HMICFRS
His Majesty's Inspectorate of Constabulary and Fire & Rescue Services

Care Quality Commission

Report on an inspection visit to police custody suites in Greater Manchester

by HM Inspectorate of Constabulary and Fire & Rescue Services and Care Quality Commission

30 August–9 September and 8–14 October 2022

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Note: Data supplied by the force.

Force

Greater Manchester Police

Chief constable

Stephen Watson

Deputy mayor for policing and crime

Kate Green

Geographical area

Greater Manchester

Date of last police custody inspection

2016

Custody suites

- North Manchester custody centre: 30 cells
- Swinton police station: 28 cells
- Ashton-under-Lyne police station: 31 cells
- Cheadle Heath police station: 36 cells
- Bolton Central police station: 19 cells
- Wigan police station: 29 cells
- Pendleton police station: 25 cells
- Bury police station: 24 cells

Total cell capacity: 222

Annual custody throughput

Rolling 12 months from July 2021 to July 2022: 45,908

Custody staffing

- 2 chief inspectors
- 9 inspectors (including 1 policy and compliance inspector)
- 115 sergeants
- 180 custody detention officers
- 1 facilities co-ordinator

Health service provider

Mitie Care & Custody

Summary

This report describes our findings following an inspection of Greater Manchester Police custody facilities. The inspection was conducted jointly by HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) and the Care Quality Commission (CQC) in August, September and October 2022. It is part of our programme of inspections covering every police custody suite in England and Wales.

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

The inspection was paused during the period of mourning for Her Majesty the Queen. We completed the final week of our inspection between 8 and 14 October 2022.

To help the force improve, we have made six recommendations to it and its police and crime commissioner. These address our main causes of concern.

We have also highlighted a further 13 areas for improvement. These are set out in section 6 of this report.

Leadership, accountability and working with partners

Greater Manchester Police has a clear governance and meeting structure in place to provide strategic oversight of custody services. Despite this, the force's custody oversight is limited, and there is little evidence of prioritisation of custody by senior officers or engagement in how custody is provided. Not enough progress has been made against the recommendations in our 2016 inspection. Significant concerns remain. The lack of senior-level oversight for custody services is a cause of concern.

The force's strategic priority to tackle crime and increase arrests has led to an increase in demand for custody services as the number of detainees rises. There has been limited monitoring of the effect of this increase on custody services or of how detainees are affected. We saw staff stretched at times and unable to carry out all the duties expected of them. We are concerned that there aren't always enough staff on duty to make sure detainees are kept safe in custody.

The force follows the College of Policing's Authorised Professional Practice. But not all staff are knowledgeable about its contents, and the guidance isn't always followed.

The force doesn't manage custody performance well enough. A range of information is collected and monitored at performance meetings, but it isn't clear how senior managers use performance information to improve custody services.

The force isn't consistently following the Police and Criminal Evidence Act 1984 (PACE) and its codes of practice. The necessity for arrest as required by PACE Code G isn't always met. Reviews of detention often don't meet the requirements of PACE Code C paragraph 15. This is a cause of concern.

The governance and oversight of the use of force in custody isn't good enough. Limited information about the use of force and little quality assurance of incidents means that Greater Manchester Police can't show that when force is used in custody it is necessary, justified and proportionate. We found, in the cases we examined, that not all incidents were handled well. This hasn't improved since our last inspection and is a cause of concern.

Recording on custody records varies. Some of the records we reviewed lacked detail, and some weren't accurate. The force does little dip sampling of custody records to quality assure the service.

The force's strategic priority to make more arrests means the force is missing opportunities to consider diverting people away from custody when it is appropriate to do so. Alternatives to arrest for children or those who are vulnerable aren't always considered.

But the force works well with mental health services to meet the needs of people with mental ill health. This has resulted in some good operational arrangements to provide mental health advice and support 24 hours a day, 7 days a week to help keep people in mental health crisis out of custody.

Pre-custody – first point of contact

Frontline officers understand what makes someone potentially vulnerable. They consider this when deciding whether to arrest, but the offence often takes precedence over vulnerability. This is also the case with children. The number of children arrested has increased during the last year. We found cases where, in our view, alternatives to custody should have been considered.

There is some good support for frontline officers when dealing with incidents involving people with potential mental ill health. Officers spoke highly of the advice and support offered by the mental health professionals in the force control room and those in the mental health response cars that attend incidents to help officers decide how to deal with people in mental health crisis. But they told us of long waits with people when they are detained for an assessment under section 136 of the Mental Health Act 1983.

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

Custody staff interact respectfully with detainees and are patient and reassuring. But privacy for detainees is limited due to the design of some of the suites. Detainee dignity isn't always protected, especially when clothing is removed. Some detainees are left naked in cells. This is a cause of concern.

The approach to meeting detainees' individual and diverse needs is mixed. The needs of some groups are recognised and met. But this isn't the case for all detainees – for example, women, people with disabilities and people who have little or no understanding of English or wish to observe their faith.

The identification of risk is generally good, but the management of detainee risk isn't good enough. This is a cause of concern. Custody officers generally set observation levels for detainees at a level commensurate with presenting risks but not always for those under the influence of alcohol and/or drugs. They routinely remove footwear and clothing with cords or laces from detainees without justifying this through an individual risk assessment. Anti-rip clothing is used too often.

At certain times of the day, there aren't enough custody detention officers on duty to always manage detainee risk appropriately. This leads to cell welfare visits being carried out late and cell call bells not being answered quickly. This doesn't ensure safe detention.

Custody officers don't always have enough information to authorise detention appropriately. Although arresting officers generally describe the circumstances of an arrest well, they don't explain the grounds for the necessity to detain well enough (as required by PACE Code G). We saw occasions when custody officers authorised detention without all the necessary information and where, in our view, detention should have been refused. But custody officers give detainees information on their rights and entitlements appropriately, together with good explanations of what they mean.

Some detainees spend longer than necessary in custody because their cases aren't dealt with expeditiously. Reviews of detention are poor and often don't meet the requirements of PACE and its codes of practice. Detainees are released on bail or released under investigation appropriately.

In the custody cell, safeguarding and healthcare

The custody suites are generally clean and well maintained. But all of them have potential ligature points – mainly around benches in cells, the fitting of some cell doors, the shower areas and the exercise yards.

Staff show a caring attitude towards detainees, and the detainees we spoke to were positive about the care they had received while in custody. But we found a mixed approach to detainee care. Detainees aren't always advised of the care provision available to them, and while food and drinks are offered routinely, other care, such as showers, exercise or reading material, aren't. These things aren't always given to detainees even when they have been requested.

Custody staff have a good understanding of their safeguarding responsibilities and interact well with young people and vulnerable adults. But they don't always secure appropriate adults for them soon enough, and some detainees wait a long time before receiving support.

We found some children detained in custody when, in our view, detention should have been refused. Some spent a long time in custody because their case wasn't dealt with promptly. Children who are charged and refused bail stay in custody until they go to court. They are rarely moved to alternative accommodation as they should be.

Competent and experienced healthcare practitioners (HCPs) usually assess detainees promptly. They are caring and respectful in their interactions with them. Detainees with mental health needs are assessed appropriately and referred to community services as appropriate. Detainees who need a mental health act assessment are either assessed in custody or transferred to a mental health facility. But some detainees wait a long time for an assessment and, if needed, transfer to a mental health bed space.

HCPs support detainees experiencing drug and alcohol withdrawal while in custody, and the liaison and diversion (L&D) team makes referrals to community substance misuse services and community engagement workers as appropriate.

Some medicines aren't managed well enough. Custody staff don't maintain accurate records of controlled medicines, and they don't always securely store medicines brought in with detainees. This is a risk for the force and is a cause of concern.

Release and transfer from custody

Custody officers generally interact well with detainees to complete their pre-release risk assessments to make sure they are released safely. But there is less engagement with detainees released to court whose risk assessments are completed earlier on in their detention and not always when the detainee is present.

Custody detention officers complete digital person escort records and arrange the transport for detainees appearing in court. Custody officers rarely check these records, and we found that some had important information missing.

Detainees remanded to court are usually collected promptly in the morning, are appropriately dressed and are presented before the first available court. Detainees arrested on warrant or remanded after the morning court run can sometimes be accepted by the court later in the day. This means most detainees are held for no longer than necessary. This is an improvement since our last inspection.

Causes of concern and recommendations

Cause of concern: leadership

Leadership for custody provision isn't strong enough to make sure the service is provided well and achieves appropriate outcomes for detainees. There is limited prioritisation of custody by senior officers or engagement in how custody is provided. There hasn't been enough improvement since our previous inspection. Significant concerns remain.

The position is exacerbated by a large increase in the number of detainees entering custody. This makes it difficult for staff to fulfil all their duties and meet detainees' needs.

Limited performance management and quality assurance of the service means concerns haven't been identified and addressed.

The other causes of concern below are largely due to a lack of strategic input in overseeing and managing the service.

Recommendation

The force should have comprehensive governance arrangements, with appropriate senior officer involvement, to robustly oversee custody provision. These should identify concerns and establish the improvements needed to address them. They should be supported by comprehensive performance management and quality assurance that makes sure appropriate outcomes for detainees are achieved.

Cause of concern: meeting legal requirements and guidance

The force isn't always meeting the requirements of PACE and its codes of practice for the detention, treatment and questioning of persons, particularly in terms of how detention is authorised and the way in which reviews of detention are carried out.

Recommendation

The force should take immediate action to make sure that all custody procedures and practices comply with legislation and guidance.

