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

CareQuality Commission

Report on an inspection visit to police custody suites in Dorset

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

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Fact page

Note: Data supplied by the force.

Force

Dorset

Chief constable

Samantha de Reya (Acting)

Police and crime commissioner

David Sidwick

Geographical area

Dorset

Date of last police custody inspection

2016

Custody suites

- Bournemouth: 34 cells
- Weymouth: 19 cells
- Poole (contingency): 24 cells

Annual custody throughput

7,945 between 1 February 2022 and 31 January 2023

Custody staffing

- 25 custody sergeants
- 36 detention officers

Health service provider

Mitie Care & Custody

Summary

This report describes our findings following an inspection of Dorset 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 February 2023. 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.

To help the force improve, we have made one recommendation to it and its police and crime commissioner. This addresses our main causes of concern.

We have also highlighted a further 14 areas for improvement. These are set out in section 6 of this report.

Leadership, accountability and working with partners

Dorset Police has effective governance arrangements to provide safe and respectful custody services and the force has improved its custody services since our last inspection.

There are usually enough staff on duty to manage custody safely and meet the welfare needs of detainees. However, staff are stretched during shift handovers, when there are less of them on duty, making it more difficult to care for and manage detainees safely.

The force generally follows Police and Criminal Evidence Act 1984 (PACE) and its codes of practice, although not in all areas such as some aspects of reviews of detention. It has adopted the College of Policing's Authorised Professional Practice (APP), but it isn't always followed.

The force regularly monitors performance of custody services, but some important areas are missing, for example, how long detainees wait for an assessment under the Mental Health Act 1983. It isn't clear how performance information is used to improve outcomes for detainees, such as trying to reduce the time they spend in custody.

There is some detailed recording about the use of force in custody and some quality assurance over incidents, but strategic oversight is less clear. Some incidents we reviewed weren't well managed, suggesting scrutiny of the use of force needs to improve.

The quality of recording on custody records is generally good. A sample of records are regularly and comprehensively reviewed.

The force understands its responsibilities under the public sector equality duty. It collects data on detainees to identify and assess any disproportionality, for example, in relation to strip searching.

The force has a clear priority to divert children and vulnerable adults away from custody. It works well with local authorities to help keep children away from the criminal justice system.

However, joint working between the force and its mental health service partners is limited. Relationships are strained and the arrangements aren't working effectively to support those with mental ill health both inside and outside custody. There are some poor outcomes for those with mental ill health. It is a cause of concern.

Pre-custody – first point of contact

Frontline officers have a good understanding of what makes someone potentially vulnerable and take account of this when deciding whether to arrest a person. However, information from call handlers in the force control room isn't always good enough to support those decisions. Officers only arrest children as a last resort, using alternatives such as voluntary attendance interviews where possible.

Officers told us they can't always get advice regarding people with mental health promptly, or sometimes at all. This means some people may be detained rather than considering if other, more appropriate, health-based solutions are available. Officers also said they often experience long waits when they take a person with mental ill health to a designated place of safety.

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

Custody staff interact respectfully with detainees and are patient and reassuring with them. Privacy for them is generally good. Detainees are usually suitably dressed when moving about the suite, but their dignity isn't always protected when their clothing is removed and replaced with safety suits.

Custody staff understand how to meet the needs of detainees with protected characteristics, or from minority groups. They generally try their best to meet these needs but facilities to achieve this are limited.

The identification of risk is good, but there are some weaknesses with its ongoing management. Observation levels for detainees are set appropriately and are commensurate with the risks presented. Checks on detainees are carried out well. Some custody officers allow detainees to keep their corded clothing and other items based on the risks they pose.

However, during the shift handover, there aren't always enough staff to manage detainee risks safely. Handovers between shifts to share information on detainee risks don't include all staff.

Detainees are generally booked into custody promptly and their detention is appropriately authorised. Officers give them good explanations about their rights and entitlements in custody.

Reviews of detention are generally carried out well, but not all aspects comply with PACE and its codes of practice. Some detainees spend longer than necessary in custody because cases aren't dealt with quickly enough.

