection. There was some monitoring across key aspects of custody to assess how well custody services were performing, identify trends, inform learning, and hold partners and contract providers to account. Senior managers had access to daily management reports and could see how well custody functions were performed across the suites, and on a team-by-team basis - for example, to assess the timeliness of welfare checks and how long detainees waited to be booked in. The force was working to improve its data further to address some gaps, such as the overall time that detainees were held after charge (see paragraph 3.37). There were also some areas where the data collected was not fully accurate, such as that relating to the ethnicity of detainees.

1.12 The force had insufficient mechanisms to assure itself, the Police and Crime Commissioner and the public that the use of force in detention and custody was always safe and proportionate. Data on incidents in custody suites were available and comprehensive, but detention logs recorded insufficient detail to justify why force or restraint had been necessary, and not all staff submitted individual use of force forms as required by the National Police Chiefs Council. (See cause of concern and recommendation S53.) While there was some governance and oversight processes, there was not enough cross-reference to CCTV footage to provide assurance that the techniques used were proportionate and safely deployed (see paragraph 4.15).

1.13 The force did not always follow the requirements of the Police and Criminal Evidence Act 1984 (PACE) codes of practice for the detention, treatment and questioning of persons. Concerns included the way in which detainees were booked into custody so that they fully understood why they were there, and that they were not given a written copy of their rights and entitlements or actively offered the PACE code C booklet. Several aspects of reviews of detention also did not meet the requirements of PACE code C: for example, detainees were not told that an inspector had conducted a review of their detention while they were asleep or given the opportunity to make representations about their continued detention. (See cause of concern and recommendation S53 and paragraphs 3.36, 3.47 and 3.48.)

1.14 The quality of recording on detention logs was inconsistent and lacked sufficient detail, and did not reflect the mostly good practice we observed in suites. The grounds for arrest were often vague and sometimes not recorded at all, and not all detainees signed the custody record to show they had received their rights and entitlements. There was insufficient information recorded to justify why actions such as strip searches had been required or to show the rationale behind changes to a detainee's observation levels. Custody record entries did not always show the sequence of actions and were often confusing to follow.

1.15 While there were quality assurance processes and inspectors were expected to audit a sample of records, these checks were not sufficient in number or robust enough to ensure that custody services were delivered to the required standards. They had not identified the concerns we found. The quality of recording and the quality assurance of custody records were a cause of concern. (See cause of concern and recommendation S53.)

1.16 The force was unable to demonstrate that it was meeting the public sector equality duty in relation to custody. While staff had received training in identifying and responding to diverse needs, not all detainees brought into custody were asked to self-define their ethnicity and the force did not use the full set of ethnicity identifying markers.[6] This lack of comprehensive data meant the force was unable to monitor effectively and show that outcomes for detainees were fair and equitable (see paragraph 3.14 and area for improvement 3.22).

1.17 The force was receptive to feedback and gave access to external scrutiny. There was an effective independent custody visitor (ICV) scheme and the force responded positively to issues raised by ICVs. The force had also invited neighbouring forces to conduct a peer review of its custody services, and had created an improvement plan to respond to recommendations made.

Areas for improvement

1.18 The force should strengthen its approach to performance management by addressing any gaps in performance information and improving the accuracy of its data.

1.19 The force should provide assurance that any force used in its suites is always safe and proportionate by having robust governance arrangements, including viewing incidents on CCTV.

Partnerships

1.20 There was a clear strategic priority to divert children and vulnerable people away from custody, which all officers understood. The force was working with partners to provide a range of diversion schemes to help achieve this aim. Initiatives such as Get Connected and Divan were giving support to children. A pathfinder scheme 'Through the Gate' was providing a range of support services for females. The force also supported 'Project Nova' run by RFEA, the forces employment charity for former armed services personnel. These initiatives demonstrated the force's commitment to working with partners to reduce reoffending and prevent children and vulnerable people from coming into the criminal justice system.

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[6] Based on Census ethnicity codes, police are required to record this information under section 95, Criminal Justice Act 1991.

1.21 There was positive engagement between the force and the six local authorities in its area to help move children who were charged and refused bail from custody to alternative accommodation. However, this had not yet led to improved outcomes with few children moved, as partners lacked the capacity and capability to meet their statutory requirement.

1.22 The force had a clear commitment to improving services for people with mental ill health and there was good evidence of diversion from custody. No detainees had been taken to police custody under section 136 of the Mental Health Act 1983 (see footnote 3) since 2016 (see paragraph 4.63). Officers had access to telephone advice, street triage and a crisis team, which helped ensure that custody was not used as a place of safety for people with mental ill health.

Section 2. Pre-custody: first point of contact

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

Assessment at first point of contact

2.1 Frontline officers had a good understanding of individuals' vulnerability, citing a wide range of relevant factors, such as age or learning difficulties, as well as the circumstances that an individual might find themselves in. The force had a definition of vulnerability and had also set out a number of categories to determine whether a person was vulnerable. All children were regarded as vulnerable because of their age.

2.2 Training for officers was focused on vulnerability and safeguarding to assist them in carrying out their role when dealing with vulnerable people. It was clear that officers took account of vulnerability when deciding what action to take when dealing with an incident, and whether to arrest an individual or find an alternative solution.

2.3 Frontline officers told us that they generally received good quality and prompt information from the call handling centres when responding to incidents. Although this varied between the different call handlers, they said they could ask for more information and access it directly on their mobile phones. In their view they had sufficient information about the individuals involved in an incident, and any vulnerabilities they might have, to inform their decision making.

2.4 There was a strong focus on diverting children away from custody and entering the criminal justice system. Alternatives such as voluntary interviews, community resolutions and restorative justice[7] options were regularly used, as well as taking a common-sense approach such as interviewing a child at home with their parents. Frontline officers said that they only took children into custody as a last resort, and where they could robustly demonstrate to the custody officer that arrest was necessary. Most of the children we saw in custody, and in the cases we looked at, had committed serious offences or were under the influence of alcohol or drugs.

2.5 There were schemes and other help to prevent children reoffending and keep them from entering the criminal justice system provided through the youth offending teams (YOTs). These were for children who had either been in custody or interviewed as voluntary attendees and admitted the offence. Frontline officers could not access this help directly from the street but were aware of some of the work carried out with these children. They were also aware of some of the force's wider diversion activities aimed, for example, at preventing knife crime or to help children at risk of being involved in organised crime (see paragraph 1.20), but had little direct involvement with these schemes or how to access them.

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[7] Under voluntary attendance, suspects involved in minor offences attend a police station by appointment for interview, avoiding the need for arrest and subsequent detention; community resolution of a less serious offence or antisocial behaviour incident involves informal agreement between the parties rather than progression through the criminal justice process; in restorative justice programmes, offenders consider the consequences of their offending for all parties and can offer an apology or reparation.

2.6 There was good support for frontline officers dealing with individuals with mental ill health through the mental health triage scheme. Police officers and mental health professionals working out of two police cars provided telephone advice and attended incidents from 10am to 3am. Frontline officers told us they valued this service greatly and that it enabled them to avoid detaining some individuals under section 136 of the Mental Health Act 1983 by finding more appropriate health-based alternatives. Where section 136 detentions were necessary, the mental health triage officers facilitated the arrangements to take the detainee to a health-based place of safety. Out-of-hours advice was available through the mental health crisis teams but did not offer the same level of support. Frontline officers said they would never use custody as a place of safety for an individual detained under section 136.

2.7 Frontline officers' experience of waiting with detainees at health-based places of safety varied. At the Hopewood Park health facility in Sunderland, detainees were left in the care of health professionals without the need for officers to wait with them. However, officers reported long delays at the other health-based places of safety, as they were required to wait with detainees until a mental health assessment could be carried out. Detainees were taken to hospital emergency departments if they had any physical injury that required treatment.