Cause of concern: use of force

The force's governance and oversight of the use of force in custody isn't good enough. Limited recording on custody records, a lack of use-of-force forms for incidents and little quality assurance mean it doesn't have accurate information to support effective scrutiny. Our CCTV review found incidents weren't always managed well. The force can't show that when force is used in custody it is always necessary, justified and proportionate.

Recommendation

Greater Manchester Police should scrutinise the use of force and restraint in custody to show that when it is used in custody, it is necessary, justified and proportionate. This scrutiny should be based on accurate information and robust quality assurance.

Cause of concern: detainee dignity

The force isn't always maintaining the dignity of detainees when clothing is removed. Detainees are sometimes left naked in their cells and not encouraged to put on replacement clothing.

Recommendation

The force should make sure that the dignity of detainees is protected and maintained at all times.

Cause of concern: risk management

The management of risk isn't good enough, and the force isn't always assuring detainee safety. Our concerns are:

- At certain times of the day, there aren't always enough staff on duty to manage risk appropriately and make sure detainees are kept safe.
- Detainees are routinely held in vans in the custody docks, and there is limited assessment of any risks posed while they are held there to prioritise them for booking-in.
- Detainees under the influence of alcohol and/or drugs aren't always placed on Level 2 observations with rousals.
- Checks on detainees are often carried out through spyholes, are sometimes late and are poorly recorded in custody records.
- Level 4 (close proximity) observations aren't always conducted in line with Authorised Professional Practice guidance. Briefings to officers conducting them are poor, and the details are rarely recorded in the custody record.

- Most custody officers routinely remove cords, belts and laces from detainees without an individualised risk assessment.
- Anti-rip clothing is used too frequently, often without clear rationale or justification.
- Handovers between shifts aren't attended by all custody staff, and not all custody officers visit the detainees in their personal care.
- Not all staff routinely carry anti-ligature knives.
- Custody staff don't always keep control of cell keys.

Recommendation

The force should take immediate action to mitigate the risk to detainees by making sure there are enough staff to safely manage risks, and that risk management practices are safe, follow Authorised Professional Practice guidance and are consistently carried out to the required standard.

Cause of concern: medicines management

The force's records of detainees' medicines aren't consistently maintained or accurate, and it doesn't always securely store medicines brought in with detainees. The lack of control over these medicines presents a significant risk to the force.

Recommendation

Custody staff should maintain accurate records of all medicines and store medicines brought in with detainees securely.

Introduction

This report is one in a series of inspections of police custody carried out jointly by HMICFRS and CQC. These inspections are 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).

The national rolling programme of police custody inspections, which began in 2008, makes sure that custody facilities in all 43 forces in England and Wales are inspected regularly.

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. HMICFRS and CQC are two of several bodies making up the NPM in the UK.

Our inspections assess how well each police force fulfils its responsibilities when detaining people in police custody, and the outcomes for them. This includes how safely they are managed and how respectfully they are treated.

Our assessments are made against the criteria set out in our *Expectations for police custody*. These standards are underpinned by international human rights standards and are developed by the two inspectorates. We consult other expert bodies on them across the sector and they are regularly reviewed. This helps to achieve best custodial practice and promote improvements.

The expectations are grouped under five inspection areas:

- leadership, accountability and working with partners;
- pre-custody – first point of contact;
- in the custody suite – booking-in, individual needs and legal rights;
- in the custody cell: safeguarding and healthcare; and
- release and transfer from custody.

The inspections also assess compliance with the PACE 1984, its codes of practice and the College of Policing's Authorised Professional Practice – Detention and Custody.

The methodology for carrying out the inspections is based on:

- a review of a force's strategies, policies and procedures;
- an analysis of force data;
- interviews and focus groups with staff;
- observations in suites, including discussions with detainees; and
- an examination of case records.

We also analyse a representative sample of custody records from all suites in the force area for the week before the inspection starts. For Greater Manchester Police, we analysed a sample of 100 records. The methodology for our inspection is set out in full at Appendix I.

Section 1. Leadership, accountability and working with partners

Expected outcomes

Chief officers have a clear priority to protect the safety and wellbeing of detainees and to divert vulnerable people away from custody.

Leadership

Greater Manchester Police has a clear governance and meeting structure in place to provide strategic oversight of custody services. Despite this, the force's custody oversight is limited. There is little prioritisation of custody by senior officers or engagement in how custody is provided. Not enough progress has been made against the recommendations from our 2016 inspection. Significant concerns remain.

An assistant chief constable has overall responsibility for custody, with a chief superintendent as head of criminal justice. A superintendent responsible for criminal justice and custody supports them. During our inspection, in response to our concerns about the lack of oversight in custody, the force designated a superintendent with sole responsibility for custody services.

Prior to this inspection, the force had recognised concerns with its custody provision and arranged for a full review of the service. During our inspection, and in response to our findings, it set up a strategic governance group to oversee improvements. The assistant chief constable chairs the group. This gives us more confidence that oversight will improve and result in better outcomes for detainees. But the lack of leadership for custody services is still a cause of concern.

The force has a strategic priority to tackle crime and increase arrests. Between 1 September 2021 and 31 August 2022, the number of arrests increased compared to the same period during 2020/21. Information given to us by the force showed the number of adults detained in custody rose from 30,903 to 43,414, and children from 2,377 to 4,160. This means demand for custody services has risen. We found staff sometimes struggled to provide services and meet detainees' needs.

Staffing levels consist of:

- two chief inspectors responsible for the day-to-day management of custody;
- nine inspectors (including one policy and compliance inspector);
- 115 custody sergeants; and
- 180 custody detention officers.

There are few vacancies, and staff work overtime when needed.

The force reopened the custody suite at Bolton to help manage the increase in the number of detainees. But there is little monitoring of the effect of this increase on custody services or of how detainees are affected by it. We saw staff stretched at times and not able to carry out all the duties expected of them, such as arranging for detainees to shower or take exercise. And inspectors weren't always available to carry out reviews of detention at the appropriate times.

We are concerned that there aren't always enough staff on duty to make sure detainees are kept safe in custody. For example, we found that staff couldn't always complete cell checks on time and call bells sometimes went unanswered for a long time.

The force manages its custody services across eight custody suites at:

- North Manchester
- Swinton
- Ashton-under-Lyne
- Cheadle Heath
- Bolton
- Wigan
- Bury
- Pendleton.

The custody estate is fairly modern; six of the eight facilities are relatively new private finance initiative buildings, provided by an external company. But we found potential ligature points in all eight suites. We gave the force a physical conditions report, which it responded to quickly. The suite at Bolton was closed to deal with some of the issues we highlighted.

Initial training for staff is comprehensive and follows the nationally-approved course developed by the College of Policing. The force has its own dedicated custody trainer. Custody officers have three weeks of training, and detention officers have six weeks. Newly qualified staff should undergo a workplace assessment and be mentored by more experienced staff before carrying out their duties. But we were told by some staff that this doesn't always happen in practice.

The force gives ongoing training to staff every eight weeks, with a one-day training course built into their shift patterns. Recent training has included mental health awareness. A regular custody bulletin is used to share learning and give additional guidance to staff.

The force follows the College of Policing's APP guidance. But not all staff are knowledgeable about the content of the guidance, especially on setting observation levels to manage detainee risks, and some guidance isn't followed. For example, not all staff carry anti-ligature knives, even though they have been given personal-issue knives, and some welfare checks are conducted through the spyhole in cell doors rather than through the hatch.

Since our last inspection, there has been one death in custody, at Ashton-under-Lyne. This was investigated by the Independent Office for Police Conduct. A detainee also died following police custody at Cheadle Heath.

Area for improvement

The force should make sure that staff understand and follow Authorised Professional Practice guidance.

Accountability

The force doesn't always manage custody performance well enough. It collects a range of information, but there are some gaps. For example, it doesn't record how long detainees are held before and after charge. And some information is inaccurate, especially on use of force.

Custody information and performance are discussed at various force meetings.

- There is a daily management meeting, chaired by a chief inspector, which oversees operational matters in the suites.
- The superintendent chairs a monthly performance meeting, which examines wider custody performance including arrests, children in custody, strip searching and waiting times for booking-in.
- There are wider performance meetings, such as the quarterly performance meeting chaired by the assistant chief constable and a children's scrutiny panel attended by the force and the mayor's office.

But it isn't clear how senior managers use performance information to improve custody services. Nor is it clear how the 11 custody-related risks on the force risk register are prioritised or dealt with or how complaints are used to improve services.

A high proportion of the complaints we saw related to the lack of dignity for detainees when their clothing was removed. But the force seems to have taken little action to address the concerns raised by these complaints, and we found cases where detainees were treated disrespectfully.

The force responded positively to our concerns about performance management. It now monitors reviews of detention and aspects of detainee care such as showers and exercise. But the approach to performance management forms part of our cause of concern about leadership.

The force isn't consistently following PACE and its codes of practice. The necessity for arrest as required by PACE Code G isn't always met, and we saw custody officers sometimes making decisions to authorise detention without enough information. It is our view that in some cases detention should have been refused.

Many aspects of the force's reviews of detention don't meet the requirements of PACE Code C paragraphs 15.1–15.14. For example, some detainees weren't given the opportunity to make any representations or informed by inspectors that their detention was being further authorised. Some reviews didn't take place at all, which is a breach of section 40 of PACE. This is a cause of concern.

The force can't assure itself, the public or the deputy mayor for policing and crime that when force or restraint is used in custody, it is necessary, justified and proportionate. The governance and oversight of the use of force in custody isn't good enough and hasn't improved since our last inspection. This is a cause of concern.