In the custody cell, safeguarding and healthcare

The force has two custody suites at Bournemouth and Weymouth and a contingency suite at Poole. There is natural light in most cells and no graffiti. Cleanliness at the two main suites is good. However, there are potential ligature points, mostly at Weymouth and Poole. Detainees are generally well cared for. Those we spoke to were positive about the care they had received. There is a good range of food and drink, which is provided regularly. We saw detainees using the shower and exercise facilities, and distraction materials such as foam balls. Their comfort could be improved by having better mattresses and warmer blankets.

Custody staff and police officers have a good understanding of their safeguarding responsibilities for children and vulnerable adults and make referrals to partner agencies as appropriate. Children generally don't wait too long before receiving support from an appropriate adult (AA), but this isn't always the case for vulnerable adults.

Children are only held in custody when necessary and the force aims to keep them there for the least time possible. Custody staff care for them well. However, we saw some children held for longer than necessary, including overnight, because of delays in investigations.

Physical health services for detainees have improved following some initial difficulties when Mitie Care & Custody took over the contract in October 2022. Experienced and competent healthcare practitioners (HCPs) treat detainees respectfully and carry out comprehensive assessments of their health needs. The criminal justice liaison and diversion (CJLD) service provides good support to detainees with all types of vulnerabilities.

However, some detainees who need a Mental Health Act assessment in custody wait a long time, with a further wait before they are taken to a mental health facility. The force sometimes uses section 136 of the Mental Health Act 1983 to transfer detainees out of custody. There is little monitoring or joint working between the force and mental health services to try to improve the situation.

Release and transfer from custody

Custody staff engage well with detainees to complete pre-release risk assessments and make sure all risks are understood and considered before the person is released. They help with arrangements to get detainees home safely. Custody officers appropriately oversee the release of detainees being taken to court.

When detainees are remanded to court, they are usually collected promptly in the morning, and sometimes they are accepted by the court later in the day. This is a good outcome for detainees as it minimises their time in police custody.

Cause of concern and recommendation

Cause of concern

The force and mental health services don't have good enough arrangements to deal with people with mental ill health. Frontline officers called to incidents in public places can't always get the support they need from mental health professionals. This potentially leads to people being detained under section 136 of the Mental Health Act 1983, when other more appropriate solutions may have been available. Detainees wait too long for a Mental Health Act assessment in custody when required, with further waits before they are transferred to a mental health facility. There is very little information and no monitoring to show how well the needs of people with mental ill health are met, and little joint work to try to improve outcomes for them.

Recommendation

The force should work with mental health services to make sure people with mental ill health are dealt with appropriately and their needs met. This should include collecting and scrutinising information on the numbers of people with mental ill health coming into contact with the police or entering custody and assessing the outcomes achieved for them. This information should be used to improve services.

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 Dorset 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

Dorset Police has a clear governance structure to provide safe and respectful custody services. An assistant chief constable is responsible for custody services, supported by the chief superintendent, who is the head of criminal justice. A superintendent and chief inspector oversee day-to-day delivery of custody services.

There are effective governance arrangements for custody. Fortnightly management meetings chaired by the chief inspector consider, for example, staffing, training and recruitment. They monitor adverse incidents. The monthly investigative standards board oversees custody activities and custody is discussed at force daily meetings.

These arrangements have supported the force to make good progress in improving custody services since our last inspection.

The healthcare contract has recently been awarded to Mitie Care & Custody and there are good arrangements to oversee it at both force and regional level.

There are two full-time custody suites at Bournemouth and Weymouth and a contingency suite at Poole. There are some potential ligature points. We provided a report to the force detailing these and the general physical condition of the suites. The force responded promptly and started to deal with some of the concerns straightaway.

There are four custody inspectors, two at each full-time suite. Bournemouth has 17 custody officers and 24 detention officers. Weymouth has 8 custody officers and 12 detention officers. There is a custody support team with two experienced members of staff managing custody data collection, record reviews and custody policy.

There are 20 police officers trained to act as detention officers and 21 frontline sergeants trained to act as custody officers. This allows sufficient cover for staff absences in the suites.

There are generally enough staff on duty to manage custody safely and meet detainee welfare needs. However, at shift handovers, from 5.30am to 7am and 5.30pm to 7pm, there is only 1 detention officer on duty at each suite. If the suite is busy, they are unable to answer call bells or conduct visits promptly. The difference in shift patterns also means that all staff aren't present at handovers when detainee risks are discussed.

