Report on an unannounced inspection visit to police custody suites in

Humberside

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

2–13 October 2017

This inspection was carried out in partnership with the Care Quality Commission.

Glossary of terms

We try to make our reports as clear as possible, but if you find terms that you do not know, please see the glossary in our 'Guide for writing inspection reports' on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

Any enquiries regarding this publication should be sent to HM Inspectorate of Prisons at Clive House, 5th Floor 70 Petty France, London SW1H 9EX, or hmiprisons.enquiries@hmiprisons.gsi.gov.uk, or HM Inspectorate of Constabulary and Fire & Rescue Services at 6th Floor, Globe House, 89 Eccleston Square, London SW1V 1PN, or contact@hmic.gsi.gov.uk

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

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

Contents

Section 1. Introduction

This report is part of a programme of unannounced inspections of police custody carried out jointly by our two inspectorates and which form a key part of the joint work programme of the criminal justice inspectorates. These inspections also contribute to the United Kingdom's response to its international obligation to ensure regular and independent inspection of all places of detention. The inspections look at strategy, treatment and conditions, individual rights and health care.

This is our first inspection of police custody in Humberside since 2012. Our findings suggest that although progress had been made in some areas, overall improvement was limited. A new custody suite had opened in Hull, providing a better environment for detainees, and there had been significant progress to avoid taking individuals detained under section 136 of the Mental Health Act 1983 into custody as a place of safety.

Among the positive outcomes we observed, we found that detainees were generally treated respectfully and officers dealt well with challenging detainees. Risks were generally assessed and managed well, and overall health care provision for detainees was good.

There was a good focus on diverting children away from custody or minimising the time they spent there. The number of children entering custody had reduced significantly over the last few years.

We highlight several concerns, however. The force was not complying with some of the requirements under code C of the Police and Criminal Evidence Act 1984 (PACE) for the detention, treatment and questioning of suspects, nor with some aspects of the College of Policing Authorised Professional Practice for detention and custody. As in our previous inspection, we identified a number of potential ligature points in custody suites, which posed a risk to detainees. There had also been little improvement in the provision of appropriate adult (AA) services to support children and vulnerable adults while in custody.

There were different working practices among custody officers and a reliance on frontline officers to ensure sufficient staffing levels in the custody suites. This potentially led to inconsistent outcomes for detainees. Performance information was not comprehensive and there was insufficient governance of the use of force. Despite some good partnership arrangements, of those children still entering custody, too many continued to be held overnight when they should have been moved to other more suitable accommodation.

We noted that only four of our 23 previous recommendations had been achieved and a further five had been partially achieved, 12 had not been achieved and two were no longer relevant.

This report provides three recommendations to the force and highlights 43 areas for improvement.

Dru Sharpling CBE
HM Inspector of Constabulary

Peter Clarke CVO OBE QPM
HM Chief Inspector of Prisons

January 2018

Section 2. Background and key findings

2.1 This report is one in a series relating to inspections of police custody carried out jointly by HM Inspectorate of Prisons (HMI Prisons) and HM Inspectorate of Constabulary and Fire & 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. HM Inspectorate of Prisons and HM Inspectorate of Constabulary and Fire & Rescue Services are two of several bodies making up the NPM in the UK.

2.2 The inspections of police custody look beyond the implementation of the Police and Criminal Evidence Act 1984 (PACE) codes of practice and the College of Policing's *Authorised Professional Practice - Detention and Custody* at force-wide strategies, treatment and conditions, individual rights and health care. They are also informed by a set of *Expectations for Police Custody*[1] about the appropriate treatment of detainees and conditions of detention, developed by the two inspectorates to assist best custodial practice.

2.3 A documentary analysis of custody records was conducted as part of the police custody inspection. The custody record analysis was carried out on a representative sample of the custody records, across all of the suites in that area, opened in the week prior to the inspection being announced. Records analysed were chosen at random and a robust statistical formula provided by a government department statistician was used to calculate the sample size required to ensure that our records analysis reflected the throughput of the force's custody suites during that week.[2] The analysis focused 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.[3] A total sample of 96 records were analysed.

2.4 A data collection template was completed by the force during the inspection and was based on police custody data for the 36 months prior to inspection. The template requested a range of information including data on the demographics of the custody population, the number of voluntary attendees and average length of time in police detention.

2.5 This was our second inspections of Humberside police custody; the first inspection was on 3-6 January 2012. During the 2017 inspection, the designated cells and cell capacity in the force area were as follows:

Custody cells	Cell capacity
Bridlington (contingency suite)	4
Clough Road, Hull	40
Grimsby	23
Priory Road (contingency suite)	20
Scunthorpe	14

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

2 95% confidence interval with a sampling error of 7%.

3 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.

2.6 Priory Road and Bridlington were contingency suites, used occasionally to meet demand.

Leadership, accountability and partnerships

2.7 Humberside Police had a clear governance structure for custody under the direction of the assistant chief constable, who had overall responsibility for the custody function. This structure provided clear accountability for the safe delivery of custody. There were effective internal meetings to oversee provision of custody services. The force facilitated access to external scrutiny and was open to challenge. However, the force had made only limited improvements since our last inspection, and different operational practices across the suites and between shifts were leading to inconsistent outcomes for detainees.

2.8 Initial custody training was good. However, although there were four additional professional development days a year, these were not sufficiently focused on improvements to custody practices. Custody staff reported that their working arrangements prevented them from attending additional training events, for example concerning vulnerability, that would benefit them in their role in custody.

2.9 There were generally sufficient custody staff resources, but there was a reliance on frontline officers to provide additional cover. There was little staffing resilience to cope with busy periods.

2.10 In several areas the force was not complying with code C of the PACE codes of practice for the detention, treatment and questioning of suspects, which was a significant concern. Also, although the force had adopted the College of Policing's *Authorised Professional Practice - Detention and Custody*, a number of the processes and practices we observed did not comply with this.

2.11 Performance management was not comprehensive and, in particular, the force did not have adequate 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.

2.12 The force had recently moved from the NSPIS (national strategy for police information systems) custody IT application to the Connect system. The quality of custody records on the new system required improvement.

2.13 There were gaps in ethnicity data on custody, which prevented the force from identifying areas of potential inequitable treatment. The force was unable to demonstrate how it met its obligations under the public sector equality duty.

2.14 The force had a clear strategic focus on protecting and diverting vulnerable people from custody, together with effective engagement. Of the individuals detained under section 136 of the Mental Health Act,[4] only two had been taken to custody as a place of safety - a significant achievement.

2.15 While there was clear engagement with local authority partners, too many children who were charged and had bail refused were detained in custody overnight, although this picture was beginning to improve.

---

[4] Section 136 of the Mental Health Act 1983 enables a police officer to remove, from a public place, someone who they believe to be suffering from a mental disorder and in need of immediate care and control, and take them to a place of safety - for example, a health or social care facility, or the home of a relative or friend. In exceptional circumstances (for example if the person's behaviour would pose an unmanageably high risk to others), the place of safety may be police custody.

Pre-custody: first point of contact

2.16 Frontline officers had a good understanding of people who were vulnerable and took account of this when making decisions about whether to make an arrest. However, the information they received on individuals was of variable quality and not always complete, timely or accurate, requiring them to make further enquiries of the call centre. Frontline officers were clearly focused on diverting vulnerable people and children away from custody.

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

2.17 The interactions we observed between staff and detainees were mostly adequate, but there were some concerning practices. Booking-in desks at Grimsby and Scunthorpe lacked sufficient privacy.

2.18 Custody staff had not received any recent diversity training and some were not sufficiently aware of how to meet the diverse needs of detainees. Women detainees were not always told of their female officer single point of contact, and staff did not ask all detainees if they had dependents who would be affected by their detention.

2.19 Both sergeants and detention officers carried out appropriate risk assessments of detainees, although there were some inconsistent practices between suites and individual shifts. Staff generally knew about the importance of regular monitoring and rousing of detainees who came in intoxicated. Most shift handovers had an appropriate focus on detainee welfare and risk.

2.20 We saw arresting officers provide reasons to detainees for arrest and custody sergeants authorise detention appropriately. We observed cases that were progressed promptly, but there were some delays due to the non-availability of investigating officers or waits for appropriate adults (AAs) or interpreters, which led to unnecessary and prolonged detention.

2.21 Up-to-date information on detainee rights and entitlements were available in all the custody suites but not all custody staff offered detainees a printed copy of these. We found some copies of the current version of PACE code C in all the suites but staff did not actively offer these to detainees.

2.22 Some PACE reviews of detention that we observed only met the basic legal requirements and did not explore other aspects of the detention. The records of reviews and telling detainees their rights were poor and unclear.

2.23 Oversight and governance of bail management and people 'released under investigation' were not adequate. At the time of our inspection, the force could not tell us how many people were released under investigation, so there was no assurance that those detainees would have swift justice.

In the custody cell, safeguarding and health care

2.24 The physical conditions across the custody estate were mixed. The cells in the older suites were in poor condition, although the communal areas were mostly clean. In contrast, the new suite at Clough Road, Hull was a better facility. We found potential ligature points in all the suites, both in cells and in some communal areas; these potentially posed a significant risk to individual detainees and the force.

2.25 Throughout the inspection, we saw staff dealing with challenging detainees patiently and they had de-escalated some difficult situations well. However, in the cases we examined, the use of force was not always proportionate to the risk posed. Some techniques were deployed poorly - including prone restraint. Use of force was not always recorded.

2.26 Food and drink were available for detainees outside of meal times, but practice in offering these varied significantly between the custody sergeants on shift. Detainees were not generally informed of or offered reading materials, exercise or showers, although staff were amenable to facilitating requests.

2.27 Frontline and custody officers understood safeguarding issues, although there was limited training to help custody staff identify safeguarding concerns. Safeguarding referrals were made by response or investigating officers, with limited involvement by custody officers and staff. Custody staff interactions with children showed an understanding of their needs and the use of age-appropriate language, but the custody records we examined did not reflect the care we saw in the custody suites.

2.28 Children and vulnerable adults did not always receive early support from AAs. There were good AA arrangements for children but limited arrangements for vulnerable adults, and inadequate provision for both overnight. Some custody processes were carried out without an AA present, including strip searching of children, which was a breach of PACE code C.

2.29 Custody sergeants were focused on avoiding or minimising the length of detention for children. However, there was limited monitoring to show the number of children detained overnight, or to ensure that all steps were taken to avoid overnight detention. The force and its local authority partners were working to the children's concordat to transfer children charged and refused bail to alternative accommodation. This had resulted in some children being moved from custody to more suitable accommodation, including one child who was moved to alternative secure accommodation.

2.30 We observed good police partnership working with health care professionals, and this was confirmed by custody staff. We saw some good patient care with a focus on risk and sensitivity to individual needs.

2.31 All three suites had good access to substance misuse workers, including at weekends. All the suites also offered drug and alcohol services to detainees both for mandated appointments and on request, with scope to signpost services for children.