Data relating to incidents involving the use of force isn't accurate as not all incidents are properly recorded on custody records, and not all staff complete use-of-force forms. Custody inspectors are only expected to review two cases each month, which is too few. They also don't routinely cross-reference incidents on CCTV to make sure that force is applied safely. A strategic force board provides oversight of use-of-force incidents but few cases involving custody are reviewed. In our review of 26 cases, we found that incidents weren't always managed well. We had concerns in eight cases, which we referred to the force.

The force custody IT system is dated, and staff told us adding custody entries is a slow process and some information is difficult to retrieve – for example, about detainee risk.

The quality of recording on custody records varies. We saw some detailed custody entries, but in some records important information was missing. For example:

- the circumstances of arrest (only circumstances of the offence were recorded);
- the necessity for the use of handcuffs and the time they were removed;
- safeguarding arrangements made for children and vulnerable detainees; and
- the provision of food and drink to detainees.

We also have concerns that some detention log entries recorded actions as having been taken when our observations showed they hadn't.

Quality assurance arrangements aren't robust. Inspectors should dip sample 13 records a month, but this doesn't always happen. The force's arrangements aren't identifying the type of concerns we found. This forms part of our cause of concern about leadership.

The force understands its responsibilities under the public sector equality duty, and staff have received training on the Equality Act 2010. There is a comprehensive diversity, equality and inclusion strategy, which is published on the force's website. Arrest data is monitored to establish any disproportionality. But the accuracy of the data on self-defined ethnicity is limited as the custody system defaults to the description given by the detainee on the first time they entered custody. This description can't be updated if the detainee comes into custody again.

The force is open to external scrutiny. Independent custody visitors (ICVs) visit suites weekly. They complete checklists following their visits, and any issues they find are raised with the force. Some issues raised by the ICVs are similar to those we have found, such as detainee dignity and staffing levels. It isn't clear how ICV concerns are addressed by the force. The ICV scheme manager is involved in some force meetings but doesn't have access to custody performance data.

Working with partners

The force works with partner organisations to provide diversion schemes. The schemes include the violence reduction unit for children, the mentally vulnerable offenders panel and a women's pathway scheme. They are intended to help keep children and vulnerable people out of the criminal justice system.

But the force's strategic priority to increase arrests means officers often don't give due consideration to diverting people away from custody, even when it is appropriate to do so.

The number of children entering custody has increased. There isn't enough monitoring by the force to make sure all detentions are necessary. We saw children detained with seemingly questionable justification and where, in our view, alternatives to arrest were more appropriate.

Although the force works well with partners (such as children's social services) for children who are charged and refused bail, these children are rarely moved to appropriate alternative accommodation as they should be.

The force works well with mental health service partners to meet the needs of people with mental ill health. There are regular meetings with them at a strategic level and some good operational arrangements to provide mental health advice and support 24 hours a day, 7 days a week. But there are still significant challenges, which the force is working hard to address.

Area for improvement

The force should make sure proper consideration is given to diverting vulnerable people and children away from custody where it is appropriate to do so.

Section 2. Pre-custody – first point of contact

Expected outcomes

Police officers and staff actively consider alternatives to custody. They effectively identify vulnerabilities that may increase individuals' risk of harm. They divert children and vulnerable adults away from custody when detention may not be appropriate.

Assessment and diversion at first point of contact

Frontline officers have a reasonable understanding of what makes someone potentially vulnerable. They consider a range of factors, particularly those relating to age and mental health. While training to help them recognise and deal with vulnerable people is limited, some training has been given – for example, on considering that children can be both victims and suspects when an offence is committed.

The force's strategic priority to increase the number of arrests is an important consideration when officers are deciding whether to arrest a person or to explore alternative options. Officers told us they consider a person's vulnerability, but the offence often takes precedence over any vulnerability.

Between 1 September 2021 and 31 August 2022, Greater Manchester Police arrested 4,160 children. This is an increase from 2,377 in the previous year, reflecting the strategic priority described above.

Some of the officers we spoke to were aware of the importance of diverting children away from custody. They told us that custody officers sometimes also carefully consider whether to accept a child into custody. But in the cases we examined, and during our observations in suites, we found examples of children brought in and detained in custody for low-level offences which might have been better dealt with by other methods, such as voluntary attendance interviews.

There are also few arrangements with local care homes to try and keep looked-after children away from custody and avoid their criminalisation. In response to our feedback during the inspection, the force increased its scrutiny of detention decisions. Like us, it found missed opportunities to potentially divert vulnerable individuals away from custody.

The officers we spoke to were generally satisfied with the quality of information they receive from call handlers in the force control room while attending incidents. Call handlers pass on any information they receive about individuals during the call or that is available from any previous contact or on force IT systems. Officers also use their mobile devices and laptops to get information if they have time to do so. Officers said there were some occasions where the information given by call handlers could have been better, but in general they felt they had enough information to make decisions.

Before making an arrest, officers are required to telephone the force's cell allocation unit. The unit, which is staffed by custody-trained officers, directs which suite individuals should be taken to. It also checks some of the details about the arrest – for example, whether a detainee has physical injuries and needs to go to hospital before custody.

But the unit's role isn't entirely clear – particularly its involvement in determining the necessity for arrest (as required by PACE Code C paragraph 3.4). Officers also told us there were sometimes difficulties contacting the unit. This leads to regular delays, with officers waiting up to an hour with detainees at the scene of an incident, possibly in challenging circumstances.

Frontline officers are generally well-supported when dealing with incidents involving individuals with potential mental ill health. There is 24-hour support provided by mental health professionals in the force's control room, who check health records and offer specialist advice. Officers told us this support was valuable when considering whether to detain someone under section 136 of the Mental Health Act 1983. The hours of coverage provided by this service is better than we usually find.

Mental health response cars, staffed by a mental health professional and a police officer, are also available to attend incidents to help officers deal with individuals in potential mental health crisis. The response car service has recently been extended to cover most of the force area and works between 4pm and midnight when demand is at its highest. Officers spoke highly of this service.

If officers attend an incident where an offence has been committed, they normally make an arrest, and any mental health concerns are dealt with in custody. We found some cases where individuals were arrested for minor offences but subsequently detained under mental health powers, rather than officers considering the use of these powers before the arrest.

Frontline officers told us they sometimes attend custody to take detainees detained under section 136 of the Mental Health Act 1983 to a mental health facility for a mental health act assessment. This can happen at any time during a person's detention if there is increasing concern for their mental health.

Officers don't take people detained under section 136 to police custody as a place of safety. They usually take these detainees to hospital. They told us it was rarely possible to take them directly to a specific health-based place of safety for an assessment. They said they often wait a long time, sometimes a whole shift, with individuals who are awaiting assessment. This is a poor outcome for those in mental health crisis and a poor use of police officer time.

Individuals with mobility issues are transported to custody in police vehicles, as there are no bespoke transport arrangements. Officers also regularly use police vehicles to transport individuals detained under mental health powers because ambulances aren't available.

Area for improvement

The force should make sure it promotes alternatives to arrest and that frontline officers use these appropriately to divert children and vulnerable people away from custody.

Section 3. In the custody suite – booking-in, individual needs and legal rights

Expected outcomes

Detainees are treated respectfully in the custody suite and their individual needs are identified and met. Detainees' risks are identified at the earliest opportunity and managed effectively. Detention is appropriately authorised. Detainees are informed of their legal rights and can freely exercise these rights while in custody.

Respect

Custody staff interact respectfully with detainees and are patient and reassuring. But due to the design of some of the suites, if more than one detainee is dealt with at the same time, the environment can be noisy and other detainees can potentially overhear sensitive conversations. Only one suite has a discrete custody desk, but it is rarely used. Custody officers routinely offer detainees the opportunity to speak with them in private, although few take this up.

Detainees are given suitable replacement clothing if theirs is removed. They can keep their shoes (with no laces) or are given plimsolls to wear in their cell.

But detainee dignity isn't always protected, and some practices are disrespectful. We are concerned that when all clothing is removed and anti-rip clothing is given instead, detainees aren't always encouraged to put this on. We found some detainees left naked in their cells. In one case, a detainee was left naked for ten hours in their cell. In another, the detainee had soiled their cell. Staff didn't engage with the detainee. The detainee wasn't offered a shower or moved from the cell so it could be cleaned. They had food pushed through the cell hatch. We referred these cases to the force. The lack of detainee dignity is a cause of concern.

Detainees in cells monitored by CCTV don't have this explained to them. They also aren't informed that the toilet area is obscured so it can't be seen on the CCTV monitors.

Some shower areas can be seen from corridors and cells, but they are supervised sensitively to offer some privacy to detainees.

Meeting diverse and individual needs

Custody staff recognise and do their best to meet detainees' individual and diverse needs. But facilities in the suites sometimes make this difficult. While most of Greater Manchester's custody suites have accessible cells and toilets, there are few adjustments for detainees with physical, hearing or sight disabilities. For example:

- only one suite has a wheelchair available for detainees;
- benches are low and there are no extra-thick mattresses;
- few suites have sightlines (markings to help visually impaired people judge the positioning of walls and obstructions) on cell walls, or rights and entitlement information available in Braille; and
- most suites don't have hearing loops (sound systems used by people with hearing aids).

Custody staff generally understand neurodiverse needs, and we saw some good individual care for detainees with these needs. Distraction activities have been introduced in the suites, but they aren't routinely offered to those with neurodiverse needs or to other detainees who may benefit from them.

Staff have good awareness of how to meet the needs of transgender detainees.