2.8 Individuals who showed signs of mental ill health but had committed an offence for which they needed to be arrested were taken into custody. Officers said that detainees received good support from the mental health professionals based in custody, and any health needs were addressed before there was any action in relation to the offence.

2.9 Frontline officers transported individuals to health-based places of safety in police cars. They recognised that this was inappropriate but said it was preferable to long waits with the detainee before an ambulance arrived. They took other detainees to custody in their own police cars or police vans depending on the risks posed. There were no arrangements for transporting a person in a wheelchair, but officers said they would deal with each case as it arose.

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 generally engaged well with detainees and were respectful, courteous and showed empathy. They asked detainees how they wish to be addressed (such as by their first names), which helped improve rapport. Most detainees we spoke to felt they had been treated respectfully by custody staff.

3.2 However, some interactions were not respectful and did not maintain detainee dignity. We observed five incidents during our review of CCTV footage where clothing had been removed, resulting in two detainees left naked and three only partially clothed (see paragraph 4.14). Other custody staff could easily have viewed images of these detainees on the CCTV monitors, which adversely impacted on these detainees' dignity.

3.3 Footwear was routinely removed from all the detainees we observed, rather than on the basis of an assessment of risks posed. Even though plimsolls were readily available, we saw detainees wearing just their socks or barefoot in their cells or walking around the custody suite. This was undignified and could have affected their health. At Southwick, we also saw shoes and other clothing left on the floor outside cells, even though lockers were available; this too showed a lack of respect for detainees.

3.4 Privacy for detainees at the booking-in desks was limited, primarily because of the design of the custody suites. Conversations between custody officers and detainees could easily be overheard between the booking-in desks, with the consequence that detainees could be reluctant to disclose personal or confidential information. We only saw one custody officer offering detainees the opportunity to speak in private, adhering to the recent changes (from 21 August 2019) under section 67 (7a) of the Police and Criminal Evidence Act (PACE) code C on the detention, treatment and questioning of persons by police officers.

3.5 The booking-in desks at all the custody suites were also high, making interactions between detainees and staff difficult at times: this could have been detrimental and intimidating for some detainees.

3.6 Other than at Middle Engine Lane custody suite, there were discrete booking-in desks to deal with detainees charged with sensitive or serious offences. These allowed sufficient privacy for confidential conversations and for detainees to disclose sensitive information. We saw this facility used well at Southwick when a detainee was booked in for a serious offence.

3.7 None of the suites had telephone facilities in the cells to connect the detainee with their legal representative. This meant that detainees were often brought to the booking-in desk areas to make or receive telephone calls, where conversations could be overheard (see paragraph 3.42). However, Forth Banks had two cubicles where detainees could speak in private to their legal representatives or others.

3.8 There were a few notices advising detainees that CCTV recording was taking place, but these were not always displayed at the custody suites (see paragraph 4.4). We observed that detainees were not routinely informed that CCTV cameras were monitoring them in their cells.

3.9 The CCTV screens covering the cells did not obscure the toilets and staff could see detainees when they were using them. This had a significant effect on their dignity and privacy. Although we highlighted this concern to the force during the first week of the inspection, we saw this inappropriate practice continuing. This did not follow *Authorised Professional Practice* guidance or meet the requirements of recent amendments to PACE code C. The force was informed that this practice must cease immediately. (See cause of concern and recommendation S54.)

3.10 Detainees were not routinely provided with toilet paper and had to request this from custody staff, which was undignified and did not follow *Authorised Professional Practice* guidance.

3.11 The design of the shower and toilet doors on the end of corridors at Forth Banks and Middle Engine Lane custody suites offered minimal privacy for detainees.

Area for improvement

3.12 The force should improve its approach to the dignity of detainees by:

- **ensuring that detainees are left appropriately clothed and with footwear when their own clothing and footwear have been removed**
- **informing all detainees that they can speak privately to custody staff, in line with the changes in PACE code C**
- **informing all detainees that CCTV is operating in their cells, if this information is not displayed in the cell**
- **making sure that shower and toilet doors allow sufficient privacy for detainees, and providing toilet paper routinely, unless the risk assessment identifies otherwise.**

Meeting diverse and individual needs

3.13 Custody staff were able to understand and manage the wide range of needs of those coming into custody well. They had received specific training as part of their continuous professional development, which had covered a wide range of topics - including recognising the needs of transgender detainees, those with visual impairments, use of guide dogs in cells, dealing with disabled detainees, different religious requirements and meeting the needs of vulnerable detainees. When booking detainees into custody, custody officers routinely asked them if they had any religious observance and/or dietary requirements.

3.14 However, detainees were not routinely asked to self-define their ethnicity. We often observed custody officers assuming their ethnicity and asking the detainee to confirm this. This meant that the data on the ethnicity of those coming into custody was not necessarily accurate enough to support effective monitoring.

3.15 There was an extensive range and sufficient stocks of religious artefacts for Christians, Muslims, Hindus, Jews, Buddhists and Sikhs at all the custody suites, except Middle Engine Lane, where there were none for Sikhs or Jews. The religious books were all stored as required by the different faiths. There were compasses and signs in cells depicting the direction for prayers for Muslims. The force recognised the requirements of many faiths, and a wide range of detainees could practise their religion while in custody.

3.16 With the exception of Forth Banks, there were insufficient arrangements for detainees with mobility impairments. Neither Middle Engine Lane or Southwick custody suites had lowered call bells in any cells. Although Middle Engine Lane had a disabled-access toilet, detainees had to request assistance from custody staff to use it. Southwick had no such facilities. However, all the suites had wheelchairs, and Forth Banks and Middle Engine Lane had walking aids. Exercise yards at Forth Banks and Middle Engine Lane were easily accessible to wheelchair users but not the yard at Southwick, due to the design of the custody suite. Extra-thick mattresses and pillows were available for detainees who required extra comfort.

3.17 Good support arrangements for detainees with sight or hearing impairments included hearing loops to assist detainees with limited hearing and Braille versions of the rights and entitlements documents at all the custody suites. There were easy-read rights and entitlements booklets for children or detainees who had difficulties in reading. There were no British Sign Language DVDs at any of the custody suites.

3.18 There was a good focus on meeting the needs of female detainees. 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, and were assigned a named female member of custody staff in case they wished to discuss any personal issues confidentially. They were routinely offered female menstrual care products from a well-stocked range, including disposal bags.

3.19 Custody officers understood their responsibilities to inform a foreign national detainee's embassy or consulate when required or requested, and could contact them without difficulty.

3.20 Telephone interpreting services were available to communicate with non-English speaking detainees, with two-way handsets available in all the custody suites. Custody officers told us the service was easy to use and worked well when interpreting services were required over the telephone. However, they said there were sometimes considerable delays when interpreters were required to attend in person for interviews. This led to detainees remaining in custody for longer than necessary or having to be released under investigation pending interpreting arrangements being made (see paragraph 3.39).

3.21 Custody officers were able to access rights and entitlements documents in several languages through the force's IT system linked to the relevant website.

Area for improvement

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

- **ensuring all detainees are asked to self-define their ethnicity and recording this accurately on custody records**
- **having arrangements to help detainees with mobility impairments so that they can easily call for assistance from their cells, and making arrangements at Southwick when the suite is unable to meet the needs of these detainees**

- **ensuring detainees have prompt access to interpreters and are not kept in custody for longer than necessary while waiting for them to attend.**

Risk assessments

3.23 The approach to identifying and managing risk was good. Initial risk assessments were conducted methodically, based on a comprehensive set of questions that enabled a good understanding of a detainee's risk. Custody officers used information markers held on the national and the force's own computer systems to inform their assessment. They engaged effectively with detainees, building trust, and asked arresting officers to share relevant information that might affect the risk assessment.