2.32 The force did not monitor the time detainees waited for mental health assessments but staff said there were some lengthy waits for mental health assessments, due to the lack of approved mental health practitioners and doctors, as well as some long waits for mental health beds.

Release and transfer from custody

2.33 Although a template was used for completing pre-release risk assessments for detainees, the management of the process was not applied consistently and the recording of release arrangements on detention logs was not always clear.

2.34 A fully integrated liaison and diversion service was available to vulnerable detainees released from the Grimsby and Scunthorpe suites but was not provided in the Clough Road suite, which led to an inequitable service across the force area.

2.35 There were effective arrangements for ensuring detainees could attend court promptly.

Areas of concern and recommendations

2.36 **Area of concern**: We found a number of potential ligature points in all suites across the force custody estate. This posed a risk to detainees and the force.

Recommendation: The force should take immediate action to remove or manage any ligature points, to ensure safe custody.

2.37 **Area of concern:** The force did not comply with PACE code C and with the College of Policing *Authorised Professional Practice* guidance in several areas, which it needed to address as a matter of urgency.

Recommendation The force should ensure that all custody processes comply with the Police and Criminal Evidence Act 1984.

2.38 **Area of concern:** The arrangements for obtaining appropriate adults (AAs) did not ensure early and effective support for all children and vulnerable adults detained. Some custody processes, such as strip searches, took place without an AA present and without adequate justification for this, breaching the requirements under PACE.

Recommendation: The force must comply with PACE in ensuring an appropriate adult (AA) is present for the required stages of the custody process, and should work with local authority partners to ensure early and effective 24-hour AA support to detainees. The force should accurately record in custody records details of requests for AAs, their arrival times, relationship to the detainee and presence during the custody process, and monitor this information to assess the effectiveness of the AA arrangements and outcomes for detainees.

Section 3. 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

3.1 Humberside Police had a clear governance structure for custody, under the direction of the assistant chief constable (ACC), who had overall responsibility for the custody function. There was a superintendent head of criminal justice, a chief inspector, two inspector custody managers for the north and south of the force area, 20 dedicated custody sergeants and 52 detention officers who were on the police staff, as well as a policy sergeant and project coordinator. This structure provided clear accountability for the safe delivery of custody.

3.2 There were satisfactory internal meetings to oversee provision of custody services. A custody user group meeting chaired by a chief inspector fed into a strategic custody meeting chaired by the ACC. Minutes of these meetings showed clear progression of actions for custody improvements.

3.3 Despite the clear strategic framework, we found variation in the operational delivery of custody services between the suites, and often between the different shifts. This was of concern as there were different working arrangements for managing detainee risk, which led to inconsistent outcomes. The force was unable to demonstrate that it identified and mitigated risk for all detainees in the same way.

3.4 The force's strategic management had also not driven significant improvements in the delivery of custody services. It had achieved only four of the 23 recommendations we made at our last inspection.

3.5 The force was investing in its custody estate. There was a new suite at Clough Road, Hull since the last inspection. A new 36-cell custody suite in the south of the force area, to replace the suites at Grimsby and Scunthorpe, was due to open in 2019.

3.6 Our inspection identified potential ligature points in all custody suites, which we referred to the force. While we understood that the force would not wish to invest in suites due to be decommissioned, it needed to take action to mitigate the risks posed. We asked for the force to respond on how they planned to do this. (See recommendation 2.36.)

3.7 Initial training for custody staff was good. Staff undertook a nationally approved four-week training course, completed a professional development portfolio and shadowed experienced staff before taking on custody duties. However, subsequent training was not satisfactory. There were four additional professional development days a year, but these did not focus sufficiently on improvements to custody practices, and custody staff had not received wider training offered to other officers, for example in relation to vulnerability, which would have benefited them in their role in custody. There was an over-reliance on electronic learning, and staff told us they were unable to keep updated because of lack of time.

3.8 There was a reliance on the use of frontline officers trained in custody to meet minimum staffing levels. There was little staff capacity to manage busy periods, and little assessment of the effectiveness and efficiency of custody working practices. In our observations and case audits we found some poor practices, such as in the multiple recording of cell checks and adhering to set observation levels (see paragraph 5.19). The force needed sufficient staffing levels on all shifts to ensure the safe detention of all detainees.

3.9 The force had adopted the College of Policing's *Authorised Professional Practice - Detention and Custody*. This was complemented by some local policies where additional guidance was required. However, we observed that some processes and practices did not comply with the authorised practice, such as the automatic removal of detainee belts, cords and shoes, and pre-release risk assessments (see paragraphs 6.21 and 7.1).

3.10 Force leadership in clinical governance and monitoring of health services was generally good, with satisfactory arrangements for managing the health care contract. There were regular meetings to monitor performance, and the force enforced the contract to ensure that service requirements were met.

Areas for improvement

3.11 The force should ensure that the strategic management of custody delivers consistent working practices and good outcomes for detainees across all its suites.

3.12 There should be sufficient staffing levels on all shifts to ensure the safe detention of all detainees.

3.13 All custody staff should receive relevant refresher and continual professional development training that focuses on the key areas of activities to support them in delivering their role.

Accountability

3.14 The collation and monitoring of performance data on custody were not comprehensive across all key areas. For example, there was no monitoring of detainees' average time in custody after charge, arrival and detention times, or the use of police cells as a place of safety. The force had recognised that there were gaps and was developing some targeted performance reports. However, at the time of the inspection it was unable to demonstrate that it had adequate data to assess how well custody services were performing, identify trends and inform organisational learning.

3.15 The force did not have adequate 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. While there was some monitoring and oversight of incidents, and good recording of the details of officers involved, this was not routinely checked against CCTV footage. The force collated comprehensive data on the use of force in its custody suites, as required by the National Police Chiefs Council, but this was relatively recent and the force was not yet in a position to report this to the Home Office as part of the annual data return.

3.16 There were several areas where the force did not comply with the Police and Criminal Evidence Act 1984 (PACE) code of practice (code C) for the detention, treatment and questioning of suspects. These included detainees not being provided with a paper copy of their rights and entitlements, not being informed of a review of their detention while they

were asleep, and the lack of appropriate adults (see paragraphs 5.34, 5.46 and 6.38). This was a serious concern that the force needed to take urgent action on (see recommendations 2.37 and 2.38).

3.17 The quality of custody records was variable and in some cases poor. The force had moved from the NSPIS (national strategy for police information systems) custody IT application to the Connect system. Custody and other staff were still getting to grips with the new system but we found that the pro-forma entries often appeared to contradict wider narrative entries. This confused the picture of the detainee's time in custody, and it was difficult for the force to demonstrate the care they received.

3.18 There were quality assurance samples of a number of custody records each month from each suite. Trends were identified and lessons learned were shared with custody staff. However, the quality of record keeping was poor, and quality assurance of custody records had not been sufficiently robust to improve this.

3.19 The force was unable to demonstrate how it was meeting its obligations under the public sector equality duty. There was no Equality Act training for custody staff following induction, and none of the staff we spoke to had received recent equality and diversity training. No information was published, as required, on the force's website. There was an equality, diversity and human rights (EDHR) strategy and a strategic EDHR board, chaired by the deputy chief constable but these did not have any oversight or monitoring of custody.

3.20 The force also was failing to collect comprehensive ethnicity data on detainees. We observed few detainees being asked their ethnicity, and some custody records we saw either did not gather this or relied on police national records. Between the introduction of the new Connect system in June 2017 until the end of September 2017, the force did not record the ethnicity of detainees strip searched in 72% of cases. The lack of accurately recorded data prevented the force from identifying areas of potential inequity and meant it could not demonstrate that all detainees received fair and equal treatment.

3.21 The force facilitated access to external scrutiny and was open to challenge. It had invited a peer review from another force and was using the findings from this to inform improvements.

3.22 The force had a good relationship with its independent custody visitors (ICVs). The ICVs reported good and timely access to the suites and were able to raise issues with the staff and, if required, could escalate issues to the custody board.

Areas for improvement

3.23 The force should develop comprehensive performance monitoring across all aspects of custody services.

3.24 The force should strengthen its monitoring of use of force by cross-referencing incidents to CCTV, and should ensure that it can meet the requirement to report on the use of force in its custody suites to the Home Office as part of the annual data return.

3.25 The force should improve the quality of its custody records so that they are clear when and what actions have been taken, and that the care that a detainee receives while in custody can be clearly evidenced.

3.26 The force should take action to demonstrate that it meets the public sector equality duty.

3.27 The ethnicity of all detainees should be accurately recorded and monitored to assess that custody services and processes are delivered fairly, and any disproportionality should be identified and addressed.

Partnerships

3.28 The force had a strong focus on diverting vulnerable people and children away from custody. It engaged effectively with partners at a strategic level to make arrangements to achieve this in several areas.

3.29 A multi-agency mental health protocol had been agreed in January 2017 by a wide range of partner agencies. This covered the respective responsibilities of partners when dealing with individuals detained under section 136 of the Mental Health Act 1983.[5] In the last year, only two detainees had been taken to police custody under section 136, with the remainder taken to health based places of safety. This was a significant achievement.

3.30 The force had a protocol with its local authority partners to implement the concordat on children in custody. This was being followed and had started to result in some improvements with some children charged and refused bail transferred from custody to more appropriate accommodation. However, too many children continued to remain in custody overnight (see paragraph 6.36).

3.31 There were some good liaison and diversion services to support vulnerable detainees leaving custody. However, although integrated services were offered in the Grimsby and Scunthorpe suites and were successful, they were not available in the Clough Road suite. As a result, detainees did not receive an equitable service across the force area. Other diversion services available included the national 'Project Nova' scheme to support ex-armed force's personnel leaving custody. There was also a 'Women Together' scheme that took women referrals. However, there was little monitoring by the force to show how successful these schemes were.

3.32 The force recognised that more work with partners was needed to improve support for dealing with vulnerable people and to develop a more comprehensive approach to diversion.

[5] Section 136 of the Mental Health Act 1983 enables a police officer to remove, from a public place, someone who they believe to be suffering from a mental disorder and in need of immediate care and control, and take them to a place of safety - for example, a health or social care facility, or the home of a relative or friend. In exceptional circumstances (for example if the person's behaviour would pose an unmanageably high risk to others), the place of safety may be police custody.

Section 4. 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

4.1 Frontline officers who responded to incidents had a good understanding of vulnerability. They gave examples of why a person might be vulnerable, such as drug misuse, mental ill health or age, and also recognised that the circumstances a person found themselves in affected their vulnerability. Officers were aware of the force definition of vulnerability but tended to use their own experience and knowledge when assessing an individual. Frontline officers were confident in assessing vulnerability and took account of this when deciding what action to take**.**

4.2 Officers had received training in a range of vulnerability issues – including child sexual exploitation, mental health and autism – to help them identify and deal with vulnerable individuals. There was also vulnerability information on the intranet and officers had recently been given a booklet on the issue, although officers said they had little time to keep up to date with information.