There is a range of religious items in the suites to allow detainees to observe their faith while in custody. But staff knowledge of religious practices varies across the suites. Some staff we spoke to had excellent knowledge of how to meet the religious needs of detainees, but others were less sure and said that they hadn't received any training to help them. We found some Qurans not stored respectfully, having been left uncovered in boxes even though covers for them were available.

The force could meet the needs of women better. There is a good stock of menstrual products in all suites. These are routinely offered to detainees on booking-in. But disposal arrangements are unsatisfactory as detainees are left with used products in their cells until they leave. Women are allocated a female officer to speak with and meet any care needs, but this doesn't always happen in practice as there aren't always female staff on duty.

There is reasonable provision for detainees who speak little or no English. But interpreters are mainly used for the booking-in process and not for other important custody processes such as reviews of detention. This potentially limits the detainees' understanding. There are no two-way handsets or mobile phones, and conversations are conducted over the loudspeaker at the custody desk, reducing privacy. Custody staff can access rights and entitlements in a range of languages and print these out where needed.

Area for improvement

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

- making adequate provision for detainees with disabilities;
- arranging for women to speak with a female officer if they wish to do so;
- having satisfactory disposal arrangements for menstrual products;
- consistently meeting the needs of detainees who wish to observe their faith; and
- using private telephone interpreting services at all points during detention where important information needs to be given or requested.

Risk assessments

The force's identification of risk is generally good, but the management of detainee risk isn't good enough. Some working practices mean the force isn't making sure that detainees are kept safe. This is a cause of concern that we expect it to address immediately.

Not all detainees are booked in promptly. When there is a queue, a combination of poorly-situated holding rooms with little privacy and a culture of keeping arrested persons in vehicles means some detainees wait a long time in police vans. Queues for booking detainees in aren't managed well as staff don't assess risk or prioritise children or vulnerable adults.

When completing initial risk assessments with detainees, custody officers focus appropriately on identifying risks, vulnerability factors and welfare concerns. They generally interact well with detainees and ask relevant supplementary and probing questions. But staff don't always explain the purpose of the risk assessment or explain it well enough – for example, why such personal questions need to be asked. Most custody officers use other available information and previous risk assessments to help establish additional risk, although staff told us the force's IT system isn't as good as it should be at identifying risks. Custody officers often fail to ask arresting or escorting officers if they have any more information to contribute.

Custody officers usually set observation levels at a level commensurate with presenting risks. But not all detainees under the influence of alcohol and/or drugs are placed on Level 2 observations and rousal checks as set out by APP guidance. Custody officers generally have a poor understanding of APP guidance on detainees under the influence of alcohol and/or drugs.

When Level 2 observations are set correctly, detainees are usually roused by detention officers in the right way, at the right time, and this is recorded correctly in the custody record. In most cases, the same staff complete the rousal checks. This is important as it makes it easier to establish changes in a detainee's behaviour or condition when under the influence of alcohol or drugs.

Checks that don't involve rousing the detainee are frequently carried out by looking through the cell door spyhole. This isn't an acceptable welfare check and doesn't follow APP guidance. These checks aren't always on time or recorded accurately with a bespoke entry in the custody record.

When detainees are assessed as needing closer observation due to heightened risk, they are placed on Level 4 (close proximity) observations. The officers responsible for these observations should be briefed by the custody officer about the specific risks the detainee presents. The details of the briefing should be recorded in the custody record, and the physical observations should be carried out through open cell doors with officers staying vigilant, in accordance with APP guidance. This doesn't always happen.

Regardless of presenting risks, most custody officers continue to routinely remove footwear and clothing with cords or laces from detainees, rather than justifying this through an individual risk assessment recording the reasons why the removal is necessary. This is a poor outcome for detainees, who are often made to change their clothing or, in some cases, have their clothing removed by force, which further escalates any risk. This practice doesn't follow APP guidance.

Anti-rip clothing is used too often and sometimes without clear reason or justification for its use. Detainees' clothing is sometimes removed by force and their dignity isn't always maintained. This practice is sometimes a disproportionate response to managing risk and leads to poor outcomes for detainees, particularly when force is used. It is our view that risks could be better managed by higher levels of observations and by staff engaging better with detainees.

There is no collective handover between the incoming and outgoing custody staff to make sure that all relevant information is passed on to those taking over responsibility for detainees. Because of different shift start times, custody officers carry out handovers separately from custody detention officers. Staff understand the value of a collective briefing and expressed frustration that they are unable to do this together at the beginning of shifts.

The incoming shift try to have a team meeting when all staff (including HCPs and L&D staff) have arrived for duty, but these aren't consistently carried out and can be several hours into the shift, which is too late. Following handovers, not all custody officers visit and interact with the detainees they are responsible for. Instead, one custody officer visits all detainees. These practices don't follow APP guidance.

At certain times of the day, particularly at the beginning and end of shifts, there aren't enough custody detention officers on duty to always manage detainee risk appropriately. We saw that during these periods, staff were sometimes excessively busy, leading to cell call bells not being answered quickly enough and delays in carrying out cell welfare visits. We also saw longer waits for detainees being booked into custody.

Cell call bells aren't always clearly audible and have poor sound quality.

Not all custody staff carry anti-ligature knives, despite being given personal-issue knives. This limits their ability to respond to an incident if needed and could compromise detainee safety. This is poor practice.

The management and control of cell keys is poor. There is little oversight when they are given to non-custody staff, which diminishes the control that custody staff should always maintain with detainees.

Individual legal rights – detention

Waiting times for detainees to be booked into custody varies, and some wait too long. We found some detainees were booked in promptly, within 30 minutes. Others waited over an hour. There is no triage system for those waiting to be booked in to prioritise, for example, children or vulnerable persons.

Arresting officers don't always give enough information about the circumstances of the arrest or adequately explain why it is necessary (as required by PACE Code G). We found they often stated the necessity was for a "prompt and effective" investigation, but they gave no details of what this involved. This means custody officers don't always have enough information to appropriately authorise detention.

Custody officers told us that the force's emphasis on increasing the number of arrests means they lack confidence in challenging or refusing detention. They felt any decisions to refuse detention wouldn't be supported by senior officers, despite a force directive during our inspection that this wouldn't be the case. We saw occasions when detention was authorised without all the necessary information and where, in our view, detention should have been refused. This is a cause of concern.

Voluntary attendance interviews aren't effectively used to avoid taking a person into custody. Information given to us by the force showed that between 1 September 2021 and 31 August 2022, its use of voluntary attendance interviews decreased by about 25 percent compared to the previous 12 months. During the same period, the number of arrests made by the force increased. We saw some cases where, in our view, a voluntary interview would have been more appropriate than detention.

Detainees spend longer than necessary in custody because not all cases are dealt with expeditiously. The force doesn't monitor average detention times, so it is difficult to assess outcomes for detainees. But we found some detainees were waiting too long for their investigation to progress because no investigating officers were available to make enquiries and interview them. We saw many detainees stay in custody for 18 to 19 hours before their case was dealt with.

Detainees are appropriately bailed or released under investigation when it isn't possible for officers to complete the investigation within the first period of detention (24 hours) because further enquiries are needed. We saw bail appropriately authorised, and any bail conditions or restrictions commensurate to the offences under investigation are explained to the detainee in detail.

Information given to us by the force shows that between 1 September 2021 and 31 August 2022, the number of immigration detainees increased compared to the previous 12 months. These detainees have an average detention time of 20 hours and 10 minutes. Once an IS91 form is served, detainees should be transferred to immigration detention facilities. But the force is unable to analyse its data to show how long detainees wait in custody after they are served with an IS91 form.

Custody staff told us they have good working relationships with immigration services and receive a good service from them.

Area for improvement

Custody officers should be confident in refusing detention when appropriate to do so, or when there are other ways of dealing with the investigation.

Area for improvement

The force should deal with detainees promptly and minimise the time they spend in custody by:

- booking detainees into custody promptly and prioritising them appropriately, especially children and those who are vulnerable; and
- dealing with investigations expeditiously so that detainees stay in custody for no longer than necessary.

Individual legal rights – detainees' rights and entitlements

Custody officers give good explanations to detainees about their rights and entitlements. These include:

- 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.

All detainees are given a leaflet which outlines these rights and also gives other information about detainees' entitlements while in custody.

Detainees are offered the opportunity to read the PACE codes of practice, but there aren't enough copies of the PACE Code C books to easily do so. There is only one copy at each suite, so if a detainee asks for a copy, the whole document (113 pages) must be printed out. This is time consuming for custody staff, and we saw occasions when it was forgotten and not given to the detainee because the suite was busy.

There are enough copies of the easy-read version of the book, which outlines the rights and entitlements of children or others who may need help in understanding their rights. We saw this handed out where needed.

When detainees are held incommunicado (delaying their right to have someone informed of their arrest), this is appropriately authorised by an inspector or someone above the rank of inspector. The authority for this is removed when no longer needed, and the detainee can speak to the person they have requested.

When a detainee declines free legal advice, we expect custody officers to explore the reasons for this. We didn't see this consistently happen or detainees being reminded that legal advice is free of charge and that they can change their minds at any time.

Legal representatives mostly attend in person to represent detainees.

Posters advertising the right to free legal advice in different languages (as required by PACE Code C paragraph 6.3) are in most suites, but not all posters are in the required languages.

Not all custody officers we spoke to were aware of the requirements of PACE Code C Annex M (the translation of documents and records). This makes sure detainees can receive important information about custody processes in a language they can understand.

There are enough interview and consultation rooms for detainees to privately consult with their legal representatives. Detainees wishing to speak to their legal representatives on the telephone can do so in private.

Custody officers are aware of how to contact the relevant embassies, consulates or high commissions for foreign nationals coming into custody. We saw this happening in practice.