The force has an arrangement with Devon and Cornwall Police to jointly provide training. Custody and detention officers receive five weeks' initial training, which follows the nationally accredited course. They then receive mentoring from experienced staff before carrying out their duties. Continuing professional development is provided two days a year. Recent topics included fire safety, adverse incidents and understanding neurodiversity. Staff we spoke to were generally positive about the training they received.

The force sends out regular newsletters to custody staff. These are well presented and include good information about which aspects of custody are working well and where there is scope to improve.

The force has adopted the College of Policing's Authorised Professional Practice. Staff are reminded of this guidance regularly, but not all staff follow it all the time. For example, not all staff carry anti-ligature knives and personal items are sometimes removed from detainees without an individual risk assessment that has determined it as necessary.

The force generally follows PACE, its codes of practice and other legislation. Custody officers pay good attention to ensuring PACE code G necessity for arrest criteria are met before detention is authorised, and detainees are told and given their rights and entitlements in line with PACE Code C. But some aspects of reviews of detention don't meet the requirements of PACE codes of practice. And we found some cases where reviews were required but not carried out, which is a breach of section 40 of PACE.

There is a good approach to managing adverse incidents and learning is shared with staff through regular newsletters. There have been no deaths in custody in Dorset since our last inspection. One detainee committed suicide after being released from custody in 2020. The force referred this to the Independent Office for Police Conduct in line with its guidance.

Area for improvement

The force should make sure all custody procedures and practices comply with PACE and its codes of practice and follow Authorised Professional Practice guidance.

Accountability

The force monitors performance at fortnightly management meetings chaired by the superintendent and at the monthly investigative standards board. Any concerns are reported to a strategic performance meeting chaired by the assistant chief constable. The monitoring includes:

- adverse incidents;
- waiting times for detainees to be booked into custody;
- the number of detainees entering custody;
- the number and treatment of children; and
- average detention duration.

However, information isn't readily available or monitored for some important areas. For example, the force does not monitor the length of time detainees wait for a Mental Health Act assessment, nor the time it takes to move them from custody to a mental health facility if needed.

The force pays a lot of attention to monitoring the time detainees wait to be booked into custody. However, it isn't clear how it evaluates this and other types of performance information, such as the number of strip searches, to improve outcomes for detainees. Neither is it clear how the force acts on themes coming from complaints.

There is some detailed recording about the use of force in custody and some quality assurance over incidents. But it isn't clear if or how custody cases are considered or discussed at force meetings responsible for strategic oversight, for example, the board overseeing the use of police powers. Some incidents we reviewed weren't well managed, suggesting that scrutiny over the use of force needs to improve.

The quality of recording on custody records is generally good. We saw some detailed entries on detention logs including when food, drink and exercise were provided for detainees. Risk information and cell visits for detainees were also well recorded. In some records we found information missing, such as why it was necessary to remove a person's clothing.

The custody support staff comprehensively review a sample of custody records. They share their findings in the staff newsletter, including examples of good practice and where there needs to be improvement.

The force understands its responsibilities under the public sector equality duty. Custody staff have received training on the Equality Act 2010. It is rolling out unconscious bias training. The force collects data on detainees to identify and assess any disproportionality, for example, in relation to strip searching. Findings are reported to the standards and ethics board chaired by the deputy chief constable and to a regional group of police forces chaired by the Dorset head of custody.

The force is open to external scrutiny. Independent custody visitors conduct weekly visits to each suite. The visitors report a good relationship with the force and that the issues they raise are usually dealt with straightaway. The scheme manager is invited to relevant management meetings and receives regular custody updates via the newsletter.

Area for improvement

The force should use performance information better to identify and act where improvements are needed.

Working with partners

The force has a clear priority to divert children and vulnerable adults away from custody.

For children, it works well with local authorities, health services and others to achieve good outcomes. Joint work with the youth justice service supports children and tries to address the causes of offending. The importance of early intervention is well recognised by all the partners as a means of keeping children away from the criminal justice system.

The force works with partner organisations and charities to provide support for vulnerable adults and divert them away from custody. For example, a partnership with the charity Footprints provides support for women who come into contact with the police.