4.3 The level and quality of the information that frontline officers received from the police control centre were variable. Officers said they were not always told all relevant information about cases, which they subsequently found in the log after they had responded to the incident. In some cases, the incident details had not been recorded accurately. Officers often requested further information from the control room and could access information directly themselves, but did not always have time to do this, especially if only one officer was attending an incident. There were risks in officers not having important information to hand when they made decisions on how to deal with an incident and whether to make an arrest and take an individual into custody.

4.4 Frontline officers attempted to divert vulnerable people away from custody wherever possible. Individuals detained under section 136 of the Mental Health Act 1983[6] were mostly taken to designated health based places of safety or, if they were intoxicated, to hospital. Although this meant that officers sometimes waited a significant length of time with individuals pending a mental health assessment, which was not good use of their time, it was leading to better outcomes for individuals by avoiding police custody.

4.5 Frontline officers told us they did not always feel well supported by mental health agencies when dealing with people with mental ill health who had committed an offence but did not need to be detained under section 136. They told us that in some circumstances they felt they had no alternative but to arrest these people so that access to mental health services could be arranged in the police custody suite. Officers held the view that this led to some

[6] Section 136 of the Mental Health Act 1983 enables a police officer to remove, from a public place, someone who they believe to be suffering from a mental disorder and in need of immediate care and control, and take them to a place of safety - for example, a health or social care facility, or the home of a relative or friend. In exceptional circumstances (for example if the person's behaviour would pose an unmanageably high risk to others), the place of safety may be police custody.

individuals being taken to custody when alternatives might have been possible with more help on the street from health services.

4.6 Frontline officers were confident in determining whether a person was capable of making their own decisions under the Mental Capacity Act 2005. However, they did not feel supported by health professionals in making these decisions and only took responsibility because they had no other choice. We were told that staff from Mind, the mental health charity, worked part time in the control centre to provide mental health advice, but the frontline officers we spoke to were not aware of this service or its role.

4.7 All children were regarded as vulnerable by virtue of their age and it was evident that frontline officers were active in avoiding bringing children into custody. They used voluntary attendance,[7] allowing incidents to calm down to be dealt with later, and community resolutions.[8] Officers also contacted the youth offending team to discuss interventions they could provide to avoid taking the child into custody. Officers reported that, in general, care homes also aimed to avoid children they looked after being taken into custody and tried to deal with incidents themselves before involving the police. In the main, this had resulted in children being taken into custody for serious offences only.

4.8 Force data showed that in the year to 30 September 2017, 1,320 children were brought into custody – 8% of custody throughput. Although this was a slight increase from the previous year, it was a significant reduction over the last few years.

4.9 Officers decided how to transport a detainee using police cars or vans as appropriate, depending on the circumstances. Although ambulances should have been used for people with mental ill health, officers sometimes used their own transport to avoid long delays. There were no specific arrangements for detainees with mobility needs but officers dealt with cases as the need arose. For example, we were told of a wheelchair user who regularly attended custody who had a care plan, which included the use of an adapted taxi.

Areas for improvement

4.10 Frontline officers should have sufficient and prompt information from the control room to inform their decision-making when dealing with incidents.

4.11 The force should work with partners to ensure that frontline officers have effective support when dealing with incidents, including alternatives to custody for people with mental health issues who are not detained under the Mental Health Act.

---

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

8 The resolution of a less serious offence or antisocial behaviour incident involving an identified offender (both youth and adult), through informal agreement between the parties rather than progression through the criminal justice process.

Section 5. 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

5.1 Most custody staff treated detainees in a considered and respectful manner. However, we found a few concerning examples in the custody records where some staff had failed to treat detainees with respect and dignity. These included using disrespectful language, and a 'punitive' approach to detainee behaviour – for example, withholding basic items, such as clothing or blankets, unless their behaviour improved. In one case, a detainee had been strip searched but was not given replacement trousers, and had to return to the custody desk only partially clothed below the waist. We also found that female staff had supervised men detainees during searches, the removal of their clothing and observation visits. We referred these cases back to the force to review and take further action as appropriate.

5.2 Detainee privacy was compromised through generally poor booking-in areas, affecting those wishing to make sensitive or confidential disclosures to staff. We had raised this issue at our previous inspection and it had not been satisfactorily addressed. The booking-in desks at Grimsby and Scunthorpe offered little privacy, and were noisy when the areas were busy. Staff were aware of the problem and said they would help to offset this by processing only one individual at a time, which was encouraging. However, this approach depended on the individual custody sergeant on shift and operational demands, and we found some occasions at Scunthorpe when both desks were used simultaneously. Privacy in Clough Road, Hull, where there were multiple custody desks, was significantly better but, even there, conversations could sometimes be overheard. Although this suite had a discrete booking-in desk available, we found no evidence that it was used for detainees even where it would have been more suitable depending on the sensitivities, vulnerabilities or circumstance of the case.

5.3 There were CCTV cameras in a few cells at Grimsby and Scunthorpe and in every cell at Clough Road. Toilet areas were appropriately obscured on monitoring screens, except in one cell at Clough Road, which compromised detainee privacy. Detainees in Scunthorpe also had no privacy to make calls to their legal advisers as the telephone they could use was sited within earshot of both staff and detainees at the front desk; this was inappropriate. The CCTV monitoring screen at Scunthorpe showing footage from inside cells was also located above the custody desk in potential sight of attending detainees. Positively, one shower at Scunthorpe designated for women detainees had been taken out of use because of concerns about its lack of privacy. However, similar problems remained elsewhere. For example, at Grimsby and the Priory Road contingency suite, staff had to be in very close proximity to monitor higher risk detainees using showers, due to the physical layout and type of screen doors.

5.4 Custody staff received minimal training to support them in dealing with people with diverse needs, as with their difficulties in accessing refresher and development training (see paragraph 3.7 and area for improvement 3.13). There was no evidence that custody staff had

received any relevant equality and diversity training since their original core training, which for some had been a considerable time ago. Staff therefore largely relied on their past experiences to help them deal with the range of detainees' individual needs. This picture had not improved since our inspection in 2012.

5.5 Arrangements for detainees with restricted mobility were mostly inadequate. Although wheelchairs were available at all sites (except, currently, Priory Road), none except Clough Road had suitable accommodation or accessible facilities. Grimsby and Scunthorpe were particularly unsuitable with no step-free access to showers or exercise facilities. Although the Grimsby suite had a designated cell with a wider door to facilitate wheelchair access (subject to risk assessment), with an adjacent accessible toilet, the cell did not have a lowered call bell and the toilet had no handrail support or combined shower facility. Extra thick mattresses were not available at any suite. Staff told us they would provide multiple mattresses where detainees required more support, but this depended on the number of detainees held and available stocks (which were mostly limited). Although Clough Road had a more appropriate environment, it had only one suitable cell, and there was no clear policy or process for how to manage more than one individual with such needs, or those who were detained in Grimsby or Scunthorpe. We were not assured that detainees affected by these issues would be taken to an appropriate environment.

5.6 Detainees were routinely asked about their dietary or religious requirements, which enabled staff to manage individual needs appropriately. Most suites stocked a generally adequate and appropriately stored selection of religious artefacts, including various texts and prayer mats. However, there were poor supplies of compasses for Muslim detainees, and Grimsby lacked prayer direction markings in cells. Force custody inspectors periodically reviewed the provision of artefacts to provide governance, oversight and quality control, although these were not recorded. However, there was no specific guidance to staff, either locally or through the force's custody intranet, to assist them with any religious worship and/or dietary issues, which further compounded their lack of relevant training on such issues.

5.7 There were other gaps in identifying individual circumstances during booking in. Detainees were not routinely asked to self-define their ethnicity, and in some custody records we reviewed this information was not recorded at all (since the force had moved to the new Connect IT system in June 2017, 7% of the its custody throughput was recorded as 'not stated'). Although detainees were also expected to be asked whether their detention affected anybody else who depended on their care, during our observations this was not consistently asked of (mostly male) detainees, and depended on the individual custody or detention officer. We had raised this issue as a concern in our previous inspection. Positively, women entering custody were generally asked about any pregnancy or sanitary needs (and there were good supplies of these items at all sites), but following a change to the risk assessment template on the Connect IT system, staff did not routinely ask them if they wished to speak to a female 'specific point of contact' officer. Even where detainees were assigned a specific female contact officer, this information was not always communicated to them, undermining the importance of this practice.

Areas for improvement

5.8 There should be privacy at booking-in desks. Where facilities are not appropriate, the force should have a formal policy guiding staff on how to manage multiple and/or vulnerable detainees at the custody desk.

5.9 Cell CCTV monitors should not be visible to detainees.

5.10 Staff should have access to religious, cultural and dietary guidance to aid their understanding of detainees' religious observance and individual needs.

5.11 Women detainees should have access to designated female staff at all times and be informed about this.

Communication

5.12 A professional telephone interpreting service was available to assist non-English-speaking detainees and staff were confident in how to access and use it. However, its effectiveness was hindered by poor equipment at some suites, and not all of the dual-handset telephones available worked efficiently.

5.13 Hearing loops were either not routinely available or where they were (Clough Road and Grimsby) staff had inconsistent or little understanding of how to use them. There were also no Braille or audio materials, such as information on detainee rights and entitlements, to support visually impaired detainees, although we were told these been ordered recently.

5.14 The rights and entitlements information was available in an easy-read format to assist detainees needing help with understanding or reading. In our review of CCTV footage, we saw one detainee disclose that he was illiterate but he was not offered any version of the rights and entitlements and there was no effort to explain these to him verbally.

5.15 Legal rights and entitlements information for detainees were available in 54 languages on the official government website and most staff were aware of how to access this. Clough Road and Scunthorpe had printouts of the more commonly-used languages, such as Polish, Lithuanian and Russian.

Areas for improvement

5.16 All suites should have working double-handset telephones to facilitate telephone interpreting.

5.17 There should be hearing loops in all custody suites and custody staff should be trained in how to use them. Braille and audio materials, including the detainees' rights and entitlements document (as a minimum), should be available for visually impaired detainees.

Risk assessments

5.18 Most detainee risk assessments were carried out by detention officers under the supervision of custody sergeants. Following the completion of the assessment, the custody sergeant set the cell observations levels for detainees and authorised their detention. The standardised risk assessment questions were comprehensive with an appropriate focus on identifying risk. However, since the introduction of the new Connect IT system, the risk assessment template had changed, and officers did not always complete this with sufficient detail (see paragraph 5.7). Custody staff interacted well with detainees, asked supplementary and probing questions, and routinely identified those in custody for the first time. Despite this, there were inconsistencies in the risk assessment completion process and its oversight. During busy periods in some suites, both custody sergeants and detention officers completed risk assessments with different detainees at the same time, which reduced the sergeant's oversight of the process.