DNA samples are stored in locked freezers or rooms to maintain the integrity of the samples. They are regularly collected from the suites. We saw posters in all the suites explaining the Protection of Freedoms Act 2012 and the retention and destruction of DNA samples. But we didn't see this explained to all detainees or the poster being brought to their attention.

Area for improvement

The force should improve its approach to detainees' rights and entitlements by:

- making sure there are enough copies of the most recent PACE Code C books at all custody suites;
- prominently displaying posters advertising the right to free legal advice in all the required languages;
- making sure all custody officers are aware of the requirements of PACE Code C Annex M (translation of documents and records) so that detainees can receive important information about their detention in a language they can understand; and
- informing detainees of what happens to any DNA samples they have given.

Reviews of detention

Reviews of detention for detainees are poor. They don't always comply with PACE or its codes of practice, and they aren't carried out well enough or in the best interests of the detainee. This is a cause of concern.

We found inspectors placed little emphasis on the importance of reviewing a detainee's detention and establishing whether it was appropriate for it to continue. There has been little or no training for the inspectors responsible for carrying out reviews of detention. We found some cases where reviews of detention hadn't taken place, which breaches section 40 of PACE. There were other cases where inspectors carried out reviews late or early, without recording the reasons. In some cases, the reviewing officers didn't attend in person or speak to detainees on the telephone. Instead, custody officers were wrongly asked to carry out the reviews by the inspectors. Many of the requirements of paragraph 15 of PACE Code C aren't routinely met.

Reviewing officers don't routinely establish the progress of the investigation by speaking to investigating officers to help them decide if continued detention is needed. They rely on busy custody officers to give them this information.

In many of the reviews we saw, inspectors didn't give detainees the opportunity to make any representations about their continued detention or even tell them that their further detention was being authorised. This doesn't meet the requirements of PACE Code C paragraph 15.3.

Where a review of detention takes place while a detainee is asleep, detainees are rarely informed that this has happened or reminded of their rights and entitlements, as required by PACE Code C paragraph 15.7. This is despite clear instructions on the custody records to do so. Some reviews occurred outside recognised rest periods – for example, during the day when the detainee should have been woken and spoken to.

There are notices on cell doors at some of the custody suites to remind custody staff to tell detainees that a review of detention has taken place while they were asleep. Despite this, this still didn't routinely happen.

During the reviews we saw, inspectors spoke to detainees courteously and asked about their wellbeing and whether they had received enough food and drinks or other care. But detainees weren't always offered the opportunity to have a shower or exercise, even though some of them had been held overnight or been in custody for a long time.

During the course of our inspection, we found some improvement in the approach to reviews as the force took on board the concerns we raised with it.

Complaints

Notices outlining how detainees can make a complaint are displayed at all custody suites. But the notices don't state that the complaint should be taken by an inspector while the detainee is still in custody, as is the case.

Custody staff are aware of the procedure if detainees want to make a complaint but told us it was difficult to find an inspector to take complaints while detainees are still in custody.

We reviewed two cases. In one, the inspector recorded the complaint over the phone at the charge desk and in the other, they recorded the complaint at the front enquiry office after the detainee had been released.

None of the custody suites have any specific complaint leaflets for custody or Independent Office for Police Conduct leaflets that set out the complaints procedure for detainees.

Area for improvement

The force should make sure detainees are aware they can, and are able to, make a complaint should they wish to do so.

Section 4. In the custody cell, safeguarding and healthcare

Expected outcomes

Detainees are held in a safe and clean environment, which protects their safety during custody. If force is used on a detainee this is as a last resort. Their care needs are met, and children and vulnerable adults are protected from harm. They have their physical and mental health, and any substance misuse, needs met.

Physical environment

The custody estate at Greater Manchester Police has eight designated suites at Cheadle Heath, Pendleton, Swinton, Wigan, Bolton, Ashton-under-Lyne, North Manchester and Bury. The force owns the buildings housing the suites at Bury and North Manchester, but the other suite buildings are provided under a private finance initiative with an external company.

There are potential ligature points in all the suites, mainly due to areas around benches in cells, the fitting of some cell doors, the shower areas and exercise yards. During the inspection, we gave the force a comprehensive, illustrative report detailing these and the physical conditions in the suites more generally.

The ventilation and temperature in the suites and individual cells are satisfactory, but there is little natural light in the cells other than through light tubes (structures also known as tubular skylights which transmit and distribute daylight by using reflective materials). All cells have toilets, sinks for handwashing and signs advising detainees that the water isn't suitable for drinking.

There are no discrete booking-in areas, except for in the Bury suite, and no glass-fronted cells to help those who experience claustrophobia. Most holding areas for detainees open onto and overlook the booking-in areas. This means there is no visual or audible privacy in the booking-in areas. This is unsatisfactory and leads to the holding rooms not being used.

Cleanliness across the suites is generally good but varies. The cells in some suites were dirty, and we found some that hadn't been cleaned to a satisfactory standard between uses. Deep cleans of suites are carried out once a year. Staff told us that repairs are mostly completed quickly. There was little graffiti.

Custody staff told us they carry out daily walkthroughs of the suites to check conditions. But these walkthroughs don't include checking for ligature points, and we found that some of the daily records of the suite checks were missing. Staff also carry out more comprehensive weekly checks of cells and facilities. They complete a checklist, which is then emailed to the inspector.

CCTV operates in the suites' communal areas but only in a limited number of cells (apart from at North Manchester, where it covers all the cells). This low number of cells with CCTV limits risk management and can result in detainees being moved between cells when risks change. The amount of signage advising detainees that CCTV is operating varies between suites. In some suites, the signs aren't always placed where detainees can easily see them. The CCTV screens are monitored from positions that can't be viewed by detainees or others in the custody area.

Not all custody staff have been involved in fire evacuation drills, and their knowledge of the procedures is mixed. Some staff told us they hadn't been involved in a drill recently. Fire evacuation drills are usually carried out when suites are reopened following their deep clean but often involve only the team on duty at the time. There are fire evacuation bags in all suites, with enough handcuffs and other equipment to manage an evacuation.

Area for improvement

The force should improve the safety and environment of the custody suites by:

- keeping all cells clean to the required standard;
- addressing the safety issues involving potential ligature points and, where resources don't allow immediate rectification, managing the risks appropriately;
- making sure all daily safety and maintenance checks are completed and recorded per Authorised Professional Practice guidance;
- improving the coverage of CCTV in cells and prominently displaying notices advising CCTV is in operation throughout the suites; and
- making sure all custody staff are trained and are involved in the procedures to be followed in the event of a fire or other event requiring an emergency evacuation per Authorised Professional Practice guidance.

Use of force

When force is used on detainees in custody, it isn't always recorded on detention logs. Incidents aren't always managed well, and sometimes the force used isn't proportionate to the risks or threats posed by the detainee.

We reviewed 26 cases of use of force on CCTV. In the cases we examined, we saw some good communication from officers and staff who de-escalated situations well and therefore avoided the need to use force. But when force was used, incidents weren't always managed well. Custody officers didn't always oversee and direct the use of force well enough.

Where officers used restraint techniques, these were often deployed correctly. But this wasn't always the case. Where restraint techniques weren't deployed correctly, restraint was unsuccessfully applied, leading to an escalation of the incident and more force being used. This increased the risk of injury to the detainee.

In some cases we reviewed, force was used to remove a detainee's clothing. It wasn't always clear from our observations on CCTV or the custody records that the removal was necessary and justified. In our view, it led to use of force that could potentially have been avoided. Officers also didn't always maintain the detainee's dignity well when removing the clothing.

We referred eight of the cases where we found concerns to the force for learning. Some of these cases involved the use of poor techniques, and the force used exposed the detainee to risk of injury. In five of the cases referred, we were concerned that the dignity of the detainee hadn't been appropriately considered either during or after the application of force. We also referred another case as a positive example for the force to learn from. This case showed the safe application of force and restraint techniques.

Officers who use force on detainees in custody don't always submit individual use-of-force forms as required by National Police Chiefs' Council guidance. This is despite often being reminded to do so by custody officers and despite reminder notices in some suites. We asked for use-of-force forms for the incidents we reviewed but didn't receive any.

Use-of-force incidents are usually documented on custody records. But in the case records we examined, the details recorded were sometimes limited and didn't always reflect what we saw on the CCTV footage. We were also concerned that data given to us by the force showed a much higher use of leg restraints than we normally see in other inspections, and we weren't assured that this information was accurate.

Custody inspectors review some use-of-force incidents to quality assure and learn from them. It isn't clear how effective these arrangements are. Our review of incidents has identified concerns which don't seem to have been recognised by Greater Manchester Police's quality assurance.

Limitations around accurately recording use-of-force incidents and quality assurance make it difficult for Greater Manchester Police to show that when force is used in custody, it is necessary, justified and proportionate. This is a cause of concern.

Handcuffs aren't always removed quickly enough from compliant detainees. The reasons why handcuffs are used, and the time when they are removed, aren't recorded.

We found that the necessity and justification for strip searches were well-enough recorded on the custody records we reviewed. Strip searches were generally managed well, but the dignity of the detainee wasn't always considered.

Most custody officers and all custody detention officers are up to date with their officer safety training, and arrangements are made to train those who aren't.

Detainee care

The approach to detainee care is mixed. We found staff showed a caring attitude, and the detainees we spoke to were positive about the care they had received while in custody. But detainees aren't always advised of the care provision available to them when they are booked into custody, such as showers, exercise or reading material. Showers and exercise aren't offered routinely, but when detainees do request them, they can't always be provided because staff are too busy to arrange them. All suites have exercise yards, but not all of them have a covered area for exercise during bad weather.