3.24 Custody officers routinely visited holding rooms when detainees first arrived to check if they required urgent medical treatment that might mean sending them to hospital or seeing the health care practitioner in custody (see paragraph 3.35). There was little other triaging of risk in custody, and frontline officers told us there was little prioritisation on booking in children or individuals who might be vulnerable or distressed before other detainees. However, most detainees did not have to wait long in the holding rooms.

3.25 Custody officers completed the risk assessments as best they could for detainees who did not engage with the risk assessment process, because they were under the influence of alcohol or drugs or were behaving violently. These detainees were generally placed on appropriate observation levels so that they were properly monitored and checked in their cell, with the risk and observation level reviewed once the detainee engaged with the process. However, in the cases we looked at the risk assessment document was not always completed or updated to detail the risk information subsequently gathered or to reflect any changes.

3.26 It was not always clear from custody records why observation levels had been decided or the reasons when they were changed. Although most detainees were placed on the appropriate observation level, *Authorised Professional Practice* guidance was not always followed. This resulted in some detainees being placed on the wrong level: for example, we found that some detainees who were intoxicated had been placed on level 1 checks instead of level 2, which meant they were not roused every 30 minutes as required.

3.27 Detention officers engaged well with detainees and carried out timely and appropriate welfare visits. Where rousals were required these were conducted, and generally recorded, well. Where possible, the same detention officer carried out the welfare checks for particular detainees so that they could more easily identify any changes in mood or demeanour.

3.28 Force policy clearly stated that clothing was not to be routinely removed from detainees as a way of managing self-harm risks, but this was not always followed. While we saw some detainees keeping their own clothes and personal items, others had clothing with cords or any potential to be used to self-harm routinely removed from them without an individual risk assessment, which was a disproportionate response. However, it was positive that the force did not use anti-rip clothing for detainees at significant risk of suicide or self-harm, managing the risks posed by other means.

3.29 Custody staff clearly understood how to identify when detainees could have had medical or mental health problems and made referrals to health care staff and to the liaison and diversion team as needed.

3.30 Not all detention officers had anti-ligature knives to assist them in responding to any self-harm incident in a cell as quickly as possible. This did not follow *Authorised Professional Practice* guidance, although all sets of keys had anti-ligature knives attached.

3.31 There was a lack of control of cell keys in some suites. Cell keys were often given to other individuals who were not custody staff, and it was not always clear who had keys. This situation continued despite a recommendation to address this in our previous inspection.

3.32 Cell call bells were usually answered promptly. However, contrary to *Authorised Professional Practice* guidance, detention officers did not always seek authority from the custody officer before isolating or muting cell call bells (see paragraph 4.3).

3.33 Custody staff handovers did not always involve both custody officers and detention officers. While there was a good exchange of information about detainees' health and welfare, the handovers were not always conducted in areas that were filmed, which was not in line with *Authorised Professional Practice* guidance. Sergeants starting their shift visited the detainees.

Area for improvement

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

- **any updates to detainee risk assessments, and the reasons for changes to observation levels, should be clear and recorded on the custody record**
- **detainees' clothing should be removed only if the individual risk assessment suggests that this is necessary**
- **all custody staff should carry anti-ligature knives**
- **cell keys should be effectively managed and controlled**
- **cell call bells should only be muted with the custody officer's authority and be properly recorded in the detention log.**

Individual legal rights

3.35 Custody officers told us that they rarely had to refuse detention. Local practice was for detainees to be lodged initially in holding rooms on arrival at the custody suites while custody officers established if their detention was appropriate or, if necessary, that they should be redirected to health care professionals or hospital if they required medical attention (see paragraph 3.24). This practice also allowed detainees to be searched in the holding rooms before they were taken to the booking-in desks.

3.36 We observed that arresting officers usually explained the circumstances of an individual's arrest in the presence of the detainee, either in the holding room or at the booking-in desks, but they did not always fully explain the necessity for their arrest to the detainee. Where this was the case, custody officers did not always seek further explanation from the arresting officer to ensure the arrest was necessary or instead they offered them reasons to meet the necessity test and sought the arresting officer's agreement; this did not meet the requirements of PACE code G and code C paragraph 3.1 (see cause of concern and recommendation S52). Detainees were sometimes told in the holding rooms that their detention had been authorised and the grounds for this, but this was not always repeated at the booking-in desk; this made it unclear when detention had formally commenced. In our

case audits, the recording of the grounds and necessity for detention were often poor. These findings were similar to those of our previous inspection.

3.37 Data supplied by the force for the year to 31 August 2019 showed that an average waiting time of 20 minutes between detainees arriving at the custody suites and custody officers formally authorising their detention. Our own analysis of custody records showed an average waiting time between arrival and detention authorisation of 25 minutes, which was much poorer than the average of 19 minutes found for all police forces inspected since March 2016. However, we saw many detainees being booked in promptly after their initial assessment by a custody officer in the holding room.

3.38 The force used fixed penalty notices,[8] restorative justice processes and voluntary attendance (see also footnote 7) as alternatives to taking an individual into custody. Data from the force for the year to 31 August 2019 showed that 7,139 individuals were voluntarily interviewed, compared with 8,283 in the previous year, a decrease of 14% - a downward trend we have seen elsewhere.

3.39 Custody officers had a clear focus on ensuring that cases were progressed quickly so that detainees were released or transferred from custody as soon as possible. In our custody record analysis, the average length of detention was 12 hours 17 minutes, compared with 13 hours 56 minutes for all forces inspected since March 2016. However, we were told that investigations were not always progressed promptly. There were delays in waits for the attendance of interpreters (see paragraph 3.20) and appropriate adults (see paragraphs 4.31 and 4.32), as well as Crown Prosecution Service advice and contact with the new Defence Solicitor Call Centre (DSCC). There was also sometimes a lack of investigating officers. We saw one detainee who was bailed to return to the custody suite later as the interpreting service was unable to supply an Albanian-speaking interpreter for his interview. The force was unable to supply any data on average detention times when the detainee was not eventually charged (see paragraph 1.11).

3.40 The force had seen a 13% decrease (27 cases) in the number of immigration cases brought into custody over the last three years. Custody staff told us that many immigration detainees were moved on to immigration removal centres (IRCs) within 24 hours of being served with an IS91[9] warrant of detention. However, we were given examples of a few immigration detainees who had been held recently for between 26 and 60 hours, which was too long and similar to our findings in 2014. The force was unable to supply any data on the average time that immigration detainees spent in police custody.

3.41 During booking-in, custody officers clearly explained to detainees their three main rights while in custody (to have someone informed of their arrest, consult a solicitor and access free independent legal advice, and consult the PACE codes of practice). Although a written notice setting out a detainee's full rights and entitlements should be readily available for detainees, this was not the case in any of the custody suites. However, custody officers knew where to access these online on the Home Office website. We observed that detainees were not always given a copy of their rights and entitlements notice, which did not meet the requirements of paragraph 3.2 of PACE code C (see cause of concern and recommendation S52). However, this position improved during our inspection once we pointed this out (see paragraph 3.53).

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[8] Fixed penalty notices can be issued for many road traffic offences and disorder offences such as shoplifting, possessing cannabis and being drunk and disorderly in a public place. If payment is received by the due date, the recipient does not get a criminal conviction.

[9] Served on an immigration detainee when there is no reasonable alternative action – e.g., if there is a likelihood that they may abscond or that their removal from the UK is imminent.