5.19 There was routine cross-referencing to police national computer warning markers and historic information held on local intelligence systems to inform risk assessments further. Most care plans set detainee observations at an appropriate level, and were regularly reviewed and revised as required. Levels of observations by staff visiting detainees in cells were mostly adhered to, but we found some poor practice. For example, some staff had recorded multiple cell checks when monitoring detainees' welfare rather than individually recording the time of their visits in custody records. We also found evidence that *Authorised Professional Practice - Detention and Custody* guidance was not met with some observation levels incorrectly set, particularly for children, which was a concern (see paragraph 6.40). CCTV coverage varied from only two to three cells in the smaller suites to every cell at Clough Road. In most cases, CCTV was used appropriately to enhance observations, rather than to replace physical checks.

5.20 Although anti-rip clothing was not used, which was positive, the routine removal of detainees' clothing with cords, belts and footwear, without an individual risk assessment, was a disproportionate response to managing risk. Replacement footwear was not routinely offered to detainees, which was inappropriate (see paragraph 6.21). Staff were competent in rousing intoxicated detainees and understood the importance of regular checks, especially for those withdrawing from alcohol. Rousing checks were documented well in custody records.

5.21 As at the last inspection, not all custody staff carried personal issue anti-ligature knives. A new anti-ligature knife had been issued to all staff since the last inspection but they had not received any training and lacked confidence in how to use it. This posed a significant potential risk to vulnerable detainees.

5.22 The staff shift handovers we observed had an appropriate focus on risk, detainee welfare and case progression, and took place in private. Although all custody staff were present, health care staff did not routinely attend.

Areas for improvement

5.23 Risk assessments should be completed thoroughly and resulting care plans, including levels of observation, should adequately identify and manage risks.

5.24 Detainees' clothing and footwear should only be removed on the basis of an individual risk assessment, and the dignity of the detainee should always be maintained.

5.25 All custody staff should be trained in how to use the new design anti-ligature knife and carry them when working in the custody suite.

Individual legal rights

5.26 Custody sergeants and detention officers under supervision booked detainees into custody. In most cases, arresting officers provided a full explanation of the circumstances of and the necessity criteria for arrest under Police and Criminal Evidence Act 1984 (PACE) code G (code of practice for the statutory power of arrest by police officers) before detention was authorised. Posters to remind officers of the necessity criteria were displayed at Clough Road and Grimsby but not at Scunthorpe.

5.27 Sergeants told us that they were confident in refusing detention when the circumstances did not merit it, and provided details of such cases. We saw detention being refused for a

mentally vulnerable detainee at Clough Road who the custody sergeant believed was in need of medical intervention. The detainee agreed to attend voluntarily at a health based section 136[9] suite, which resulted in the detainee being appropriately diverted there from custody.

5.28 Alternatives to custody were available through community resolutions, penalty notices for disorder and voluntary attendance.[10] There were facilities for interviewing voluntary attendees outside of custody at several police stations. Force data showed that 1,002 voluntary attendees were interviewed between 6 June 2017 and 30 September 2017, but we could not establish where these individuals were interviewed or the effectiveness of this diversion from custody as the force did not provide any data pre-June 2017.

5.29 Most detainees were booked in promptly on arrival at the custody suites but we saw some delays of between 25 and 75 minutes. Force data showed an average waiting time of 24 minutes to be booked in between 6 June 2017 and 30 September 2017 across the force area, which was in line with findings elsewhere. Frontline officers in our focus groups said they regularly experienced long waits, on some occasions up to three hours, to have their detainees booked into custody. Such delays were unacceptable, particularly when they involved vulnerable and compliant detainees who could remain in handcuffs throughout this period (see paragraph 6.11).

5.30 Custody sergeants were aware of the need to minimise time in detention and to progress cases quickly. We observed some custody sergeants who were active in liaising with investigating officers to ensure cases were prioritised, particularly when these involved vulnerable detainees. We were told and observed that investigations were not always progressed promptly with delays due to the non-availability of investigating officers and appropriate adults (see paragraph 6.37), which lengthened detention in police custody. In one case we saw at Clough Road, a detainee was admitted to hospital overnight due to his level of intoxication but remained in police custody. He was released appropriately under investigation on return the following evening when the custody inspector learned that there were no investigating officers to deal with him. We were told of one case at Scunthorpe when a Polish interpreter left the suite at 2pm due to other commitments and it was 8.30pm before another interpreter was able to attend, delaying the investigation.

5.31 Two Home Office immigration enforcement staff were based full time at Clough Road custody suite, which had led to a streamlining in dealing with immigration detainees. The staff worked a variety of shifts over a seven-day period with cover provided from local immigration offices outside these times. Both custody and immigration staff reported good working relations and saw the joint working as a positive initiative. During our inspection, this service was further extended to Scunthorpe with the secondment of an additional Home Office immigration enforcement staff member there to cover both the Scunthorpe and Grimsby areas. We were told that in most cases immigration detainees who were to be transferred to immigration removal centres (IRCs) were usually moved on within 24 hours, although there were sometimes longer delays. Force data showed that 128 immigration detainees had been held in the year to 30 September 2017, which was a 5% decrease from the 135 held in the year to 30 September 2015. Force data also showed that the average

---

[9] Section 136 of the Mental Health Act 1983 enables a police officer to remove, from a public place, someone who they believe to be suffering from a mental disorder and in need of immediate care and control, and take them to a place of safety - for example, a health or social care facility, or the home of a relative or friend. In exceptional circumstances (for example if the person's behaviour would pose an unmanageably high risk to others), the place of safety may be police custody.

[10] Community resolution applies to the resolution of a less serious offence or antisocial behaviour incident involving an identified offender (both youth and adult), through informal agreement between the parties rather than progression through the criminal justice process. Penalty notices for disorder are a quick and effective alternative to deal with low level, anti-social and nuisance behaviour. Voluntary attendance is usually used for lesser offences, and involves suspects attending by appointment at a police station to be interviewed about these, avoiding the need for arrest and subsequent detention.

length of detention for immigration detainees following service of an IS91 warrant of detention[11] to transfer to an IRC between 1 October 2016 and 5 June 2017 was 15 hours 53 minutes, which was an improvement on what we found during our previous inspection.

5.32 Custody sergeants and detention officers told detainees of their rights[12] during booking-in, but in many cases detainees were not routinely offered a written notice setting out their rights and entitlements, which was contrary to PACE code C on the detention, treatment and questioning of persons by police officers (see area of concern and recommendation 2.37). These notices could be accessed in a range of foreign languages, and we saw these appropriately issued.

5.33 We saw detainees told that they could inform someone of their arrest, which staff facilitated. They sometimes also allowed the detainee to speak to their nominated representative while still at the booking-in desk.

5.34 All detainees were offered free legal representation and were told that if they declined they could change their mind at any time and accept this offer. Those wishing to telephone their legal advisers could not do so in private at Grimsby or Scunthorpe as all telephone calls had to be taken near the booking-in desks, which was inappropriate and contrary to PACE code C (see area of concern and recommendation 2.37). There were sufficient consultation and interview rooms at all the suites. Although we saw a queue of officers waiting to use these facilities at Grimsby, we were told that this happened infrequently. Legal advisers were given a printout of their client's front sheet custody record on request.

5.35 Detainees were told during booking in that they could read the PACE codes of practice but these were not always fully explained or actively offered to detainees. There were insufficient up-to-date copies of PACE code C in the suites, and at Bridlington these had not been updated to the current version.

5.36 Custody sergeants were aware of the availability of translated documents – such as authorisation of detention, charge details – in 31 languages but not all knew to access these.[13] We found evidence in our case audits that these were appropriately issued and we also observed this at Clough Road where a Mandarin-speaking detainee was issued with a translated document advising him of his detention for immigration matters, in addition to having access to a telephone interpreting service (see paragraph 5.14). Posters in several foreign languages informing detainees of their right to free legal advice were displayed at Clough Road but not at Grimsby or Scunthorpe.

5.37 Clough Road custody suite did not display any notices in the detainee entrance and main booking-in areas advising detainees that CCTV cameras were installed and recording, and the paper notices at Scunthorpe were not positioned prominently, contrary to PACE code C (see area of concern and recommendation 2.37).

5.38 There was an effective weekly system for collecting DNA samples taken in custody but we found a few old DNA and blood samples in a number of freezers across the suites, including Bridlington.

---

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

[12] Includes the right to have someone informed of their arrest, to consult a solicitor and access free independent legal advice, and to consult the PACE codes of practice.

[13] PACE code C annex M details the documents considered essential for the creation and provision of written translations.

Areas for improvement

5.39 Humberside Police should monitor the time that detainees are kept in custody to ensure that there are no unnecessary delays in progressing their cases.

5.40 Notices that CCTV cameras are in use should be clear and prominently displayed.

PACE reviews

5.41 PACE reviews of detention were carried out inconsistently. Some we observed only met the basic legal requirements (telling the detainee about their right to legal advice), with just brief details on the status of their investigation. Inspectors rarely covered other aspects of detention, such as the detainee's care and welfare needs. Some reviews were well conducted, indicating that the quality of a detainee's review depended on the individual inspector.

5.42 Although the detention log entries were confusing, it seemed that most detainees were visited in their cells for a review rather than inspectors conducting the review over the telephone, which was positive. However, many reviews took place while the detainee was asleep. In our custody record analysis, 40 of the 93 first reviews took place while the detainee was asleep, and not necessarily in a recognised period of rest. Our case audits and observations also showed that detainees were not routinely told when a review had taken place while they were asleep, which did not comply with PACE code C. We were particularly concerned about a child who had two reviews of detention while she was sleeping, of which one was by telephone. She was not informed of these, and there was no appropriate adult involved to assist in understanding and/or making any representations.

5.43 Many of the reviews were conducted early. In our custody record analysis, 24 of the 93 reviews were early, and we also observed early reviews. First reviews of detention should take place after six hours, yet in some cases, reviews took place within three hours of detention being authorised. The custody record entries for reviews were generally poor and unclear.

Areas for improvement

5.44 Where reviews of detention take place while a detainee is asleep, they should be informed of the review as soon as practicable, and this should be recorded on the custody record.

5.45 PACE reviews should be carried out to a consistently high standard, and information entered on custody records should be clear and adequately detailed.

Access to swift justice

5.46 The Police and Crime Act 2017 was introduced in April 2017. This had brought about changes to pre-charge bail and the introduction of some detainees being 'released under investigation' pending ongoing inquiries into their cases, which meant that not all detainees were now subject to bail conditions. The force could not demonstrate that all detainees received access to swift justice. Oversight and governance of detainees released on bail and released under investigation (RUI) were not adequate. RUI detainees were not obliged to return to the police station by a certain date, and the officer in the case did not have a

deadline to complete all necessary enquiries. There was no monitoring of RUI and at the time of our inspection the force could not tell us how many people were currently RUI. The force could also not provide any information on people who remained on bail under the 1976 Bail Act.