Soap and towels are available but only given out on request. Similarly, detainees must request toilet paper. Shaving facilities are available at all the suites but are rarely used, even when requested, due to the perceived risk.

The quality and quantity of reading material vary greatly across the suites. There are no arrangements to restock, and there isn't much reading material available in foreign languages or that is suitable for children.

Food preparation areas are generally clean and tidy, and the dietary information for the microwave meals is prominently displayed in all the suites. The range of food is good and meets most dietary requirements. It includes cereal bars, microwaveable meals, instant porridge, tea, coffee, squash and water. These are offered and given regularly, but staff don't always record this on the custody record.

There are enough supplies of replacement clothing, plimsolls and underwear in a range of sizes in all the suites.

All cells have a mattress, but there are limited pillows available so staff sometimes provide an extra blanket instead. Mattresses are in a poor state of repair, with most too thin to offer comfort and lacking support. There are no extra-thick mattresses available in any of the suites.

Area for improvement

The force should improve the way in which it cares for detainees by:

- making sure detainees know what care facilities are available to them;
- offering and providing showers and exercise to detainees, especially those in custody for a long time;
- providing toilet paper and other hygiene items without the detainee needing to request them;
- extending the range of reading materials and providing more choice for children and more reading materials in other languages; and
- having mattresses in a good state of repair that are comfortable enough for detainees and having enough pillows in all cells.

Safeguarding children and vulnerable people

Custody staff have a good understanding of their safeguarding responsibilities and interact well with young people and vulnerable adults. Staff have received training on neurodiversity and trauma-informed policing. We saw custody staff taking account of safeguarding concerns and making appropriate arrangements to address them, but they didn't always record what they had done.

Custody officers have little oversight over safeguarding referrals made to social services or other partner agencies for children and vulnerable adults. Referral forms aren't always submitted by arresting or investigating officers. Although some of the forms we examined were comprehensive, others didn't contain important information such as disclosures made to custody staff.

All children brought into custody should be referred to an HCP and the L&D team. This provides an additional safeguarding measure to identify and address concerns. The force and its partner organisations monitor how well these arrangements work to make sure children are spoken with, but consultations aren't always recorded on police systems. This means that when HCPs or L&D workers raise concerns, it isn't always clear whether they are appropriately shared with police staff.

Children and vulnerable adults are released into the care of their families. Where this isn't possible, or where there are safeguarding concerns preventing their return, the force considers alternative arrangements to make sure they are kept safe.

Appropriate adults

Custody staff don't always secure appropriate adults (AAs) soon enough. Some children and vulnerable adults wait a long time before receiving support from AAs. This was an area for improvement in our previous inspection.

Staff contact detainees' families or friends to act as AAs in the first instance. Where this can't be arranged, Child Action Northwest provides AAs for children and vulnerable adults from 9am until midnight. They are available later for serious cases, if necessary.

But many children and vulnerable adults are left waiting a long time before receiving support from an AA. Custody staff often arrange for AAs to attend in time for the detainee's interview with investigating officers, rather than to give early support to them regarding their rights and entitlements and overall welfare needs.

Custody staff are aware of their responsibilities to secure an AA when a detainee is vulnerable. They have had training to raise awareness of this need. But in some of the cases we examined, there was information to suggest the detainee was vulnerable and staff should have considered an AA but didn't.

A leaflet produced by Child Action Northwest gives guidance to AAs about their role in actively protecting the detainees' rights, but it isn't always given to parents or carers.

The facilities to allow an AA to speak to a child or vulnerable adult at any time and in private are poor in some of the custody suites.

Area for improvement

The force should arrange for appropriate adults to attend custody as soon as possible so that children and vulnerable adults receive support early on in detention.

Children

Custody officers told us that they weren't always satisfied that alternatives to police custody had been considered for children. But any refusal to detain must be reported to the custody manager, and officers were concerned their decisions wouldn't be supported by senior officers. We found cases where, in our view, detention should have been refused.

We found some children with autism or mental health needs detained for minor offences committed at home. There were only minor injuries, and the parent(s) didn't support the arrest. Alternative ways of dealing with these incidents may have been more appropriate.

Some children are dealt with promptly, but we found other cases where delays led to long detention times for children. Reviews of detention are often poor, and inspectors aren't scrutinising the need for further detention or assessing the progress of cases to make sure children don't stay in custody for longer than necessary.

Female custody staff are available and assigned to girls, as required by the Children and Young Persons Act 1933. But although the force assigns female staff to girls in custody, they aren't expected to speak or actively engage with them, and it wasn't clear from custody records whether they did so.

There are distraction activities and devices to help children during their time in custody. These include foam balls, puzzles and fidget toys. But we didn't see these routinely offered to help children who could have benefited from them. There is little detail on custody records to show whether they have been given out.

The force and its ten local authorities have a joint protocol, setting out the responsibilities and arrangements for alternative accommodation for children who have been charged and refused bail. There are also regular meetings to monitor and discuss the outcomes for children dealt with under the protocol.

In practice, a lack of alternative accommodation means few children are moved as they should be. Between 1 September 2021 to 31 August 2022, 80 children were charged and refused bail. The force assessed 58 of them as requiring transfer to alternative accommodation. One child was transferred to a secure children's home, and another was returned to their children's home. The remaining 56 children stayed in custody overnight as no accommodation was available. This is a poor outcome for those children.

Nine out of the ten local authorities share payment for a dedicated bed in a childcare facility at Burnage in Manchester. But this accommodation is limited to boys who are 16 or 17 years old and isn't well used.

Custody officers complete juvenile detention certificates for the court, but the four certificates we reviewed were poorly completed. There was little detail justifying the detention of the child in police custody overnight.

Area for improvement

The force should strengthen its approach to caring for children in custody by:

- only detaining children where necessary and keeping their time in custody to a minimum;
- making sure female officers assigned to care for girls actively engage with them to meet their needs; and
- continuing to work with local authority partners so children charged and refused bail are transferred to alternative accommodation as they should be.

Healthcare

Mitie Care & Custody is contracted to provide physical healthcare support to detainees and carry out forensic testing in custody. HCPs are allocated to each custody suite to provide healthcare cover 24 hours a day, 7 days a week. Senior HCPs are available to support the service each day and provide extra support for the rota if staff shortages occur. Where cover isn't provided as required by the contract, the force can apply 'financial credits' (penalties). The service has some vacancies and recruitment is ongoing.

Greater Manchester Mental Health NHS Foundation Trust (GMMH) is subcontracted by Mitie Care & Custody to provide L&D services across Greater Manchester custody suites. The Greater Manchester integrated care system and Mitie Care & Custody oversee and monitor the L&D service contract along with the force.

The force and its contractors work together well. There are well-integrated governance procedures to monitor the safety, quality and performance of health services. As the lead provider, Mitie Care & Custody shares and reviews monthly data with the force at contract review meetings. There is a regular clinical audit of care records, medicines and infection prevention and control, with action plans to improve the quality of care for detainees.

The sub-contract arrangement between Mitie Care & Custody and GMMH Trust allows good information sharing between HCPs and L&D staff. Both can access the same single patient record for each detainee.

HCPs and L&D staff receive relevant training for their roles and undergo annual appraisals of their performance. Additional joint training helps give seamless care to detainees. All staff have the opportunity to be supervised, but this isn't regularly taken up or monitored well enough by senior staff.

Not all medical rooms are compliant with infection prevention and control guidance. Walls and floors are in a poor state of repair. Medical rooms aren't cleaned well enough. This was an area for improvement at the last inspection but it hasn't been acted on. But when medical rooms are used for forensic sampling, they are forensically cleaned before and after examinations.

Medical rooms have essential emergency equipment, and all custody suites have easily-accessible, police-owned automated external defibrillators. Equipment is regularly checked to make sure it is fit for purpose and ready for use.

Healthcare staff have access to interpretation services for detainees whose first language isn't English.

Both health providers report incidents through their electronic reporting systems. Incidents are investigated and learning is shared with staff. Outcomes of investigations are reviewed and shared with the force as part of regular contract monitoring meetings.

Both providers have a confidential complaints process. However, there is no visible information displayed for detainees on how to make a health-related complaint, which we expect. Few complaints are received by the providers, although some complaints are made directly to the police.

Physical health

Detainees receive timely clinical assessment and treatment from experienced and competent HCPs. Staff we spoke with and observed were respectful and caring during their interactions with detainees.

The service is contracted to provide embedded HCPs in all eight custody suites. There are some vacancies. This means there are regular gaps in the staff rota and staff are required to cover other custody suites as needed. Recruitment is ongoing. But from the information we received and our observations, detainees are usually assessed promptly.

HCPs receive appropriate training for their roles. This helps them contribute to custody officer decisions such as risk, fitness to detain, interview and safe release. Most HCPs spoke positively about their access to good-quality training.

HCPs complete clinical assessments and examinations in dedicated clinical rooms. But they don't always maintain the privacy and dignity of detainees when doing so. The door to the clinical room stays open when HCPs are consulting with any detainee, rather than staff carrying out individual risk assessments to decide whether this is needed. This was an area for improvement identified at the last inspection.

The service employs both male and female HCPs, and staff arrange (when possible) an assessment by an HCP of the gender requested by the detainee.

Staff seek consent from detainees for healthcare interventions, and detainees' mental capacity is assessed and recorded clearly where appropriate. Information-sharing protocols allow healthcare staff to share relevant information with custody staff.