3.42 All detainees were offered free legal representation; if they declined, they were asked the reasons why and these were recorded. There were no posters informing detainees of their right to free legal advice displayed in any custody suite, which did not meet the requirements of paragraph 6.3 of PACE code C (see cause of concern and recommendation S52). There were sufficient interview/consultation rooms in all custody suites for detainees to consult their legal representatives in private. Detainees who wished to speak to their legal representatives on the telephone could do so in private at Forth Banks (which we saw taking place) and at Southwick. However, at Middle Engine Lane these calls still had to be taken at the booking-in desk, which lacked privacy and which did not meet the requirement of paragraph 6.1 of PACE code C (see cause of concern and recommendation S52 and paragraph 3.7). Legal representatives were routinely given a summary printout of the front sheet of their client's custody record on request.

3.43 Several copies of the PACE codes of practice were available in the suites but these were out of date, and they were not routinely explained or actively offered to detainees, as required under paragraph 1.2 of PACE code C (see cause of concern and recommendation S51). Although rights and entitlements could be obtained in a range of foreign languages, no custody officers who we spoke to were aware of the availability of PACE code C annex M translated documents. This meant that not all non-English speaking detainees would be provided with a range of written translated documents about their detention in their own language, as required.

3.44 There was a good process for the management and transportation of DNA samples, but a backlog of legitimate items had not been cleared at Middle Engine Lane. None of the sample refrigerators in the custody suites had locks, which could have affected the integrity of stored samples. We found a few additional refrigerators containing evidential exhibits that should not have been stored in the custody environment.

PACE reviews

3.45 PACE reviews of detention were undertaken by dedicated custody inspectors and operational inspectors from many roles and departments across the force area. Some reviews we observed were well conducted and prompt, while others only met the basic legal requirements (reminding detainees of their rights), with just brief details on the status of the investigation. Inspectors did not always cover other aspects of detention, such as the detainee's care and welfare needs.

3.46 Although many reviews were conducted on time few took place with the detainee in person. In our custody record analysis, only 36% of first reviews (33 out of 91) were carried out face to face, which was poor. Some reviews were carried out too early. Our analysis found that 33% of first reviews (30 out of 91) were conducted early - in one case a detainee was reviewed after only two hours 50 minutes with no rationale recorded for why this was necessary. Inspectors told us that they were under considerable pressure during their shift trying to balance conducting reviews alongside their other duties.

3.47 Where reviews had taken place while the detainee was asleep (46% in our analysis, 42 out of 91 first reviews), most of these were overnight during the detainee's period of rest. However, most detainees were not informed when they awoke that these had taken place. This did not meet the requirements of paragraph 15.7 PACE code C (see cause of concern and recommendation S53).

3.48 We observed some PACE reviews in which detainees were told that their continued detention was being authorised before the reviewing officer had given them the opportunity to make any representations regarding their continued detention. This did not meet the

requirements of paragraph 15.3 of PACE code C (see cause of concern and recommendation S53).

3.49 Reviews were often poorly recorded on custody records. They lacked detail and focused on processes rather than ensuring that the detainee's continued detention was necessary.

Access to swift justice

3.50 The force was focused on completing investigations during the first period of detention to avoid releasing detainees subject to further investigation. Our analysis of custody records identified that 78% of detainees (114 out of 146) had their cases concluded during their first period in custody. This was a good outcome for those detainees.

3.51 We observed that where custody officers identified that there was insufficient evidence to charge detainees, decisions to release them under investigation or to seek authorisation from senior officers to bail were made through the appropriate channels. Detainees released under investigation (RUI) or on police bail with conditions were told of the consequences if they attempted to compromise their investigations and they were given the relevant papers.

3.52 The progress of bail cases was closely monitored by the force bail manager, who was responsible for the administrative processes to ensure enquiries were pursued and applicable bail periods adhered to. At the time of our inspection, there were 282 active bail cases. In contrast, however, there were over 3,800 active RUI cases, of which 3,246 were over 28 days old. While there was monthly supervision of these cases, it was not clear that they were properly disposed of or that RUI was effectively managed to reduce investigation time and minimise the extended periods of RUI for detainees.

Complaints

3.53 No information on the complaints process was displayed in the custody suites. Information on how to complain was contained in the rights and entitlements notices but, as mentioned above, these were rarely offered to detainees, although this position improved during our inspection (see paragraph 3.41). Two of the main custody suites had out-of-date force leaflets on how to make a complaint, but we did not see these issued to any detainees. These were updated at one suite during our inspection.

3.54 Most custody staff told us they would notify the duty inspector if a detainee wished to make a complaint or would direct the individual to attend the police station front desk on release. A few custody officers said they would note the complaint if directed by the duty inspector and were aware of how to record them on the force computer system.

3.55 Force data showed that in the seven months to 31 July 2019, 91 complaints were received from individuals regarding custody-related incidents. Although we saw two detainees express concern that they had been assaulted by staff during their arrest - one as he arrived at the custody suite and one as he was being released - neither was asked if they wished to make a formal complaint and managers were not made aware of their concerns. This did not assure us that a detainee would be able to make a complaint while they were still in police custody.

Area for improvement

3.56 Complaints should be taken while detainees are still in custody, unless there is a legitimate reason not to do so.

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

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

Physical environment is safe

4.1 The custody estate in Northumbria had reduced significantly since the 2014 inspection from seven full-time suites and six part-time resilience suites to three full-time suites - at Forth Banks, Middle Engine Lane and Southwick - and six resilience suites - at Bedlington, Berwick, Etal Lane, South Shields, and the two football stadiums at St James' Park and the Stadium of Light. We inspected all the custody suites, except for Berwick, which was closed as part of a refurbishment programme but scheduled to re-open later in 2019. We found that most of the resilience suites were not in a condition or properly stocked to meet the needs of detainees if they had to be opened at short notice (see paragraph 1.3). We also found potential ligature points in all the suites, predominantly due to the design of toilets and some benches. At the end of the inspection we provided the force with a comprehensive illustrative report detailing these, which they responded to positively, taking immediate action to remedy some of the issues highlighted.

4.2 Conditions and cleanliness across the suites were good overall, with little evidence of in-cell graffiti. Southwick was dated compared with the two other full-time suites and lacked some amenities, for example it had no search room, glass fronted-cells, adaptations for disabled detainees, separate hub or discrete position for CCTV monitors (see paragraph 1.3). Most cells, other than designated dry cells, contained toilets and handwashing basins, but it was not always clear if the water in the basins was drinking water (see paragraph 4.21). All cells had natural light. Although staff were unable to control the temperature in cells, they were alert to this and could move detainees to alternative cells or issue extra blankets when necessary. The cleaners had specialist equipment to deep clean cells that had biological hazards, and an external contractor was used in the case of an emergency.

4.3 Cell call bells that we tested were functioning but in one suite their audio capability had been turned off, which posed significant risks. This was reinstated when we highlighted the issue (see paragraph 3.32 and area for improvement 3.34).

4.4 Although all suites had notices advising detainees that CCTV was operating they were not always prominently displayed as required by paragraph 3.11 of PACE code C (see cause of concern and recommendation S52 and paragraph 3.8). Neither were detainees advised of the CCTV cameras in all the cells (except at St James' Park) and there were no signs about this. (see paragraph 3.8 and area for improvement 3.12). During our review of CCTV footage we found a lack of audio coverage in key areas, such as holding rooms and cell corridors, and while there was audio coverage at the booking-in desks, this was not always effective. This gap did not afford adequate protection to detainees and staff alike (see paragraph 4.14).

4.5 Detention officers (DOs) conducted daily checks of the physical environment, including cells and communal areas, against a checklist, which ensured a consistent approach. Although the

checks were recorded to show they had been completed, we found a substantial number of gaps in the recording of these checks across the full-time suites, and some records were missing. This meant we could not be confident these checks were always completed comprehensively, as they had failed to identify any of the potential ligature points and other issues we found. Any damage or faults were recorded locally and reported online or by telephone to a central department or direct to the delegated contractors in an emergency. Responses to minor faults were mostly prompt but staff told us that some repairs could take a considerable time.