5.47 Since the changes to the bail legislation in April 2017, there has been a considerable reduction in the number of detainees bailed, down to 2% at the time of the inspection compared with 18% before the new law took effect. Although the force had prepared officers and staff for the new legislation, the new custody IT system did not enable the changes to be effectively managed. Staff had to work around the systems in place to set timescales and allow proper supervision of RUI cases. Without effective processes to manage RUI, the force could not ensure that investigations were completed promptly, and detainees had no information about when they were likely to hear the outcome of the investigation into their case.

5.48 The administration of bail was also not effective. While the process to apply for initial bail was straightforward and well understood, record keeping was inadequate with some information held on emails, which were not auditable and at risk of deletion. Re-bail applications were also not adequately recorded, and the cases we looked at did not record any rationale for the decisions for re-bailing, including when requests for re-bail were refused.

5.49 Where detainees were released on conditional bail, our case audits showed sufficient rationale to justify this, with the protection of vulnerable witnesses the primary reason. A sergeant at each custody suite was responsible for managing bail, but the procedure for sending weekly reminders to investigating officers, so that they were ready to deal with detainees on their bail return, was not followed consistently. As a result, the force had mixed success in managing individuals on bail effectively and ensuring they had access to swift justice.

Areas for improvement

5.50 All information on decisions about a detainee's detention and release should be recorded and retained.

5.51 The progress of investigations for detainees released under investigation should be monitored robustly to ensure there are no unnecessary delays and that cases are dealt with as quickly as possible.

Complaints

5.52 There was limited information displayed in the Clough Road and Grimsby suites informing detainees about what to do if they had any concerns about their arrest or detention. Not all the suites displayed this information at all, or in easy view or foreign languages, and staff did not inform detainees about making complaints during their booking in. Rights and entitlement documents, which included information about complaints, were not routinely provided to detainees as required (see paragraph 5.31).

5.53 Despite the lack of information, custody staff consistently said they would try to resolve issues about detainee welfare themselves, to help the detainee while they were in custody, but would refer more significant issues on to custody sergeants and/or duty inspectors. Although inspectors were expected to deal with any issues and meet the detainee before they left custody, this was not always possible because of operational demands. We identified

some cases where detainees had raised concerns with custody staff, including serious allegations such as assault, but staff had failed to deal with them appropriately. We referred these cases back to the force to review. We had raised similar concerns in our 2012 inspection, but the force has not taken sufficient action to address them

Area for improvement

5.54 Signs informing detainees how to lodge complaints should be displayed in clear view and different languages in all custody desk areas, and this information should be provided to detainees when they are booked in. Custody staff should immediately refer complaints received to custody sergeants and inspectors to consider.

Section 6. 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

6.1 The custody estate in Humberside had reduced since the previous inspection from six full-time designated suites and one reserve suite to three full-time designated suites and two reserve suites. As at the previous inspection, physical conditions across the custody estate were mixed. In the older suites, some cells were in poor condition, although the communal areas were mostly clean. There was too much ingrained dirt and graffiti in cells, and the in-cell toilets were grimy and stained. In contrast, the new suite at Clough Road, Hull, opened since the last inspection, had spacious clean cells with adequate hand washing facilities. There were no signs in the Clough Road suite to indicate that the water in the in-cell sinks was not suitable to drink. Ventilation in most cells was adequate, although some of the cells in Grimsby were too cold during cold weather. Exercise yards were small but in a fair condition. Plans to replace the facilities at Scunthorpe and Grimsby with a new 36-cell suite were advanced. We anticipated the new suite would address some of our concerns about the environments.

6.2 We found numerous potential ligature points in all the suites, both in cells and in some communal areas. In cells these were mostly in ventilation grilles and cell door hatches. This posed a risk to detainees and the force. We provided the force with a detailed illustrative report at the end of the inspection. (See area of concern and recommendation 2.36.)

6.3 Cell call bells were in reasonably good working order and custody staff explained to detainees how to use them. However, staff sometimes muted bells so that they could not hear the constant sound of them ringing, which could pose a significant risk to vulnerable detainees. Some detainees were escorted to their cells by patrol officers who did not always explain that they could speak to staff using the in-cell call bell.

6.4 The maintenance of suites was generally good, with most repairs carried out promptly. Only a small number of cells were out of use during the inspection. Detention officers completed daily fabric checks of cells, and sergeants carried out weekly health and safety checks of the whole suite. These checklists were collated on an electronic system that was monitored centrally. Deep cleaning took place when required.

6.5 There had been emergency evacuation exercises in most suites in the previous six months, and fire drills took place and were recorded centrally, although the suite logs did not always contain accurate records. Testing of fire and smoke detection equipment took place weekly. Staff knowledge of fire evacuation procedures was generally good. Well-equipped emergency evacuation bags were easily accessible in each suite, and staff knew where and how to evacuate detainees during an emergency. There were sufficient handcuffs in each suite to evacuate detainees safely in an emergency.

Areas for improvement

6.6 Cells should be free of graffiti and ingrained dirt.

6.7 Staff should not mute cell call bells.

Safety: use of force

6.8 Although the force collected data on the use of force in custody, its governance and oversight were inadequate. The force told us that most detention officers were out of date with their safety/personal protection training, although they were unable to provide a percentage figure. Some custody sergeants, and some police constables who worked in custody infrequently, were also out of date with their safety/personal protection training. Training for custody staff was scheduled for January 2018 to bring them up to date (see also area for improvement 3.13).

6.9 Custody staff generally dealt patiently and sensitively with some challenging detainees. They told us they would only use force as a last resort and following appropriate negotiations with detainees. However, individual staff accountability for use of force against detainees was inadequate. Staff did not always submit recording forms following incidents, and not all staff involved in incidents submitted individual forms. Forms did not always provide meaningful information about the necessity for using force. Detention logs generally contained reasonable information about the incident to justify why force had been used, but some accounts did not always reflect what we viewed on CCTV. We were not assured that the force always reviewed use of force in custody to ensure proportionality or to assist with individual and organisational learning (see area for improvement 3.24).

6.10 Through our custody record analysis, case audits and observations we identified 16 recent cases involving the use of force that we reviewed in depth, including cross-referencing against CCTV footage. Half the incidents we reviewed were managed well. We found at least learning points in the remainder. Concerns from the CCTV footage included some cases where force was heavy-handed, not used as a last resort and not proportionate to the risk posed, and poor use of techniques, one of which was potentially injurious to the detainee when pressure was placed on his back in the prone position. We referred one case to the force for a full review, although this was not directly related to the use of force (see area for improvement 3.24)

6.11 Most detainees arrived in custody wearing handcuffs, but we saw many examples where handcuffs remained in place on compliant detainees for too long (see also paragraph 5.29). This was disproportionate to the threat posed in the controlled custody environment, and was similar to what we found in our 2012 inspection.

6.12 Senior managers told us that Tasers had not been used in custody in the previous 12 months, and we were assured that they would only be used in exceptional circumstances. The force was piloting the use of spit guards and had introduced a policy to provide staff guidance on their use. The pilot was being scrutinised by an independent panel that included the independent custody visitors scheme manager. We reviewed a case at Clough Road that occurred during our inspection, which involved the use of a spit guard on a 17-year-old child. We referred this case to the force on several grounds, including concerns about the proportionality and governance of the use of spit guards in the custody environment and, in particular, on a child.

6.13 In the previous 12 months, 1,401 detainees (9%) had been subject to a strip search in custody, which was similar to comparative findings elsewhere. However, since the force had

changed its custody computer system in June 2017, the ethnicity details for 286 of these detainees had not been recorded, which did not convince us that this area was being effectively monitored (see paragraph 3.20). We saw few strip searches authorised during the inspection, but where these took place there were appropriate grounds for doing so.

Areas for improvement

6.14 Each member of staff involved in using force against a detainee should submit an individual use of force form.

6.15 Handcuffs should be removed immediately from detainees in holding areas unless a risk assessment indicates the need for restraints for the safety of staff and others.

Detainee care

6.16 There was a small selection of microwaveable meals for detainees. At Clough Road, freshly prepared food had been available from an on-site canteen but this had been withdrawn. Limited vegetarian, vegan and Halal-suitable options were available, although there was no guidance to assist staff in assessing suitability for other dietary needs. Contrary to *Approved Professional Practice*, there was also no clear or consistent process setting out what staff should do when detainees' health and dietary requirements required suitable alternatives, and staff had limited knowledge about what to do in such situations. Some food stocks at Grimsby and Priory Road were also out of date or close to expiry. Hot and cold drinks and water were available on request, but there was no drinking water in cells (see also paragraph 6.1).

6.17 Timings of meals varied slightly between suites, with breakfast dependent on when detainees were collected for transfer to courts. Staff said that food was available outside of meal times, including night times, and could be provided in multiple quantities if requested. However, many detention officers acknowledged that this depended on the custody sergeant on shift. We saw little evidence of food served between meal times. For example, at Clough Road a woman detainee who had arrived in custody intoxicated the previous night requested some food at about 11am the following day but had to wait until the lunch at approximately 90 minutes later. We also found no evidence that arrivals were asked whether they wanted something to eat, although we did observe offers of drinks. In our custody record analysis, 83 of 114 detainees reviewed (73%) were offered a meal during their detention, including all 17 of those detained for longer than 24 hours. In our case audits, some records showed no offers of food or drink, even where the individual had been detained for a lengthy period. Some staff said that complications with the new IT system had made recording such details more difficult, and so the actual practice might have differed from the records, but this was not possible to verify.

6.18 Mattresses and pillows were routinely provided in all cells (although reserve stocks were mostly in limited supply), and cleaned where required between uses. Stocks of blankets were generally good and staff were mostly happy to provide these in multiple quantities if requested and supplies allowed. Temperatures in the suites during our visits were mostly acceptable, although Bridlington was too warm and staff at Grimsby reported longstanding difficulties in cold weather that they had to try to offset where possible (see paragraph 6.1).

6.19 Toilet paper was not routinely provided, contrary to *Approved Professional Practice*, and so some detainees had to request this. Hand washing facilities were not available in cells at Grimsby or Scunthorpe and detainees had to request to leave their cell and use wash basins

if staff were available. Cotton towels were available in all suites as well as a variable selection of toiletries. Female sanitary packs were available in plentiful supply and offered at all suites, which was positive.

6.20 Every suite had at least one shower, with specific facilities for women detainees at Grimsby, Scunthorpe and Priory Road, and children at Grimsby and Priory Road. Aside from the newer facilities at Clough Road, these were mainly in variable to poor condition with inadequate privacy. A dual shower area at Grimsby posed multiple significant ligature concerns, but staff were aware of this and said they would offset these risks without breaching detainee privacy. Showers were not routinely offered and we saw some detainees going to court who had not had a shower (or a hand wash), although staff said they would always try to facilitate them wherever possible on request. However, we did also see a few cases where detainees could have a shower or wash during the day. In our case audits, we found no examples of detainees offered or receiving showers, despite some lengthy and/or overnight detentions, and the general lack of provision was further revealed in our custody record analysis, in which only eight of 114 detainees (7%) were offered a shower - the picture was slightly better for detainees held for more than 24 hours, where six out of 17 (35%) had been offered a shower.