Staff complete electronic clinical records for detainees, in which they assess a range of detainees' needs. These include physical and mental health, substance misuse, safeguarding and social needs. The clinical records we reviewed were comprehensive and contained plans of care that reflected the assessed needs of the detainees, so care was safe and appropriate. HCPs and GMMH staff have access to the same clinical record system, so all healthcare staff have a full overview of detainees' treatment and care. This is positive.

Most HCPs update custody records to make sure custody staff have current information about the healthcare needs of detainees. But some HCPs don't have access to custody records. So, although they orally give information to custody staff, some relevant healthcare information isn't always recorded.

HCPs don't directly contribute to the completion of detainees' person escort records for when they leave custody. Instead, custody staff extract available healthcare information from custody records. This means the most up-to-date and accurate detainee healthcare information may not be included in their person escort records.

Not all HCPs were compliant with infection prevention and control standards.

Mental health

Detainees' mental health needs are identified and assessed appropriately, with onward referral to community services following their release from custody.

GMMH is subcontracted to provide an L&D service to detainees. Dedicated and skilled staff give good support to vulnerable detainees, including help with housing, social problems and drug and alcohol issues. Depending on detainees' individual needs, staff will refer them on to community engagement workers and peer mentors to support them following their release from custody.

Staff from GMMH are based in all eight custody suites, 7 days a week, from 7am to 10pm. There are staffing shortages, which limit the service, but the provider is working hard to address these. Staff work across different custody suites to cover gaps in the rota, and HCPs provide acute and out-of-hours mental health support as part of their role.

There is a clear referral pathway for custody staff to refer a detainee for assessment of their mental health and wellbeing. L&D staff use a triage tool to identify detainees' needs, establish any previous contact with mental health services and prioritise assessments. Assessments for women and children are prioritised as a matter of course. Other priority risk groups include people with learning disabilities, veterans, and detainees arrested in relation to sexual images.

L&D staff have read-only access to custody records. They must email or orally hand over relevant information about detainees to custody staff. This means there is a risk that custody records may not reflect an up-to-date picture of detainee care.

L&D staff, including staff based in the courts, attend daily virtual team meetings to discuss detainee care. These help in decision making and allocating staff appropriately across the custody suites to meet detainees' needs and manage risk.

We reviewed a small sample of clinical records and found staff completed comprehensive assessments of detainees' needs. Staff signpost and refer detainees to a range of community services and give them written information upon release from custody. This is positive. The records also include interventions by community engagement workers following referrals from L&D staff. Having one shared clinical care record for each detainee works well. It makes sure there is good oversight of all detainee healthcare needs while they are in custody and on release.

The force's use of section 136 of the Mental Health Act 1983, to detain a person and take them to a mental health facility, is high. Between 1 September 2021 and 31 August 2022, it used it 1,991 times. Custody shouldn't be used as a place of safety unless there are exceptional circumstances.

Custody staff regularly use section 136 to transfer detainees showing acute mental health problems from custody to a health-based place of safety. Information given to us by the force shows that between 1 September 2021 and 31 August 2022, it used section 136 on 343 occasions. There is a shortage of beds at health-based places of safety in Greater Manchester. The force faces significant difficulty in accessing them for detainees. This can result in delays in getting support for detainees.

Detainees can wait a long time in custody for mental health act assessments under section 2 of the Mental Health Act 1983. There is an even longer delay if the detainee needs to transfer to a mental health bed. Information given to us by the force shows that between 1 September 2021 and 31 August 2022, detainees waited 6.5 hours for an assessment and a further 17 hours for a bed to become available, on average. But we found 4 cases where detainees stayed in custody between 36 and 77 hours until a mental health bed could be found. This suggests the Mental Health Act referral pathway isn't working as effectively as it should.

But in the health records we examined, it is clear the force and its health partners try to move detainees in mental health crisis from custody as soon as possible. Health staff record detailed actions taken to support detainees in custody awaiting transfer under the Mental Health Act 1983. Custody staff also record the progress of cases on custody records and escalate them when there are delays.

As well as the L&D service, GMMH has a mental health clinician in the force control room 24 hours a day, 7 days a week. This is better than we normally see, and frontline officers value this service. The clinician has access to the force's IT system and clinical information held by GMMH. This helps the clinician to support frontline officers to decide the best action to take when dealing with someone with mental ill health. GMMH recorded 2,727 incidents involving people with mental ill health between March 2022 and August 2022.

GMMH and the Pennine Foundation Trust provide mental health response cars. These provide a clinical response, alongside police officers, to incidents involving people with mental ill health. The cars cover most of the force area from 4pm to midnight, which are the hours when the service is most in demand.

Substance misuse

HCPs carry out initial assessments and, where needed, give treatment to detainees who are experiencing drug and alcohol withdrawal while in custody.

Staff work with detainees with chronic and complex needs, including dual diagnosis. HCPs use nationally-recognised assessment tools to monitor and inform decisions regarding withdrawal. When clinically indicated, staff administer medicines to relieve symptoms of withdrawal. The care records we reviewed reflected appropriate clinical decision making and clear treatment care plans for those experiencing withdrawal.

Staff support detainees already in treatment in the community to continue opiate substitute treatment while in custody, subject to confirmation of ongoing compliance. This process is supported by appropriate patient group directions.

There is no dedicated substance misuse service in the custody suites. But the L&D team engages with detainees with drug and alcohol problems in custody and makes referrals to community substance misuse services and community engagement workers as needed.

Medicines management

Staff provide a range of care and treatment interventions that are suitable for detainees and consistent with national guidance and best practice. The service has several patient group directions to support staff with decisions relating to a range of health issues, including acute withdrawal from alcohol and drugs. The service doesn't offer nicotine replacement therapy.

Mitie Care & Custody has robust governance arrangements to manage medicines. HCPs use systems and processes to safely administer, record and store medicines. HCPs manage controlled drugs appropriately and complete regular audits of medicines to identify any potential errors. Staff report medicine errors through the electronic reporting system. Staff investigate these reports promptly.

Custody staff don't always securely store medicines brought in with detainees. Some medicines are stored in the detainees' property lockers or a locked cupboard, but we saw other medicines left on top of cupboards or in drawers. Controlled drugs are stored in locked cupboards, but records of these medicines aren't consistently maintained or accurate. The lack of scrutiny and oversight by custody staff leads to poor medicines management, which increases risk. This is a cause of concern.

Custody staff arrange for detainees' medicines to be transferred with them to court or to other care providers.

Section 5. Release and transfer from custody

Expected outcomes

Detainees are released or transferred from custody safely. Those due to appear in court in person or by video do so promptly.

Safe release and transfer arrangements

The force has a clear focus on ensuring detainees are released safely. We saw some good attention and care given to detainees on release.

Custody officers generally engage well with detainees to complete pre-release risk assessments, asking the set questions and making sure detainees are, and feel, safe to be released. We saw detainees present for most of the pre-release process, and any risks were discussed with them.

But custody officers rarely engage face to face with detainees being transferred to court in the morning. The pre-release risk assessment is normally completed by a previous shift and not always when the detainee is present. Not assessing risk immediately before transfer removes the opportunity to check that the detainee's risk hasn't changed overnight.

Custody officers mostly explained bail conditions or being released under investigation well. They take time to make sure detainees understand their bail conditions and the consequences of breaching them. They explain to those released under investigation the possible offences they may commit if they interfere with victims or witnesses while the investigation is ongoing. Written information is also given.

There is good support agency information available for detainees on release. Staff give an information leaflet to most detainees. For detainees who are being transferred to court, the leaflet should be included with their property, but this doesn't always happen. The leaflet is only available in English.

Staff generally give good support to detainees who don't have the means to get home safely. We saw some caring support where they arranged taxis or explained bus stop or tram locations. Sometimes they arranged police vehicle transport, especially for children and vulnerable adults.

Detention officers complete digital person escort records and arrange the transport for detainees appearing in court. Custody officers rarely check the content of these records or sign them off before a detainee leaves the suite. We checked some records and found several omissions, particularly regarding health concerns and medication.

Custody officers have very little involvement with the release of detainees transferring to court. Instead, detention officers supervise the process with little, if any, oversight from the custody officer. This practice doesn't follow APP guidance.

Area for improvement

The force should strengthen its approach when transferring detainees safely to court or other agencies by making sure that:

- all relevant information identified during custody, including any health concerns, is fully recorded in the electronic person escort record in line with Authorised Professional Practice guidance; and
- custody officers oversee the transfer process and engage personally with detainees transferred to court to identify and mitigate risks prior to their transfer from police custody.

Courts

Detainees remanded to court are usually collected promptly in the morning, are appropriately dressed and are presented before the first available court. There can be delays because it is sometimes difficult for the escort provider to cope with the number of detainees requiring transfer.

Detainees who are arrested on warrant during the day or who are remanded after charge can sometimes be accepted by the court later in the day. This is an improvement since our last inspection and means most detainees are held for no longer than necessary.

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

Causes of concern and recommendations

Cause of concern: leadership

Leadership for custody provision isn't strong enough to make sure the service is provided well and achieves appropriate outcomes for detainees. There is limited prioritisation of custody by senior officers or engagement in how custody is provided. There hasn't been enough improvement since our previous inspection. Significant concerns remain.

The position is exacerbated by a large increase in the number of detainees entering custody. This makes it difficult for staff to fulfil all their duties and meet detainees' needs.

Limited performance management and quality assurance of the service means concerns haven't been identified and addressed.

The other causes of concern below are largely due to a lack of strategic input in overseeing and managing the service.