4.6 Custody staff were reasonably aware of emergency evacuation procedures and how and where to evacuate detainees in an emergency. However, most told us that they had not been involved in a fire drill in the previous 18 months, which contravened legal requirements. Force data showed that there had been a few drills and some scenario exercises in the previous eight months, but these did not cover all the teams and did not always identify which staff had taken part. There were insufficient sets of handcuffs in the custody suites to evacuate detainees from cells safely if required. These findings showed little improvement since our previous inspection.

4.7 A standardised emergency bag containing essential life support equipment was held in each clinical room. The contents were appropriate and included a defibrillator, and monitoring and checking arrangements were regular and appropriate. All custody staff we spoke to had received basic life support training.

Areas for improvement

4.8 The audio capability of call bell systems should not be switched off.

4.9 Notices advising detainees that CCTV cameras are in use in the custody suite and cells should be clear and prominently displayed throughout the custody suites.

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

Safety: use of force

4.11 Governance and oversight of the use of force in custody were inadequate. Although the force collected data on the use of force, it could only provide disaggregated data to show when force was used in custody from January 2019 onwards. Staff involved in the use of force against detainees did not always complete the required use of force forms. In the incidents for which we requested documentation, there were no use of force documents in just under half the cases, and we did not receive the full number of forms in most of the remaining cases. The recording of information in custody records did not always make clear that force had been used and, when it did, the entries did not always justify the use of force or detail the techniques used (see paragraph 1.12 and cause of concern and recommendation S53).

4.12 Force data showed that not all staff were up to date with their officer safety training. While some explanations for this were provided, it was unacceptable that some training had not been achieved simply due to staff leave affecting their availability, as some staff had been out of date for between four and five months. We were told that scheduled training was due to bring staff up to date. Custody staff did not routinely carry personal safety equipment in the custody suites, but handcuffs, leg restraints and spit guards were readily available if required.

4.13 Custody staff generally dealt patiently and sensitively with some challenging detainees. The force promoted a clear focus on de-escalation. Staff told us they would only use force as a last resort following negotiations with detainees to de-escalate situations where possible.

4.14 Through our custody record analysis, case audits and observations we identified 15 recent incidents involving the use of force that we reviewed in depth, including cross-referencing against CCTV footage. Our review of CCTV footage was restricted, however, due to deficiencies in the audio coverage (see paragraph 4.4). Eleven of the incidents were managed well overall in the level of force used. However, in four cases we had concerns over the choice of techniques used, and we referred these to the force so that lessons could be learned. In addition, we referred a further three cases to the force where we were concerned about the respect and dignity of detainees following removal of their clothing (see paragraph 3.2).

4.15 We were told there were some oversight processes to monitor use of force cases in custody, but this did not involve any cross-referencing to CCTV footage, and it was unclear how managers assured themselves that the force used in custody had been proportionate to the risks/threat posed or to identify any learning points (see paragraph 1.12 and area for improvement 1.19).

4.16 We observed many detainees arriving in custody wearing handcuffs, mostly for compliant transportation. In most cases these were removed quickly while the detainee was in the holding room, which was positive, but it was not always clear in the custody records when handcuffs were removed.

4.17 Force data showed that in the 12 months to 31 August 2019, 8.8% of all detainees had been subject to a strip search. Our custody record analysis found that only 5% of detainees had been strip searched, which compared favourably with the 9% average for all forces inspected since March 2016. We saw few strip searches authorised during the inspection. These took place appropriately in search rooms or in a cell without the CCTV camera switched on. However, the records we examined did not always indicate any reason or justification for the strip search or the removal of clothing to prevent self-harm, with or without force.

Areas for improvement

4.18 All staff involved in the use of force against a detainee should submit an individual use of force form.

4.19 The grounds and justification for a strip search or the removal of clothing should be fully recorded on a detainee's custody record.

Detainee care

4.20 Our custody record analysis showed that meals and drinks were regularly offered and provided to detainees - 68% had been offered a meal, as had all those held for over 24 hours. We also saw food and drinks regularly offered to detainees. There were sufficient stocks of microwaveable meals, including vegetarian and halal options, as well as hot drinks, and all were within their use-by dates. However, there were no specific provisions for any variation in meals, particularly for detainees in custody for lengthy periods.

4.21 None of the custody suites had drinking water in the cells and detainees had to ask for this (see paragraph 4.2).

4.22 There were handwashing facilities in the cells in the full-time suites except for the older section of Southwick, where detainees had to request access to this amenity.

4.23 All the custody suites had sufficient supplies of toiletries, towels and replacement clothing, including underwear and footwear for men and women. Toilet paper had to be requested, and at Southwick it was not hygienically stored - toilet rolls were kept on handles of cell doors and the ledges of cell spyholes.

4.24 The blankets provided to detainees were thin and unsuitable, offering little warmth or comfort. The detainees we spoke to said they provided minimal warmth. Custody staff had acknowledged this and said they often provided two or three blankets to ensure that detainees could keep warm.

4.25 Other aspects of detainee care did not follow *Authorised Professional Practice* guidance. All suites had limited provision of reading material, such as books or magazines, including those for children, and there were only a few books in foreign languages. From our observations, very few detainees were offered or provided with any reading material, and our custody record analysis showed that only 5% had been.

4.26 Detainees were not regularly offered a shower or exercise, even those held overnight or for extended periods. This was evident from our observations, speaking to custody staff, and the cases we looked at. Our custody record analysis showed that only 15% of detainees had been offered a shower, and that exercise was offered to only 9% - and to only 19% of those held over 24 hours. In our view, there were sufficient custody staff at all the suites during our visits to have offered care services more actively. When we raised this, some detainees were then provided with exercise.

Area for improvement

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

- **providing a more varied diet to detainees in custody, particularly those held for extended periods**
- **providing suitable blankets for detainees that ensure sufficient warmth and comfort**
- **increasing the range of reading material, especially for children and non-English speakers, and offering them consistently**
- **increasing detainees' access to showers and exercise, particularly when they are held overnight or for extended periods.**

Safeguarding

4.28 Both custody and frontline officers understood how to identify and address safeguarding concerns. This reflected the force's clear strategic priority to safeguard vulnerable people, and was supported by training and operational procedures. Safeguarding was seen as everyone's responsibility.

4.29 Arresting or investigating officers were responsible for making safeguarding referrals to the multi-agency working arrangements for children and vulnerable adults. They also made

custody officers aware of any issues that might affect a detainee while in custody or on release. There were safeguarding flags on the custody computer system to identify concerns, and information about referrals and any measures in place was available to all officers, although custody officers said they would not routinely look at this. Children were released safely to the care of a responsible adult.

4.30 Custody sergeants showed a good focus on prompt contact with appropriate adults (AAs - independent individuals who provide support to children and vulnerable adults in custody) so that they could support detainees, and help them understand their rights and entitlements as early as possible in their detention. In many of the cases we looked at for children, and those we observed, AAs had been contacted quickly and had often arrived shortly afterwards, regardless of the time or whether they were family members or an AA provided by the local authority. AAs then waited if the case was ready to progress or returned later to be with the detainee for any interviews or other custody processes.

4.31 Family members or carers were sought in the first instance to act as AAs. Where this was not possible the force relied on AAs provided from the local authorities' social services. For children, custody officers reported that this generally worked well, with AAs usually attending without undue delay. However, some local authorities provided AAs on a 24/7 basis while others stopped the service at midnight. This led to inconsistent outcomes for children, and some remained in custody longer than necessary because their case could not be progressed (see paragraph 3.39).

4.32 Securing AAs for vulnerable adults was more difficult. Requests were made to social services, but they did not normally provide an AA unless the detainee was known to them. The force had set up a scheme based on volunteers from Sunderland University, but there was not always someone available to attend. This meant some long waits for detainees, and we were told, and saw, some cases, where an AA could not be secured, or did not arrive, and the detainee was released because the maximum authorised period of detention was due to run out.