6.21 Tracksuits and tops and bottoms, as well as plimsolls and foam slippers, were available for detainees whose clothing was seized due to soiling, safety or evidential purposes. Clothing stocks were mostly adequate, but there were some deficiencies, such as low supplies at Scunthorpe. Shoelaces, cords and belts were automatically confiscated from detainees, as well as, unusually, shoes without laces (see paragraph 5.20), which meant that detainees regularly required replacements. We observed many detainees walking about suites in their socks or bare feet, which was inappropriate. However, replacement underwear and socks for both men and women were usually available in good supply at all suites, and paper (safety) suits were not issued as replacement clothing, which was positive.

6.22 Facilities for detainees to exercise were generally good, with large open air areas away from public view at each suite. Although all the facilities were on CCTV, detainees using them were always accompanied by custody staff. Staff told us that they would facilitate exercise wherever possible, and we observed some limited instances of this, but some also acknowledged this was not always feasible because of staffing levels. In our custody record analysis, only 4% of the 114 detainees reviewed had been offered this, although this was slightly better (12%) for those detained over 24 hours.

6.23 Suites held little reading matter, with few child-friendly materials or anything in the most common foreign languages. We did not see reading material offered to detainees routinely, even for one who said they were 'bored', although we did observe some instances of staff providing this on request. We found that only seven of the 114 detainees reviewed (6%) were offered something to read, increasing only marginally to 12% of those held for over 24 hours.

6.24 As with other recent force inspections, and indeed our 2012 visit to Humberside, we found that staff were largely reactive rather than proactive in providing facilities or materials for detainees. Such a 'request culture' was similar to that identified in our last inspection in Humberside, and had largely remained the same. We similarly noted that Police and Criminal Evidence Act 1984 (PACE) reviews were largely focused on case progression with no consideration of detainees' welfare needs (see paragraph 5.41).

6.25 Positively, all suites (except Bridlington) had facilities for detainees to receive visits from friends and family. We were told that these were used frequently, particularly for detainees held for longer periods or on non-PACE matters (such as prison recall) during quieter periods and when staff were available. Although we did not observe any visits during our

inspection, staff cited recent examples, and we found some limited evidence of this in our custody record analysis, which was unusual.

Areas for improvement

6.26 There should be clear guidance for staff on how to manage detainee requests for alternative food required on medical and/or dietary grounds.

6.27 Detainees going to court should have the opportunity to shower.

6.28 Detainees should automatically receive toilet paper in their cells barring risk assessment indicators, as per *Approved Professional Practice* guidance.

6.29 Detainees, particularly those held for longer periods, should be routinely offered exercise, showers and a diverse selection of reading materials to improve their care and welfare while in custody.

6.30 Detainees whose clothing has been confiscated should be provided with replacement items immediately.

Safeguarding

6.31 Frontline and custody officers had an understanding of safeguarding, how to recognise concerns and the action they should take. Custody staff recognised that it was important to be alert to safeguarding issues, as detainees often disclosed concerns while in custody, and not necessarily during the more formal risk assessment.

6.32 Frontline officers routinely made safeguarding referrals to multiagency teams for both vulnerable adults and children. Custody officers had a more limited role, relying on referrals from arresting or investigating officers. However, those we spoke to clearly understood the importance of safeguarding and said they would raise concerns with the appropriate specialist team. The force had recently made custody officers responsible for making direct referrals for children, although few were yet aware of this change.

6.33 There was no specific safeguarding policy for custody, and there had been little staff training (see area for improvement 3.13). Custody staff were expected to complete mandatory e-learning packages on safeguarding with additional information spread through emails or briefing documents, which most staff told us they did not have time to read. The force was including the approach to safeguarding in its draft custody policy, and planned to deliver training on safeguarding, including child sexual exploitation, when it introduced continual professional development days for custody staff.

6.34 Children and vulnerable adults did not consistently receive early support from appropriate adults (AAs). Custody officers sought to contact parents, family members or friends, or care workers in the first instance, but relied on an AA where they were unable to obtain them.

6.35 The AA provision varied between the local authorities covering specific custody suites. For children, the local authority youth offending teams (YOTs) provided the AA service during the day and evening, and we were told that these arrangements worked well, with AAs arriving promptly. YOT workers were based in the Clough Road suite from 8.30am until 10pm offering a quick response for all aspects of the custody process, which was positive. However, the service for vulnerable adults varied between suites, with no guarantee of an early response. Custody officers relied on AAs from a variety of sources, including the local

authority social services or YOT teams, partner agencies and volunteers. The force had recognised the shortcomings in AA provision for vulnerable adults and was working with the Office of Police and Crime Commissioner and other agencies to provide a more comprehensive and reliable service.

6.36 There was inadequate AA provision for both children and vulnerable adults overnight. There were arrangements to call the national AA service, but in practice custody officers rarely used this and did not expect AAs to be provided during the night. We were told that this led to some detainees remaining in custody overnight as they could not be dealt with until an AA arrived the following day. (See area of concern and recommendation 2.38.)

6.37 Our observations and case audits showed a mixed picture on how custody officers secured AAs. While some AAs were called early and arrived promptly, others were often only asked to attend for the interview stage. This meant a delay in giving early advice and ensuring that detainees understood their rights and entitlements while in custody. We found some cases where AAs did not arrive, and they were not always present at different stages of the custody process. We had particular concerns in two cases where children were strip searched without an AA present and with insufficient rationale on the custody record to justify this, in breach of PACE code C (see areas of concern and recommendations 2.37 and 2.38).

6.38 The force did not monitor the effectiveness of the AA provision and record keeping, as in so many other areas, was inconsistent. Records often failed to show when AAs were called, when they arrived and their relationship to the child. Our custody record analysis for both vulnerable adults and children showed an average wait for AAs of just over eight hours, varying from one hour up to 23 hours. This was clearly a poor outcome for some detainees. (See area of concern and recommendation 2.38.)

6.39 We observed some good interactions between custody staff and children, showing an understanding of their needs and the use of age-appropriate language. However, we also found some examples in our case audits where children had not been treated appropriately, with some derogatory comments on custody records, and in one case a punitive approach to achieve improved behaviour.

6.40 Risk assessments for children were generally completed appropriately, although there was little involvement of health care professionals, which should have been considered in some of the cases we looked at. It was also concerning that in some of our case audits children were placed on 60-minute visits to check their welfare, which was not in line with *Authorised Professional Practice* guidance for at least 30-minute visits. There was a focus on safe release for children, and we observed custody staff ensuring arrangements to return the child safely home. However, the details were not always adequately documented on the custody record to demonstrate that this happened.

6.41 We observed some good care for children in custody, with food and drink offered and some provision of reading materials and exercise. The practice we observed was better than that indicated in the custody records. However, there was not always sufficient attention to keeping children away from adult detainees, although the juvenile cells were used in Grimsby and Scunthorpe. Although custody staff were aware of the statutory requirement to allocate a designated female officer for girls to look after their care needs, in line with the Children and Young Persons Act 1933, this was not always recorded on custody records, so the force was unable to show whether it complied. Some children had reviews of detention while they were sleeping but during the daytime, so outside of the recognised periods of rest, which was poor practice (see also paragraph 5.42).

6.42 Custody officers were focused on avoiding, or minimising, detention for children. They told us they would refuse detention where warranted, and deal with cases quickly, including

during the night if possible. However, the force did not monitor the overall number of children detained overnight, or individual cases, to ensure that all steps were taken to avoid overnight detention. This made it difficult for the force to assess how well it was performing. Our custody record analysis, case audits and observations indicated that a significant proportion of children entering custody were detained overnight.

6.43 The force had started to make progress in avoiding overnight detention for children charged and refused bail. In these circumstances, local authorities have a statutory duty to find suitable alternative accommodation for the child. The force and all its local authority partners were working to arrangements agreed under the Concordant on Children in Custody.[14] It was clear from our observations and case audits that there was good joint working, including escalation procedures, in trying to move children to alternative accommodation.

6.44 In one area, the local authority had set up a two-bedroom house to use as alternative accommodation for children charged and refused bail, with staff on call to attend as needed. The house had dual purpose but could be made readily available as alternative accommodation for children when needed. It had been used twice since June 2017.

6.45 However, the lack of both secure and non-secure accommodation prevented the transfer to alternative accommodation for many children. Force information showed that in the year to 30 September 2017, 73 children were charged and refused bail and requests for alternative accommodation were made in 61 cases, but only nine children were moved, and none to secure accommodation. All the moves were in the four months to September, and during our inspection one child was moved to secure accommodation, which indicated an improving picture. Nevertheless, outcomes for children remained poor with too many remaining in custody overnight.

6.46 Custody officers completed detention certificates for the court for children who had remained in custody instead of being transferred to alternative accommodation. However, some of these certificates were not completed accurately to show the reasons why the child had not been moved. There was also no joint monitoring by the force and its partner agencies on the effectiveness of the joint working arrangements, and there was no information to joint governance structures, such as the local children's safeguarding boards, where concerns could be addressed strategically.

Areas for improvement

6.47 The force should strengthen its approach to safeguarding children and vulnerable adults by ensuring that staff are effectively supported by policies, procedures and training. In particular, the force should ensure that:

- all children are placed on 30-minute visits as a minimum, in line with *Authorised Professional Practice* guidance;
- all girls are assigned a female officer to care for their welfare needs while in custody, in line with the Children and Young Persons Act 1933, and the details are accurately recorded on the custody record.

[14] The Home Office and the Department of Education have produced a draft concordat to prevent the detention of children in police stations following charge. This has not yet been formally published but is available for forces and local authorities to implement the guidance set out.

6.48 The force should continue to work with local authority partners to avoid the overnight detention of children in custody by their transfer to suitable alternative accommodation. Detention certificates should be accurately completed, and performance information should be monitored, with appropriate oversight at a strategic level.

6.49 The force should monitor all children detained overnight, both pre- and post-charge, so that it can assure itself and others that all necessary actions are being taken to avoid overnight detention, and to assess the effectiveness of its approach.

Governance of health care

6.50 Health services were commissioned by the Police and Crime Commissioner with provision by Leeds Community Health NHS Trust. A new regional contract across four forces was being retendered.

6.51 The force relied on the trust to provide performance data and there were monthly and quarterly contract monitoring meetings. In the year to August 2017, the overall performance against the target response time of health care professionals (HCPs) arriving within 60 minutes of being requested had increased from 91% in November 2016 to 98% in August 2017 across all the suites (including Bridlington which closed in March 2017 and hospital calls for sampling purposes).

6.52 There was some variation between the three suites, with slightly more delays at the Scunthorpe suite. There was reasonable evidence that delays were mitigated through clinical prioritisation, and there were few examples of delays in attendance to detainees with more significant clinical need. Detailed performance data were reported to the force through contract meetings, including analysis and scrutiny of calls and their clinical priority.