Joint working between the force and mental health services is limited. There are poor outcomes for some people with mental ill health. Relationships are strained and the arrangements aren't working effectively to support people both inside and outside custody. There is little information or joint monitoring to identify and address concerns. It is a cause of concern.

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 good understanding of what makes someone potentially vulnerable. They told us they consider factors such as physical disabilities, mental ill health, age or any care needs a person may have. They recognised that a suspect can also be a victim and be vulnerable because of this. They take account of vulnerability when deciding whether arrest is appropriate or if another solution can be found.

The force has provided training, both online and face-to-face, to help officers understand and assess a person's vulnerability. Officers told us they felt confident in making decisions and that vulnerability was included as a theme in most of the training they completed.

The officers we spoke to were aware of the force's priority to divert children away from custody and told us children are only arrested as a last resort. They use alternatives such as voluntary attendance interviews and work with the youth offending team to find community resolutions to avoid taking a child to custody and to keep them out of the criminal justice system where possible.

Information from call handlers in the control room isn't always good enough to help frontline officers decide what action to take. Officers told us call handlers try their best to provide information, such as any warning markers about the people involved, but it isn't always comprehensive and isn't always received in time. Officers get information through their mobile phones, which have access to the police systems, but only if they have time to do so.

The arrangements to get advice and support from mental health services to help frontline officers decide what to do with people with mental ill health aren't working well enough. When considering whether to detain a person under section 136 of the Mental Health Act 1983 for their own or other's safety, officers telephone either the local mental health hospital or the mental health service through a 24/7 telephone helpline. However, officers said calls aren't always answered quickly and sometimes they have to make decisions without any advice or knowing any information on the person's health records. This may mean some people are detained when other more appropriate solutions could have been considered.

Officers told us they often have long waits at the health-based place of safety before they hand the detained person over to mental health professionals for an assessment. They also sometimes wait a long time for ambulances to transport the person to the health-based place of safety. If the wait is too long, officers seek an inspector's authority to transport the person in a police vehicle. These waits are poor use of police time and a poor outcome for the person with mental ill health.

People with suspected mental ill health who have committed an offence are usually arrested and taken to custody. Officers continue investigating the offence while the person is assessed for potential mental ill health. If a Mental Health Act assessment is required, this is either arranged in custody under section 2 of the Mental Health Act 1983 or the person is detained under section 136 and transferred to a health-based place of safety.

However, in some of the cases we examined, it is our view that the person should have been detained under section 136 at the time of the incident and taken to a health-based place of safety, rather than arrested and taken to custody.

When officers decide that section 136 detention or arrest isn't appropriate, they can offer to take people to 1 of the 2 community facilities staffed by mental health professionals who offer support and advice. Although only open late afternoons to midnight, officers told us they valued the service as it allows them to divert rather than detain some people.

Officers risk assess whether to transport detainees in police cars or vans. They told us they would use their common sense to make arrangements for detainees with disabilities.

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 with them.

Privacy for detainees is generally good. There are barriers between custody desks to protect the detainee's privacy when speaking with the custody officer. However, the booking-in area at Weymouth is small, making conversations difficult to hear when the suite is busy. In Weymouth, screens introduced during the pandemic also hinder communication, but these are due to be removed.

Detainees are offered the opportunity to speak to someone in private when they are booked in and discreet booking-in areas are used for children and sensitive cases. CCTV covers the communal areas of the suites and some of the cells. Detainees placed in cells with CCTV are informed of this and told the toilet is obscured. CCTV monitoring screens can only be seen by staff and not by detainees or people in the communal areas.

Showers in Weymouth aren't private enough as the doors are too low. Staff try to maintain detainees' dignity when they shower by closing the corridor and discreet supervision. The showers at Bournemouth provide sufficient privacy.

Detainees are usually suitably dressed when moving about the suites and provided with adequate replacement clothing when necessary. However, their dignity isn't always protected. We found two cases where detainees had their clothing removed and were given safety suits but remained naked in their cell. We also saw occasions where doors to cells weren't always closed during the removal of clothing and staff of the opposite sex were in the corridor.

Area for improvement

The force should maintain detainee dignity at all times.

Meeting diverse and individual needs

Custody staff understand how to meet the needs of detainees with protected characteristics, or from minority groups and generally try their best to do so.