Recommendation

The force should have comprehensive governance arrangements, with appropriate senior officer involvement, to robustly oversee custody provision. These should identify concerns and establish the improvements needed to address them. They should be supported by comprehensive performance management and quality assurance that makes sure appropriate outcomes for detainees are achieved.

Cause of concern: meeting legal requirements and guidance

The force isn't always meeting the requirements of PACE and its codes of practice for the detention, treatment and questioning of persons, particularly in terms of how detention is authorised and the way in which reviews of detention are carried out.

Recommendation

The force should take immediate action to make sure that all custody procedures and practices comply with legislation and guidance.

Cause of concern: use of force

The force's governance and oversight of the use of force in custody isn't good enough. Limited recording on custody records, a lack of use-of-force forms for incidents and little quality assurance mean it doesn't have accurate information to support effective scrutiny. Our CCTV review found incidents weren't always managed well. The force can't show that when force is used in custody it is always necessary, justified and proportionate.

Recommendation

Greater Manchester Police should scrutinise the use of force and restraint in custody to show that when it is used in custody, it is necessary, justified and proportionate. This scrutiny should be based on accurate information and robust quality assurance.

Cause of concern: detainee dignity

The force isn't always maintaining the dignity of detainees when clothing is removed. Detainees are sometimes left naked in their cells and not encouraged to put on replacement clothing.

Recommendation

The force should make sure that the dignity of detainees is protected and maintained at all times.

Cause of concern: risk management

The management of risk isn't good enough, and the force isn't always assuring detainee safety. Our concerns are:

- At certain times of the day, there aren't always enough staff on duty to manage risk appropriately and make sure detainees are kept safe.
- Detainees are routinely held in vans in the custody docks, and there is limited assessment of any risks posed while they are held there to prioritise them for booking-in.
- Detainees under the influence of alcohol and/or drugs aren't always placed on Level 2 observations with rousals.
- Checks on detainees are often carried out through spyholes, are sometimes late and are poorly recorded in custody records.
- Level 4 (close proximity) observations aren't always conducted in line with Authorised Professional Practice guidance. Briefings to officers conducting them are poor, and the details are rarely recorded in the custody record.
- Most custody officers routinely remove cords, belts and laces from detainees without an individualised risk assessment.
- Anti-rip clothing is used too frequently, often without clear rationale or justification.
- Handovers between shifts aren't attended by all custody staff, and not all custody officers visit the detainees in their personal care.
- Not all staff routinely carry anti-ligature knives.
- Custody staff don't always keep control of cell keys.

Recommendation

The force should take immediate action to mitigate the risk to detainees by making sure there are enough staff to safely manage risks, and that risk management practices are safe, follow Authorised Professional Practice guidance and are consistently carried out to the required standard.

Cause of concern: medicines management

The force's records of detainees' medicines aren't consistently maintained or accurate, and it doesn't always securely store medicines brought in with detainees. The lack of control over these medicines presents a significant risk to the force.

Recommendation

Custody staff should maintain accurate records of all medicines and store medicines brought in with detainees securely.

Areas for improvement

Leadership, accountability and partnerships

The force should make sure that staff understand and follow Authorised Professional Practice guidance.

The force should make sure proper consideration is given to diverting vulnerable people and children away from custody where it is appropriate to do so.

First point of contact

The force should make sure it promotes alternatives to arrest and that frontline officers use these appropriately to divert children and vulnerable people away from custody. In the custody suite – booking-in, individual needs and legal rights

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

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

- making adequate provision for detainees with disabilities;
- arranging for women to speak with a female officer if they wish to do so;
- having satisfactory disposal arrangements for menstrual products;
- consistently meeting the needs of detainees who wish to observe their faith; and
- using private telephone interpreting services at all points during detention where important information needs to be given or requested.

Custody officers should be confident in refusing detention when appropriate to do so, or when there are other ways of dealing with the investigation.

The force should deal with detainees promptly and minimise the time they spend in custody by:

- booking detainees into custody promptly and prioritising them appropriately, especially children and those who are vulnerable; and
- dealing with investigations expeditiously so that detainees stay in custody for no longer than necessary.

The force should improve its approach to detainees' rights and entitlements by:

- making sure there are enough copies of the most recent PACE Code C books at all custody suites;
- prominently displaying posters advertising the right to free legal advice in all the required languages;
- making sure all custody officers are aware of the requirements of PACE Code C Annex M (translation of documents and records) so that detainees can receive important information about their detention in a language they can understand; and
- informing detainees of what happens to any DNA samples they have given.

The force should make sure detainees are aware they can, and are able to, make a complaint should they wish to do so.

In the custody cell, safeguarding and healthcare

The force should improve the safety and environment of the custody suites by:

- keeping all cells clean to the required standard;
- addressing the safety issues involving potential ligature points and, where resources don't allow immediate rectification, managing the risks appropriately;
- making sure all daily safety and maintenance checks are completed and recorded per Authorised Professional Practice guidance;
- improving the coverage of CCTV in cells and prominently displaying notices advising CCTV is in operation throughout the suites; and
- making sure all custody staff are trained and are involved in the procedures to be followed in the event of a fire or other event requiring an emergency evacuation per Authorised Professional Practice guidance.

The force should improve the way in which it cares for detainees by:

- making sure detainees know what care facilities are available to them;
- offering and providing showers and exercise to detainees, especially those in custody for a long time;
- providing toilet paper and other hygiene items without the detainee needing to request them;
- extending the range of reading materials and providing more choice for children and more reading materials in other languages; and
- having mattresses in a good state of repair that are comfortable enough for detainees and having enough pillows in all cells.

The force should arrange for appropriate adults to attend custody as soon as possible so that children and vulnerable adults receive support early on in detention.

The force should strengthen its approach to caring for children in custody by:

- only detaining children where necessary and keeping their time in custody to a minimum;
- making sure female officers assigned to care for girls actively engage with them to meet their needs; and
- continuing to work with local authority partners so children charged and refused bail are transferred to alternative accommodation as they should be.

Release and transfer from custody

The force should strengthen its approach when transferring detainees safely to court or other agencies by making sure that:

- all relevant information identified during custody, including any health concerns, is fully recorded in the electronic person escort record in line with Authorised Professional Practice guidance; and
- custody officers oversee the transfer process and engage personally with detainees transferred to court to identify and mitigate risks prior to their transfer from police custody.

Section 7. Appendices

Appendix I – Methodology

Police custody inspections focus on the experience of, and outcomes for, detainees from their first point of contact with the police and throughout their time in custody to their release. We visit the force over two weeks. Our methodology includes the following elements, which inform our assessments against the criteria set out in our *Expectations for police custody*.

Document review

Forces are asked to provide various important documents for us to review. These include:

- the custody policy and/or any supporting policies, such as the use of force;
- health provision policies;
- joint protocols with local authorities;
- staff training information, including officer safety training;
- minutes of any strategic and operational meetings for custody;
- partnership meeting minutes;
- equality action plans;
- complaints relating to custody in the six months before the inspection; and
- performance management information.

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

Data review

Forces are asked to complete a data collection template based on police custody data for the previous 36 months. The template requests a range of information, including:

- custody population and throughput;
- the number of voluntary attendees;
- the average time in detention;
- children; and
- detainees with mental health problems.

This information is analysed and used to provide background information and to help assess how well the force performs against some main areas of activity.

Custody record analysis

We analyse a sample of custody records drawn from all detainees entering custody over a one-week period prior to the start of our inspection. The records are stratified to reflect throughput at each custody suite and are then picked at random. Our analysis focuses on the legal rights, treatment and needs of the detainee.

Case audits

We audit around 40 case records in detail (the number may increase depending on the size and throughput of the force inspected). We do this to assess how well the force manages vulnerable detainees and specific elements of the custody process. These include examining records for children, individuals with mental health problems, those under the influence of drugs and/or alcohol and where force has been used on a detainee.

Our audits examine a range of factors to assess how well detainees are treated and cared for in custody. Audits examine, for example, the quality of risk assessments, whether observation levels are met, the quality and timing of PACE reviews, whether children and vulnerable adults get support from appropriate adults when they need it, and whether detainees are released safely. We also assess whether force used against a detainee is proportionate and justified, and is properly recorded.

Observations in custody suites

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

Interviews with staff

During the inspection we interview officers from the force. These include:

- chief officers responsible for custody;
- custody inspectors; and
- officers with lead responsibility for areas such as mental health or equality and diversity.

We speak to people involved in commissioning and running health, substance misuse and mental health services in the suites and in relevant community services, such as local Mental Health Act section 136 suites. We also speak to the co-ordinator for the Independent Custody Visitor scheme for the force.

Focus groups

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

Feedback to force

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

Appendix II – Inspection team

- Norma Collicott: HMI Constabulary and Fire & Rescue Services inspection lead
- Patricia Nixon: HMI Constabulary and Fire & Rescue Services inspection officer
- Anthony Davies: HMI Constabulary and Fire & Rescue Services inspection officer
- Ian Smith: HMI Constabulary and Fire & Rescue Services inspection officer
- Emmanuelle Versmessen: HMI Constabulary and Fire & Rescue Services inspection officer
- Marc Callaghan: HMI Constabulary and Fire & Rescue Services inspection officer
- Vijay Singh: HMI Constabulary and Fire & Rescue Services inspection officer
- Mark Calland: HMI Constabulary and Fire & Rescue Services inspection officer
- Andy Reed: HMI Constabulary and Fire & Rescue Services inspection officer
- Stephen Mathews: HMI Constabulary and Fire & Rescue Services inspection officer
- Martine Moore: HMI Constabulary and Fire & Rescue Services inspection officer
- Joanne White: CQC inspector
- Dayni Johnson: CQC inspector

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