6.53 Three HCPs and one forensic medical examiner (FME) were available 24 hours. Two HCPs were usually based at Clough Road and the third travelled between Grimsby and Scunthorpe. The current rota was under consultation to address gaps in cover across the suites.

6.54 The FME was on call for the force area and travelled between the suites. The average response times by FMEs was worse than those for HCPs. While this was partly due to the distance covered, there were a few examples with no valid reason for the delay, and we were also told of instances of FMEs refusing to come out and/or trying to address issues by telephone, which could create a risk.

6.55 Clinical governance was generally sound. Incident reporting was good with trend analysis. A total of 140 incidents had been reported in the previous six months. Detainees were able to make a complaint about health provision; the one complaint the previous year had come via the police and was not upheld. Health professionals could access all the provider policies and a range of standard operating procedures through the intranet.

6.56 There was compliance with suitable mandatory training and systematic checking of professional registration status. Management supervision was improving and clinical supervision was being developed. There were regular staff meetings and a plan to trial a Skype system to enable more staff to attend.

6.57 The Clough Road suite provided an excellent modern clinical environment, with separate forensic examination facilities. At Grimsby, the clinical room was satisfactory with

appropriate clinical equipment and furniture and access to SystmOne (the clinical IT system), although the dual-set telephone used for interpreting was not working effectively (see area for improvement 5.16). Scunthorpe had suitable clinical equipment, but the floor was not infection control compliant and the floor was visibly dirty. Sharps boxes in all the suites were kept in cupboards, which did not support safe disposal. Paper couch rolls were available but not visible.

6.58 Storage of clinical consumables, including forensic sampling kits, was reasonable but kits at Scunthorpe were kept in a metal trolley that was dusty. A few kits in Grimsby were out of date.

6.59 An annual infection control audit had been completed in April 2017 for Clough Road and Grimsby suites with related infection control action plans; there was evidence that key issues had been addressed. Scunthorpe had not been audited due to building works. We were told there was daily cleaning in all three suites but there were no cleaning schedules visible.

6.60 Electronic clinical records were factual and suitably detailed, supported by effective information sharing with custody staff. Paper records were kept for consent for examination, information sharing, body mapping and forensic sampling, hospital referrals and 'over the prescribed limit'; these were stored appropriately in locked cabinets and archived regularly. An annual documentation audit was completed.

6.61 There was excellent explanation of consent to information sharing and examination, supported by a clear form signed by the detainee. The person escort records that we reviewed identified detainee health risks and needs, but this information did not always include the dates of historic incidents to inform the current risk assessment (see also paragraph 7.5).

6.62 Emergency equipment, including automated external defibrillators, was suitable and appropriately located in the clinical rooms and near the custody desks, with daily checks scheduled. At Grimsby and Scunthorpe, there had been some periods with no recorded health staff checks of the emergency equipment. A few items in Clough Road and Scunthorpe were out of date, including a box of syringes dated 2015; this was addressed during our visit. Some custody staff said they were not in date with basic life support training (see area for improvement 3.13).

Area for improvement

6.63 Forensic medical examiner response times and reasons for non-attendance should be investigated and addressed to reduce clinical risk.

Good practice

6.64 *The explanation to detainees and documentation of consent to information sharing, examination and history taking was excellent, and enabled detainees to understand the purpose of the health assessment and give suitably informed consent to information sharing.*

Patient care

6.65 Staff reported and we observed positive partnership working between health care professionals and custody staff to ensure safe care of detainees. Detainees were referred appropriately by custody staff and could request to be seen. There was appropriate handover of health risk and care information.

6.66 We observed some good detainee assessments with a strong focus on clinical and vulnerability risk, alongside sensitivity to individual care needs. Most detainees were seen by an HCP except where there was an issue that required specific FME attention. There was also custody and health staff access to telephone advice from the FME. There was good use of an excellent informative 'leaving custody' leaflet (see paragraph 7.3).

6.67 Detainees had appropriate access to most required medications, including symptomatic relief for drug and alcohol withdrawal. However, there was no access to supervised methadone, which conflicted with national guidance on opiate substitution therapy. The force was discussing this area.

6.68 All medicines were administered by an HCP or FME, which sometimes meant delays at Grimsby and Scunthorpe. All prescribed medicines were stored securely in locked cabinets in the clinical rooms and accessible only by HCPs and FMEs. There was robust stock management and control with regular checks by a pharmacy technician. The limited supply of scheduled and controlled drugs was checked regularly and recorded; the detainee's full name was not always recorded alongside the custody number in the register.

Substance misuse

6.69 All suites had good access to a community substance misuse worker. Workers were active in identifying potential clients through visits and telephone calls to the suites. Provision included 'required assessment' (mandatory assessments for detainees charged with specific drug offences) for those testing positive to class A drugs, and voluntary advice and support for all drug and alcohol issues.

6.70 At Clough Road and Grimsby, workers had good working relationships with custody staff, who alerted them to detainee needs, as well as access to the Connect custody IT system. Clough Road had access to a Renew worker daily between 8am and 10pm. Grimsby had a Foundations worker between 8.30am and 8.30pm on weekdays, until 8pm on Saturday and between 10am and 4pm on Sunday. Scunthorpe usually had a Step Forward worker between 8am and 6pm Monday to Friday, and 8am and 4pm on Saturdays. Custody staff could also make telephone referrals outside service hours. None of the services specifically provided for children but all would either see children and/or refer them on to the local YOT or appropriate community services.

6.71 Nicotine replacement patches were readily available to support detainees who were not able to smoke in the suites.

Mental health

6.72 Navigo Health and Social Care Community Interest Company (CIC) provided very effective liaison and diversion services to Grimsby and Scunthorpe custody suites as part of a national model commissioned by NHS England. The service operated Monday to Friday 8am-6pm and 9am-5pm at weekends. The service included mental health nurses, a learning disability nurse, social workers and support workers, and provided early intervention for all vulnerable

detainees in contact with the criminal justice system. There was excellent communication between the liaison and diversion service and custody sergeants, which ensured good identification of the needs and care of vulnerable detainees.

6.73 A liaison and diversion practitioner completed an initial screening assessment to identify specific vulnerabilities, including mental ill health, physical ill health, homelessness, substance use and women (who were deemed generally vulnerable by their gender, in line with the national model). Detainees could be referred to community health and social care support services, including support to attend appointments. Support could be offered for up to 12 weeks. The service also provided support and liaison between custody staff and approved mental health professionals for requests for a formal Mental Health Act assessment. Custody staff told us that they valued the service.

6.74 Similar liaison and diversion services were not available to detainees at Clough Road. An unfunded liaison and diversion scheme had been provided by Humber NHS Foundation Trust until February 2017, when it withdrew the service. Custody sergeants told us this had left a gap in helping them identify, support and divert vulnerable detainees out of custody. NHS England told us there were plans to expand liaison and diversion services to cover Clough Road during 2019-20, in line with the national plan.

6.75 At Clough Road, detainees with identified or potential mental health needs were identified by custody staff or HCPs. The HCP referred them to the local Rapid Response team. Mental health practitioners visited the suite, although there were some delays; they also provided telephone advice. Detainees with ongoing needs, including those already in contact with the local service, could be given a follow-up community appointment.

6.76 For all suites, mental health providers coordinated the arrangements for detainees deemed to need an assessment under the Mental Health Act 1983. The force did not formally monitor the waits for assessments or hospital beds. Custody staff and community police officers across the force area reported variable and sometimes lengthy waits for assessment, which was largely due to lack of approved mental health practitioners (AMHPs) and doctors approved under section 12 of the Mental Health Act.

6.77 Only two people had been detained in custody under section 136 of the Mental Health Act in the past year which was commendable.[15] There were three health based section 136 suites in the Humberside area, with good working relationships with mental health providers for Grimsby and Scunthorpe, which ensured that vulnerable detainees were not taken to a police custody suite. We saw some examples of good informal working arrangements between police officers and mental health staff in the Grimsby area.

6.78 In the Hull area, community police officers had access to a direct telephone number for the Rapid Response team, and a waiting room where people detained under section 136 could be taken prior to formal assessment. However, there was some confusion over the purpose of this waiting room - some officers believed it to be a health based section 136 suite, and not all officers were aware of the direct contact telephone number for mental health emergency services.

6.79 The force had a mental health work lead and there were robust joint working arrangements between the police and mental health services at local and strategic levels. These involved

[15] Section 136 of the Mental Health Act 1983 enables a police officer to remove someone from a public place and take them to a place of safety – for example, a police station. It also states clearly that the purpose of being taken to the place of safety is to enable the person to be examined by a doctor and interviewed by an approved Mental Health Practitioner, and for the making of any necessary arrangements for treatment or care.

each trust and relevant local authority, which ensured that detainee outcomes were effectively monitored.

Areas for improvement

6.80 Detainees should have equitable access to liaison and diversion services across the force area.

6.81 Community police officers in the north area should be directed to use emergency contact arrangements when supporting detainees with mental health needs.

6.82 The legal status of the police waiting facility for people detained under section 136 should be clarified to support police officer understanding and appropriate use of this facility.

Section 7. 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

7.1 The pre-release risk assessments (PRRAs) for detainees were completed using a standard template that included a range of appropriate questions to ensure the safe release of detainees. However, management of the pre-release risk process was not consistent across the suites. During busy periods, we saw some detention officers completing the PRRA with detainees without sufficient supervision or oversight from sergeants, which was not in accordance with *Authorised Professional Practice*. In the cases we sampled, PRRAs were not always recorded with sufficient detail, and in too many cases the release arrangements, including how the detainee travelled home after they left the suite, were unclear.

7.2 In Grimsby and Scunthorpe, the Navigo liaison and diversion service (see paragraph 6.72) offered a wide range of support, such as housing and benefits advice to detainees both in the suite and after their release. There was good communication between the liaison and diversion service and custody sergeants, which ensured good identification of the needs and care of vulnerable detainees before their release. Practitioners from the service offered one-to-one interviews to detainees while they were in custody, and a screening to identify their specific needs and vulnerabilities. They made referrals on behalf of detainees and signposted them to community services. The service could also offer support to people for up to 12 weeks after their release from custody. Detainees at Clough Road, Hull did not have access to these liaison and diversion services, which was a gap (see area for improvement 6.80).

7.3 Before release, detainees were routinely offered up-to-date support leaflets with information about a range of local and national services. These leaflets were only available in English.

7.4 Although custody staff asked detainees how they were planning to travel home after their release, there were no travel warrants in any of the suites. In line with the force policy, vulnerable detainees and children were routinely taken home after their release.

7.5 The quality of information in the person escort records (PERs) we sampled was mixed. The risk section did not always include detailed or up-to-date information, including the dates of historic incidents, to inform a meaningful and current risk assessment.