Detainees are routinely asked if they have caring responsibilities for others so arrangements can be made if needed. They are also asked if they wish to speak to a member of staff of the same sex in private.

However, women aren't always assigned a female member of staff to speak with, and when they are it isn't clear they are subsequently spoken to. There is a range of menstrual products available and sinks for handwashing in the cells.

Staff have a reasonable awareness of neurodiversity, how it affects detainees and what they can do to minimise the effect of the custody environment on them.

There is good awareness of the treatment of transgender detainees. Staff we spoke to described appropriate care.

Both suites have a wheelchair in good condition and the Bournemouth suite has an adapted toilet, but facilities to meet the needs of detainees with disabilities are limited. For example:

- At Weymouth there are no adapted facilities. There is stepped access to the showers and exercise yard, and no hearing loop.
- Neither suite has sight lines on the cell walls to help visually impaired detainees, although rights and entitlements are available in Braille.
- Neither suite has extra-thick mattresses to help those with mobility difficulties.

Items to help detainees observe their faith are limited to Islam, Judaism and Christianity. These are stored correctly with both suites having written guidance for staff on handling the Qur'an.

Provision for detainees who speak little or no English is generally good. Interpreters are usually readily available, and conversations are conducted in private over a three-way phone. However, interpreting services are used mainly at booking-in and not always for other important custody processes.

Area for improvement

The force should improve its approach to meeting individual and diverse needs by:

- providing sufficient religious texts and items in all the main faiths; and
- using interpreting services for all important custody processes.

Risk assessments

The identification of risk is good, but there are some weaknesses with its ongoing management. Some working practices mean the force isn't always ensuring the safety of detainees.

While most detainees are booked into custody promptly, some wait a long time. When there are waits, staff told us they go to see detainees so that they can assess risk or prioritise booking in children or vulnerable adults.

Custody officers focus on identifying risks, vulnerability factors and welfare concerns when completing initial risk assessments with detainees. They interact well with them and explain the purpose of the assessment. Custody officers often ask probing or supplementary questions, and routinely cross reference with the Police National Computer and previous custody records to help inform the assessment of risk. Arresting or escorting officers are routinely asked if they have any further relevant information to contribute.

Observation levels for detainees are set appropriately and are commensurate with the risks presented, including for those under the influence of alcohol or drugs. But sometimes children are placed on 60-minute observations when they should be visited more frequently.

Observation checks on detainees are carried out well. Staff open cell door hatches and engage with detainees. These checks are on time and are mostly recorded well in the custody record.

When detainees are under the influence of alcohol or drugs, level 2 rousal checks are also carried out and recorded well. But we found these observation levels were sometimes lowered too quickly without the justification being sufficiently recorded.

Most checks, including those that require rousing, are carried out by the same member of custody staff, which provides continuity and improves risk management.

Call bells in both suites are mostly responded to promptly.

When the risk assessment indicates a higher level of risk, detainees are placed on level 4 observations; physical supervision at close proximity. These are carried out well by staff, as per APP guidance. But sometimes the specific detail of the briefing given to officers before they start observations isn't recorded well enough in the custody record. Detention officers continue with their regular checks on detainees during observations at close proximity as required by APP.

Some custody officers allow detainees to keep their corded clothing and other items based on the risks they pose as per APP guidance. However, others continue to remove them routinely without an individual risk assessment. All custody officers remove footwear without an individual risk assessment to justify it, contrary to APP guidance.

The practices concerning handovers and visiting detainees don't follow APP guidance.

The content of handovers is generally good, with sufficient information exchanged between custody staff to manage detainee risk and welfare appropriately. However, due to different starting times for custody and detention officers, they are not all present to attend the handover meeting. Healthcare staff aren't always present either. Staff try to have a meeting when everyone has arrived, but this is often too late and doesn't always happen.

After a handover, usually only the earlier starting custody officer carries out the required visits to detainees. This means the custody officer starting later hasn't visited the detainees they take responsibility for.

The shift patterns worked by custody staff with staggered starting and finishing times, means lower staffing levels from 5.30am to 7am and from 5.30pm to 7pm. This means there may not be enough staff to manage detainee risks safely or maintain good levels of care during these times. This is especially the case when the suite is busy.