4.33 The force collected and monitored information to show how long it took for an AA for a child to arrive after they had been requested. The information was broken down by day and night and was used to hold partners to account. The information from January to the end of August 2019 showed an average wait of about two and a half hours for family members to arrive after they had been called. It took longer for local authority AAs to arrive and this varied between the different local authorities.

4.34 This monitoring was helpful in showing the importance that the force placed on securing AAs early. However, the request time for AAs was sometimes entered retrospectively on the force's computer system, which meant that the information may not have been completely accurate. The data also did not include the time between the detainee arriving in custody and the first request for an AA. This would have shown the total waiting time for an AA from the child arriving in custody, to pinpoint any delays more clearly.

4.35 Custody officers said they decided on whether an AA was needed for a vulnerable adult from a range of factors, such as the detainee's previous history and how they seemed when being booked into custody. However, in some of the cases we looked at where information suggested that a vulnerable adult might have needed the support of an AA, there was no evidence that this had been considered and no AA was called. This meant that some detainees might not have received the support they were needed.

4.36 There were guidance sheets to help AAs understand their role in supporting detainees, and we saw some examples where these were given out.

4.37 Children were generally cared for well in custody. They were usually kept away from adult detainees and held in cells in a children's wing. The liaison and diversion team saw and assessed all children where possible, with ongoing support available after the child left custody. Girls were allocated a female member of staff to look after their care needs. Telephone calls were facilitated for children, and easy-read rights and entitlements materials were available, although not always given out routinely. However, children were not prioritised for booking in to help minimise their exposure to the custody environment, and the visit rooms were not used to allow parents to provide ongoing support - although we were told that AAs sometimes sat with a child in an interview room to avoid them staying in a cell.

4.38 Custody officers were clearly focused on minimising the time children were kept in custody and avoiding overnight detention. In several cases we looked at and observed, this was achieved with cases progressed quickly and the child released promptly. When children spent longer in custody, this was mainly due to the complexity of the case or where they were under the influence of alcohol or drugs and needed to sober up before they could be dealt with. Very few children were charged and refused bail or brought into custody on warrants or for breach of bail and held in custody overnight as a result.

4.39 The duty inspector was notified when a child was brought into custody and was expected to make sure that it was necessary to keep them in custody and that the case progressed without delay. The chief inspector also reviewed this, with children in custody forming part of the daily management report. This provided good oversight over each child entering custody. However, we looked at a few cases in which children had been arrested, usually following a domestic incident, and where it seemed that custody could have been avoided, but there was no evidence on the custody record that any diversion from custody had been considered.

4.40 The force met regularly with the youth offending teams. There was also ongoing work with local authorities to improve the arrangements for them to meet their statutory responsibility to provide alternative accommodation for children charged and refused bail, and in agreeing and implementing the Home Office concordat on children in custody. While these arrangements showed some good joint working on dealing with children, there was little joint monitoring of children entering custody to help assess the outcomes and to identify strategically where improvements were needed, and the actions required to implement them.

4.41 Children charged and refused bail were rarely moved into alternative accommodation. Information provided by the force for the year to 31 August 2019 showed that 20 children required alternative accommodation provided through the local authority. Requests for accommodation were made but only four were moved – two to secure accommodation and two to appropriate (non-secure) accommodation. This was a poor outcome for the children remaining in custody.

4.42 Some children were also held overnight on a warrant or for breach of bail conditions to appear at the next court hearing. Alternative accommodation was not required in these circumstances, but custody officers still tried to avoid detaining these children overnight. However, some of the custody officers we spoke with were confused about the correct course of action in these circumstances. For example, in one case we looked at a juvenile detention certificate was completed for the court but was not required.

Areas for improvement

4.43 The force should ensure that all adult detainees who are vulnerable and need an appropriate adult receive one, and that appropriate adults can be secured without undue delay.

4.44 The force should strengthen its work with local authority partners to monitor children entering custody so that outcomes can be clearly assessed, and areas for improvement identified and addressed.

Governance of health care

4.45 Mitie Care and Custody had delivered physical health care in all the custody suites since 2015. Northumberland, Tyne and Wear NHS Foundation Trust (NTW) delivered criminal justice liaison and diversion (CJLD) across all the custody suites. Substance misuse services were only delivered in Forth Banks custody. Strategic oversight of health delivery was good, and contract performance was monitored through regular joint police and provider meetings.

4.46 Clinical governance arrangements were effective and much improved since the last inspection, with monthly governance meetings informing practice and incident management systems. Response times for the arrival of health care professionals (HCPs) when requested were set at 60 minutes and were monitored. In our custody records analysis, the mean time for a HCP to respond was 33 minutes. Mitie data showed the response time was met in 99% of cases.

4.47 Since our previous inspection, HCPs were now embedded 24 hours a day, seven days a week in all full-time suites, with a senior HCP available for telephone advice or attendance at suites if required. HCPs had access to forensic medical examiners (FMEs) for advice; we were told that Mitie was planning to introduce a nurse-led service. The service was carrying some vacancies and experienced some challenges to recruitment, which were resolving at the time of the inspection. Staff shortfalls were offset through using bank, overtime and agency staff cover.

4.48 Clinical rooms were clean and well-ordered, although none of the sinks in the three suites complied with infection-prevention standards. Separate rooms were used for taking forensic samples, and all rooms had the necessary clinical equipment and in-date stock. HCPs saw all detainees in the clinical room with the door open and custody staff observing, which affected patient confidentiality.

4.49 We judged clinical leadership to be strong and all staff we spoke to felt supported. All new staff were assigned a mentor and undertook a six-month induction covering all key areas. Staff received regular supervision, annual appraisals and complied with mandatory training requirements. Registered nurses and paramedics brought a rich skill mix to the team, and the staff we spoke to demonstrated a good knowledge of the health care needs of detainees in custody and possessed the necessary competencies.

4.50 There were appropriate information-sharing protocols, as well as policies to report and manage incidents. An independent health complaints process was available in the suites.

Area for improvement

4.51 Clinical consultations should take place in a confidential environment unless an individual risk assessment suggests otherwise.

Patient care

4.52 Custody staff understood the role of health care, made appropriate referrals and valued the professional staff's input. Detainees we spoke to felt supported and that their needs were met. The care provided to detainees was good. The health staff-detainee interactions we observed were respectful and professional, and consent was obtained from the detainee.

4.53 Health care staff used the SystmOne electronic clinical record system. They made appropriate entries directly into the electronic custody record and, with consent, could access NHS medication summaries, which was positive. Relevant health and medication information was shared with custody staff. The quality of records we examined was good; they contained key health needs and risks, and were contemporaneous.

4.54 A telephone interpreting service was used to communicate with non-English speaking detainees. Health staff wore a uniform and were easily identifiable.

4.55 Medicines management arrangements were robust and stock was subject to regular checks, and to further checks by the senior HCP. A proportionate range of medicines was available including controlled drugs, which were stored securely; only health care staff had access to drug cupboard keys. Detainees received prescription medication, including access to community-prescribed opiate substitution treatment, subject to validation. However, nicotine replacement therapy was not available for detainees who smoked. Symptomatic relief for those experiencing alcohol or substance withdrawal was available and underpinned by evidence-based protocols. A suitable range of patient group directives (authorising appropriate health care professionals to administer prescription-only medication) facilitated effective detainee care.

Area for improvement

4.56 Nicotine replacement products should be available for detainees who smoke.

Substance misuse

4.57 At the Forth Banks suite, the Change, Grow, Live voluntary body provided face-to-face support to detainees with substance misuse problems and made referrals to community services if required, through a dedicated practitioner working Monday to Friday; this service was valued by custody staff and detainees. There were no substance misuse workers in the other two suites; although their custody staff and health professionals could refer detainees to local community services, the service was inequitable with only limited immediate support for detainees.