Area for improvement

7.6 Person escort records should provide risk information that includes the dates of historic incidents.

Courts

7.7 There were effective arrangements for ensuring detainees could attend court promptly. It was positive that courts accepted detainees throughout the morning and early afternoon,

minimising detention times in police custody. There was a joint-working arrangement between Humberside Police and the court warrant officers, which helped reduce the occasions when those wanted on warrant entered police custody - police officers could contact the warrant officers directly when they arrested a suspect wanted on warrant. The warrant officer often collected the arrested person and took them directly to the court cells, completing the PER themselves.

Section 8. Summary of areas of concern, recommendations and areas for improvement

Areas of concern and recommendations

8.1 **Area of concern:** We found a number of potential ligature points in all suites across the force custody estate. This posed a risk to detainees and the force.

Recommendation: The force should take immediate action to remove or manage any ligature points, to ensure safe custody. (2.36)

8.2 **Area of concern:** The force did not comply with PACE code C and with the College of Policing Authorised Professional Practice guidance in several areas, which it needed to address as a matter of urgency.

Recommendation The force should ensure that all custody processes comply with the Police and Criminal Evidence Act 1984. (2.37)

8.3 **Area of concern:** The arrangements for obtaining appropriate adults (AAs) did not ensure early and effective support for all children and vulnerable adults detained. Some custody processes, such as strip searches, took place without an AA present and without adequate justification for this, breaching the requirements under PACE.

Recommendation: The force must comply with PACE in ensuring an appropriate adult (AA) is present for the required stages of the custody process, and should work with local authority partners to ensure early and effective 24-hour AA support to detainees. The force should accurately record in custody records details of requests for AAs, their arrival times, relationship to the detainee and presence during the custody process, and monitor this information to assess the effectiveness of the AA arrangements and outcomes for detainees. (2.38)

Areas for improvement

Leadership, accountability and partnerships

8.4 The force should ensure that the strategic management of custody delivers consistent working practices and good outcomes for detainees across all its suites. (3.11)

8.5 There should be sufficient staffing levels on all shifts to ensure the safe detention of all detainees. (3.12)

8.6 All custody staff should receive relevant refresher and continual professional development training that focuses on the key areas of activities to support them in delivering their role. (3.13)

8.7 The force should develop comprehensive performance monitoring across all aspects of custody services. (3.23)

8.8 The force should strengthen its monitoring of use of force by cross-referencing incidents to CCTV, and should ensure that it can meet the requirement to report on the use of force in its custody suites to the Home Office as part of the annual data return. (3.24)

8.9 The force should improve the quality of its custody records so that they are clear when and what actions have been taken, and that the care that a detainee receives while in custody can be clearly evidenced. (3.25)

8.10 The force should take action to demonstrate that it meets the public sector equality duty. (3.26)

8.11 The ethnicity of all detainees should be accurately recorded and monitored to assess that custody services and processes are delivered fairly, and any disproportionality should be identified and addressed. (3.27)

Pre-custody: first point of contact

8.12 Frontline officers should have sufficient and prompt information from the control room to inform their decision-making when dealing with incidents. (4.10)

8.13 The force should work with partners to ensure that frontline officers have effective support when dealing with incidents, including alternatives to custody for people with mental health issues who are not detained under the Mental Health Act. (4.11)

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

8.14 There should be privacy at booking-in desks. Where facilities are not appropriate, the force should have a formal policy guiding staff on how to manage multiple and/or vulnerable detainees at the custody desk. (5.8)

8.15 Cell CCTV monitors should not be visible to detainees. (5.9)

8.16 Staff should have access to religious, cultural and dietary guidance to aid their understanding of detainees' religious observance and individual needs. (5.10)

8.17 Women detainees should have access to designated female staff at all times and be informed about this. (5.11)

8.18 All suites should have working double-handset telephones to facilitate telephone interpreting. (5.16)

8.19 There should be hearing loops in all custody suites and custody staff should be trained in how to use them. Braille and audio materials, including the detainees' rights and entitlements document (as a minimum), should be available for visually impaired detainees. (5.17)

8.20 Risk assessments should be completed thoroughly and resulting care plans, including levels of observation, should adequately identify and manage risks. (5.23)

8.21 Detainees' clothing and footwear should only be removed on the basis of an individual risk assessment, and the dignity of the detainee should always be maintained. (5.24)

8.22 All custody staff should be trained in how to use the new design anti-ligature knife and carry them when working in the custody suite. (5.25)

8.23 Humberside Police should monitor the time that detainees are kept in custody to ensure that there are no unnecessary delays in progressing their cases. (5.39)

8.24 Notices that CCTV cameras are in use should be clear and prominently displayed. (5.40)

8.25 Where reviews of detention take place while a detainee is asleep, they should be informed of the review as soon as practicable, and this should be recorded on the custody record. (5.44)

8.26 PACE reviews should be carried out to a consistently high standard, and information entered on custody records should be clear and adequately detailed. (5.45)

8.27 All information on decisions about a detainee's detention and release should be recorded and retained. (5.50)

8.28 The progress of investigations for detainees released under investigation should be monitored robustly to ensure there are no unnecessary delays and that cases are dealt with as quickly as possible. (5.51)

8.29 Signs informing detainees how to lodge complaints should be displayed in clear view and different languages in all custody desk areas, and this information should be provided to detainees when they are booked in. Custody staff should immediately refer complaints received to custody sergeants and inspectors to consider. (5.54)

In the custody cell, safeguarding and health care

8.30 Cells should be free of graffiti and ingrained dirt. (6.6)

8.31 Staff should not mute cell call bells. (6.7)

8.32 Each member of staff involved in using force against a detainee should submit an individual use of force form. (6.14)

8.33 Handcuffs should be removed immediately from detainees in holding areas unless a risk assessment indicates the need for restraints for the safety of staff and others. (6.15)

8.34 There should be clear guidance for staff on how to manage detainee requests for alternative food required on medical and/or dietary grounds. (6.26)

8.35 Detainees going to court should have the opportunity to shower. (6.27)

8.36 Detainees should automatically receive toilet paper in their cells barring risk assessment indicators, as per Approved Professional Practice guidance. (6.28)

8.37 Detainees, particularly those held for longer periods, should be routinely offered exercise, showers and a diverse selection of reading materials to improve their care and welfare while in custody. (6.29)

8.38 Detainees whose clothing has been confiscated should be provided with replacement items immediately. (6.30)

8.39 The force should strengthen its approach to safeguarding children and vulnerable adults by ensuring that staff are effectively supported by policies, procedures and training. In particular, the force should ensure that:
- all children are placed on 30-minute visits as a minimum, in line with Authorised Professional Practice guidance;
- all girls are assigned a female officer to care for their welfare needs while in custody, in line with the Children and Young Persons Act 1933, and the details are accurately recorded on the custody record. (6.47)

8.40 The force should continue to work with local authority partners to avoid the overnight detention of children in custody by their transfer to suitable alternative accommodation. Detention certificates should be accurately completed, and performance information should be monitored, with appropriate oversight at a strategic level. (6.48)

8.41 The force should monitor all children detained overnight, both pre- and post-charge, so that it can assure itself and others that all necessary actions are being taken to avoid overnight detention, and to assess the effectiveness of its approach. (6.49)

8.42 Forensic medical examiner response times and reasons for non-attendance should be investigated and addressed to reduce clinical risk. (6.63)

8.43 Detainees should have equitable access to liaison and diversion services across the force area. (6.80)

8.44 Community police officers in the north area should be directed to use emergency contact arrangements when supporting detainees with mental health needs. (6.81)

8.45 The legal status of the police waiting facility for people detained under section 136 should be clarified to support police officer understanding and appropriate use of this facility. (6.82)

Release and transfer from custody

8.46 Person escort records should provide risk information that includes the dates of historic incidents. (7.6)

Section 9. Appendices

Appendix I: Inspection team

Maneer Afsar	HMI Prisons team leader
Fionnuala Gordon	HMI Prisons inspector
Fiona Shearlaw	HMI Prisons inspector
Norma Collicott	HMICFRS inspection lead
Anthony Davies	HMICFRS inspection officer
Patricia Nixon	HMICFRS inspection officer
Viv Cutbill	HMICFRS inspection officer
Nicola Rabjohns	HMI Prisons health services inspector
Kathleen Byrne	Care Quality Commission inspector
Laura Green	HMI Prisons researcher
Joe Simmonds	HMI Prisons researcher

Appendix II: 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 recommendation

Police custody should not be used as a place of safety for section 136 assessments. (2.18)
Achieved

Recommendation

The force should introduce regular refresher training for custody staff. (3.14)
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.

Recommendations

Arrangements in booking-in areas should allow for private communication between detainees and staff. (4.8)
Not achieved

There should be clear policies and procedures to meet the specific needs of female and juvenile detainees and those with disabilities. (4.9)
Not achieved

Closed-circuit television coverage should be adequate to ensure the safety of detainees. (4.19)
Not achieved

All custody staff should carry anti-ligature knives. (4.20)
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. (4.21)
Achieved

Detainees should be handcuffed only when a risk assessment indicates that it is necessary for the safety of staff, the public or the detainee. (4.25)
Not achieved

Humberside police should monitor the use of force at each custody suite by ethnicity, age, location and officers involved, in line with Association of Chief Police Officers (ACPO) guidance. (4.26)
Not achieved

Cells should be free of graffiti, and, when ligature points cannot be readily removed, the risks presented should be managed. (4.34)
Not achieved

The use of police cells for court detainees at Scunthorpe should be reviewed, to ensure clarity about the delegation of responsibility for detainees held when the cells are shared. (4.35)
No longer relevant

All detainees held overnight, or who require one, should be offered a shower, which they should be able to take in private. (4.46)
Not achieved

Food provided should be of sufficient quality and calorific content to sustain detainees for the duration of their stay and be suitable for detainees' dietary needs. (4.47)
Not achieved

Detainees held for long periods should be offered outside exercise. (4.48)
Partially achieved

Individual rights

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

National issue

Appropriate adults should be available to support without undue delay juveniles aged 17 in custody, including out of hours. (2.19)
Not achieved

Recommendations

Humberside police should liaise with the UK Border Agency to ensure that immigration detainees are held in police custody suites for the shortest possible time. (5.10)
Achieved

Senior police officers should engage with the local authorities to ensure the provision of local authority accommodation for juveniles who have had bail denied. (5.11)
Partially achieved

Appropriate adults should be available to support without undue delay vulnerable adults in custody, including out of hours. (5.12)
Not achieved

Unless there is a clear reason not to do so, complaints should be taken while the detainee is still in custody. The force should monitor and analyse trends in complaints, and take corrective action where necessary. (5.24)
Partially achieved

Health care

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

Recommendations

All clinical rooms should be fit for purpose and meet infection control standards. (6.7)
Partially achieved

Care plans should be succinct and easy to understand. (6.15)
No longer relevant

All detainees should have equal access to a substance misuse worker while in custody. (6.21)
Achieved

All detainees should have equal access to mental health services across the force area. (6.26)
Not achieved