4.58 Detainees leaving custody were given written information on local substance misuse services and how to access them. All custody suites had access to naloxone (a drug used to counteract opioid overdose).

Area for improvement

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

Mental health

4.60 Northumberland, Tyne and Wear NHS Foundation Trust delivered criminal justice liaison and diversion services across all the custody suites, with practitioners embedded in the suites seven days a week between 7am and 7pm, and with a clinical police liaison lead. The service had recently expanded to cover all ages, including children. Out-of-hours advice was available through local crisis services and street triage. The service was very good overall and met the needs of detainees.

4.61 Custody staff we spoke to had a good knowledge of mental health issues and valued the liaison and diversion team. Referrals were made as appropriate, detainees were seen promptly and clear pathways were identified. The foundation trust subcontracted an impressive range of innovative support from community organisations that was offered to detainees for up to 12 weeks post-release from custody; these included access to counselling, social care needs and the use of peer volunteers. At the time of inspection, there were promising advanced plans to recruit paid peer workers.

4.62 Strong working relations between the service and police were evident, with regular interagency meetings informing and developing practice. The liaison and diversion team provided training to custody staff, which was valued, and the team and the force reviewed adverse incidents together and shared learning. Training and supervision for mental health staff were good, and staff we spoke to valued the regular peer supervision groups led by clinical staff.

4.63 A street triage scheme, jointly delivered by police and mental health staff, was regarded as a significant asset in diverting vulnerable people away from custody. There had been no instances of people detained in custody under section 136 of the Mental Health Act (see footnote 3) since 2016, and there were no excessive delays for detainees detained under the Mental Health Act while waiting for secure mental health beds or transport to them. Assessments under the act were undertaken promptly.

Good practice

4.64 *Detainees leaving custody could access mental health support for up to 12 weeks following release, which included counselling, social care and peer support.*

4.65 *The integration of mental health staff and Northumbria Police was well-developed and included street triage, liaison and diversion and a clinical police liaison lead, which led to positive outcomes for detainees.*

Section 5. Release and transfer from custody

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

Pre-release risk assessment

5.1 There was a good focus on ensuring that detainees were released from custody safely. Pre-release risk assessments (PRRAs) were completed with the detainee present. Custody officers engaged well with detainees, had a clear focus on vulnerability and safeguarding, and used custody records to establish how the detainee was feeling to ensure they could be safely released. However, the recording of PRRAs was poor, with little description of what had been considered by custody sergeants or of any arrangements made.

5.2 Relevant agencies were often involved in supporting the release of detainees, and a good range of support leaflets was available – although only in English. However, we did not often see these given to detainees when they were released.

5.3 There was a clear focus on ensuring that detainees were able to get home safely on release. However, not all suites could access funds for this purpose and the force did not have any agreements with local service providers to help vulnerable detainees find their way home safely.

5.4 Detention officers completed person escort records (PERs) well and those we looked at contained accurate and relevant information. Pertinent health information was included but was often in loose-leaf form rather than summarised in the PER itself or (where appropriate) in a sealed confidential envelope.

Area for improvement

5.5 The force should have consistent arrangements to access funds or services to enable detainees who lack the means to get home safely on release.

Courts

5.6 Detainees held because they were required to appear at the next court hearing were processed promptly. We were told that detainees who had been arrested on warrant early in the day could sometimes spend longer in police detention, as the courts often refused to accept detainees if they were not likely to be ready for court until after the usual afternoon acceptance time. However, in general, detainees were not held in police custody for longer than necessary.

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

Causes of concern and recommendations

6.1 Cause of concern: The force did not consistently meet the requirements of the Police and Criminal Evidence Act codes of practice for the detention, treatment and questioning of persons.

Recommendation: The force should take immediate action to ensure that all custody procedures comply with legislation and guidance, and that officers implement them consistently. (S53)

6.2 Cause of concern: The recording on custody records was inconsistent and lacked sufficient detail. Not enough information was recorded to show the reasons why certain decisions had been taken or the sequence of actions relating to the detainee. Quality assurance arrangements were not sufficiently robust.

Recommendation: The force should ensure that recording on custody records is full and accurate, and clearly reflects the individual action taken for each detainee. It should robustly quality assure custody records to identify and act on any concerns. (S54)

6.3 Cause of concern: Staff in the custody area could view detainees using the toilet in their cell because these areas were not obscured on the CCTV screen. This had a significant adverse impact for the dignity of detainees.

Recommendation: The force should take immediate steps to ensure that toilets in cells are obscured on CCTV screens to provide sufficient privacy to detainees. (S55)

Areas for improvement

Leadership, accountability and partnerships

6.4 The force should ensure that all custody staff consistently follow *Authorised Professional Practice – Detention and Custody* and its own guidance so that detainees receive the appropriate treatment and care. (1.10)

6.5 The force should strengthen its approach to performance management by addressing any gaps in performance information and improving the accuracy of its data. (1.18)

6.6 The force should provide assurance that any force used in its suites is always safe and proportionate by having robust governance arrangements, including viewing incidents on CCTV. (1.19)

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

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

- ensuring that detainees are left appropriately clothed and with footwear when their own clothing and footwear have been removed
- informing all detainees that they can speak privately to custody staff, in line with the changes in PACE code C
- informing all detainees that CCTV is operating in their cells, if this information is not displayed in the cell
- making sure that shower and toilet doors allow sufficient privacy for detainees, and providing toilet paper routinely, unless the risk assessment identifies otherwise. (3.12)

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

- ensuring all detainees are asked to self-define their ethnicity and recording this accurately on custody records
- having arrangements to help detainees with mobility impairments so that they can easily call for assistance from their cells, and making arrangements at Southwick when the suite is unable to meet the needs of these detainees
- ensuring detainees have prompt access to interpreters and are not kept in custody for longer than necessary while waiting for them to attend. (3.22)

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

- any updates to detainee risk assessments, and the reasons for changes to observation levels, should be clear and recorded on the custody record
- detainees' clothing should be removed only if the individual risk assessment suggests that this is necessary
- all custody staff should carry anti-ligature knives
- cell keys should be effectively managed and controlled
- cell call bells should only be muted with the custody officer's authority and be properly recorded in the detention log. (3.34)

6.10 Complaints should be taken while detainees are still in custody, unless there is a legitimate reason not to do so. (3.56)

In the custody cell, safeguarding and health care

6.11 The audio capability of call bell systems should not be switched off. (4.8)

6.12 Notices advising detainees that CCTV cameras are in use in the custody suite and cells should be clear and prominently displayed throughout the custody suites. (4.9)

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

6.14 All staff involved in the use of force against a detainee should submit an individual use of force form. (4.18)

6.15 The grounds and justification for a strip search or the removal of clothing should be fully recorded on a detainee's custody record. (4.19)

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

- providing a more varied diet to detainees in custody, particularly those held for extended periods
- providing suitable blankets for detainees that ensure sufficient warmth and comfort
- increasing the range of reading material, especially for children and non-English speakers, and offering them consistently
- increasing detainees' access to showers and exercise, particularly when they are held overnight or for extended periods. (4.27)

6.17 The force should ensure that all adult detainees who are vulnerable and need an appropriate adult receive one, and that appropriate adults can be secured without undue delay. (4.43)

6.18 The force should strengthen its work with local authority partners to monitor children entering custody so that outcomes can be clearly assessed, and areas for improvement identified and addressed. (4.44)

6.19 Clinical consultations should take place in a confidential environment unless an individual risk assessment suggests otherwise. (4.51)

6.20 Nicotine replacement products should be available for detainees who smoke. (4.56)

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

Release and transfer from custody

6.22 The force should have consistent arrangements to access funds or services to enable detainees who lack the means to get home safely on release. (5.5)

Examples of good practice

6.23 Detainees leaving custody could access mental health support for up to 12 weeks following release, which included counselling, social care and peer support. (4.64)

6.24 The integration of mental health staff and Northumbria Police was well-developed and included street triage, liaison and diversion and a clinical police liaison lead, which led to positive outcomes for detainees. (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.

Strategy

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

Main recommendations

Quality assurance sampling of custody records should be carried out to a consistent standard, including checking against closed-circuit television (CCTV) recordings, person escort records and staff handovers. (2.31)	**Not achieved**
The force should ensure that learning from adverse incidents has clear management ownership to ensure that there is effective monitoring of trends and areas for improvement, and is communicated to frontline staff. (2.32)	**Achieved**

Recommendations

Staffing levels should be reviewed to ensure that there are sufficient custody staff on duty at all times to meet demand, and to ensure good and safe care of detainees. (3.8)	**Achieved**
The Police and Crime Commissioner or chief officer group should discuss with local authority partners at a strategic level how to address the lack of local authority accommodation for children and young people who have been refused bail at police stations. (3.12)	**Partially achieved**

Treatment and conditions

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

Main recommendations

The quality and consistency of initial risk assessments should be dynamic and ongoing, ensuring that correct information is considered at all times for the continued safety of detainees. (2.33)	**Partially achieved**
Pre-release risk assessments should be detailed, meaningful and the subject of discussion with the detainee before release. (2.34)	**Partially achieved**

Recommendations

Booking-in areas should provide sufficient privacy to allow effective communication between staff and detainees. (4.12, repeated recommendation 4.7)	**Not achieved**
Custody sergeants should ensure that non-custodial staff do not visit detainees in cells, make entries in detention logs or handle property unsupervised. (4.13)	**Partially achieved**
There should be a clearer focus on the specific needs of juvenile, female and disabled detainees; staff should be trained to deal effectively with these detainees. (4.14, repeated recommendation 4.8)	**Achieved**
All custody staff should carry suitable anti-ligature knives while carrying out their duties in the custody suite. (4.33)	**Not achieved**
All custody staff should be involved in the same shift handover and, wherever possible, this should be away from the booking-in area and recorded. (4.34)	**Not achieved**
Detainees should be offered information about relevant support organisations at the point of release. (4.35)	**Partially achieved**
Northumbria Police Service should collate use of force data from custody and examine it for trends in accordance with the Association of Chief Police Officers policy and College of Policing guidance. (4.40, repeated recommendation 4.22)	**Partially achieved**
All cells should be clean, well maintained, and properly heated and ventilated. (4.49)	**Achieved**
Emergency practice evacuations should take place regularly, and be recorded. (4.50)	**Not achieved**
Pillows and blankets should be provided to all detainees, subject to risk assessment. (4.59)	**Partially achieved**
The shower area at Sunderland custody suite should be repaired and safe for detainees to use. (4.60)	**Achieved**
All detainees held overnight, or who require one, should be offered a shower and should be able to use one in reasonable privacy. (4.61, repeated recommendation 4.33)	**Not achieved**
Detainees, particularly those held for more than 24 hours, should be offered exercise. (4.62)	**Not achieved**

Individual rights

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

Recommendations

Custody staff should check the grounds for detention at the start of the booking-in process. (5.11)	**Partially achieved**
Northumbria Police should liaise with Home Office Immigration Enforcement to ensure that immigration detainees are held in police custody suites for the shortest possible time. (5.12)	**Not achieved**
Appropriate adults should be available at all times for children and vulnerable adults. (5.13)	**Partially achieved**
Northumbria Police should engage with the local authorities to ensure the provision of safe beds for children who cannot be bailed, to prevent them from being held in police custody overnight. (5.14)	**Partially achieved**

Detainees should be able to have a telephone consultation with their legal adviser in private. (5.27)	**Partially achieved**
Senior police managers should engage with HM Courts and Tribunals Service to ensure that detainees are not held in police custody for longer than necessary because of limited cell capacity at the courts, and that detainees are taken to the nearest available court. (5.28)	**Achieved**
Detainees should be able to make a complaint about their care and treatment before they leave custody. (5.33)	**Not achieved**

Health care

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

Main recommendation

There should be robust governance arrangements to monitor health service provision, including attendance times, training, supervision and accountability of individual practitioners in their clinical practice. (2.35)	**Achieved**

Recommendations

There should be robust infection control procedures for all clinical rooms, which should be regularly cleaned and capable of being used for taking forensic samples, and custody staff should have access to a full range of appropriate and standardised first-aid and resuscitation equipment that is checked regularly. (6.9, repeated recommendation 6.10)	**Achieved**
All clinical rooms, including fixtures and fittings, should be fit for purpose and meet current environmental guidelines. (6.10)	**Not achieved**
All clinical records should be stored in accordance with the Data Protection Act and Caldicott principles to ensure confidentiality of personal health information. (6.22, repeated recommendation 6.20)	**Achieved**
There should be robust governance of medication management, including an agreed prescribing formulary, stock checks which include expiry dates as well as quantities, and oversight by a pharmacist. (6.23)	**Achieved**
Medication should only be administered by appropriately trained staff against legible prescriptions. (6.24)	**Achieved**

Appendix II: Methodology

Police custody inspections focus on the experience of, and outcomes for, detainees from their first point of contact with the police and through their time in custody to their release. Our inspections are unannounced and we visit the force over a two-week period. Our methodology includes the following elements, which inform our assessments against the criteria set out in our *Expectations for Police Custody*.[10]

Document review

Forces are asked to provide a number of key documents for us to review. These include: the custody policy and/or any supporting policies, such as the use of force; health provision policies; joint protocols with local authorities; staff training information, including officer safety training; minutes of any strategic and operational meetings for custody; partnership meeting minutes; equality action plans; complaints relating to custody in the six months before the inspection; and performance management information.

Key documents, including performance data, are also requested from commissioners and providers of health services in the custody suites and providers of in-reach health services in custody suites, such as crisis mental health and substance misuse services.

Data review

Forces are asked to complete a data collection template, based on police custody data for the previous 36 months. The template requests a range of information, including: custody population and throughput; demographic information; the number of voluntary attendees; the average time in detention; children; and detainees with mental ill health. This information is analysed and used to provide contextual information and help assess how well the force performs against some key areas of activity.

Custody record analysis

A documentary analysis of custody records is carried out on a representative sample of the custody records opened in the week preceding the inspection across all the suites in the force area. Records analysed are chosen at random, and a robust statistical formula provided by a government department statistician is used to calculate the sample size required to ensure that our records analysis reflects the throughput of the force's custody suites during that week.[11] The analysis focuses on the legal rights and treatment and conditions of the detainee. Where comparisons between groups or with other forces are included in the report, these differences are statistically significant.[12]

Case audits

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

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

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

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

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

Observations in custody suites

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

Interviews with key staff

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

Focus groups

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

Feedback to force

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

Appendix III: Inspection team

Martin Kettle	HMI Prisons team leader
Fiona Shearlaw	HMI Prisons inspector
Norma Collicott	HMI Constabulary and Fire & Rescue Services inspection lead
Marc Callaghan	HMI Constabulary and Fire & Rescue Services inspection officer
Patricia Nixon	HMI Constabulary and Fire & Rescue Services inspection officer
Vijay Singh	HMI Constabulary and Fire & Rescue Services inspection officer
Shaun Thomson	HMI Prisons health and social care inspector
Matthew Tedstone	Care Quality Commission inspector
Helen Ranns	HMI Prisons researcher
Joe Simmonds	HMI Prisons researcher