Custody staff don't always carry anti-ligature knives. Knives are attached to cell keys rather than personally issued to all staff and carried on their belts. This could limit the ability of staff to respond to detainees attempting self-harm if needed.

The management and control of cell keys is good in both suites, which results in custody staff having a good level of control over the movement of detainees and others.

Area for improvement

The force should improve its approach to risk management by:

- making sure there is always enough staff to safely manage the risks and welfare of detainees;
- custody officers adequately justifying and recording why they are reducing the level of observations for detainees under the influence of alcohol or drugs;
- recording in detail in the custody record the briefings given to officers carrying out level 4 close-proximity observations;
- placing children on 30-minute interval checks; and
- making sure handover arrangements between shifts share information with all staff coming on duty and that all custody officers visit the detainees in their care when they come on shift.

Individual legal rights – detention

Detainees are generally booked into custody promptly. But some detainees wait a long time if there is a queue.

Detention is appropriately authorised. Arresting officers provide the circumstances of the arrest and explain the grounds for its necessity well, as required by PACE Code G. Custody officers appropriately refuse detention if there are insufficient grounds to justify it.

The force uses alternatives such as voluntary attendance interviews, cautions, restorative justice and community resolutions to divert people away from custody. There are interviewing facilities outside the custody suites for suspects invited for a voluntary attendance interview, which is good. The force monitors the number of voluntary attendance interviews so it can assess how well it is used as an alternative to custody.

Some detainees spend longer than necessary in custody because cases aren't dealt with expeditiously. Investigations aren't always allocated to investigating officers promptly, and in some instances custody officers aren't told which officer is allocated the investigation. Neither are custody officers routinely informed of how investigations are progressing. They, and inspectors reviewing detentions, have to chase investigating officers or their supervisors for this information. We observed some detainees in custody for over 14 hours before they were interviewed because of these delays.

When investigations can't be completed during the first period of detention, detainees are bailed or released under investigation. We saw bail appropriately authorised and any bail conditions or restrictions commensurate to the offences under investigation.

The force monitors how long immigration detainees spend in custody before they are transferred to immigration detention facilities. This shows people are detained an average of 7 hours and 43 minutes in custody after the immigration papers (IS91) are served, according to information provided by the force. Custody staff reported good working relationships with immigration services.

Area for improvement

The force should make sure detainees don't spend longer than necessary in custody by allocating officers to investigations and interviewing detainees promptly so that cases are dealt with expeditiously.

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.

Custody officers give detainees a leaflet with detailed information explaining their rights. This includes, for example, how to get information about their detention and their welfare entitlements. Detainees in custody for the first time, are given a further leaflet with more details about facilities in the cells, the investigation process and healthcare services should they feel unwell or need support with mental health or drug and alcohol problems.

Copies of the recent edition of the PACE Code C book are available at the suites. We saw staff routinely offer these to detainees when they were booked into custody and during reviews of their detention.

There is a copy at each suite of the easy-read version of rights and entitlements for children and other detainees who may need help to understand their rights. However, this isn't always offered when needed.

When a detainee declines free legal advice, we expect custody officers to explore the reasons for this. We saw custody officers do this and remind detainees that legal advice is free of charge, and they could change their mind and ask for it at any time.

We also expect legal representatives to be encouraged to represent detainees in person. We saw legal representatives attending in person and custody officers told us this was usually the case.

There were no posters advertising the right to free legal advice in different languages as required by PACE code C paragraph 6.3. We were informed during the inspection arrangements had been made to rectify this.

Custody officers we spoke to were aware of the requirements of PACE Code C Annex M, which states that detainees should receive documents and records on important information about custody processes in a language they can understand. They know where to find the translated documents to give to detainees who need them.

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 but are brought to the custody desk to make the call. This limits the privacy of any conversations. Legal representatives are given a copy of the detainee's custody record when requested.

When detainees are held incommunicado (delaying their right to have someone informed of their arrest) this is appropriately authorised. But it wasn't clearly recorded when this delay was no longer required, and the detainee was able to exercise their right to have someone informed, as required by PACE code C Annex B paragraph 6.

Detainees who are foreign nationals have the right to speak to somebody at their country's embassy, consulate or high commission at any time. Custody officers arrange this if requested. When custody officers are required to notify these bodies because an agreement exists with the relevant country, this is done.

Detention officers inform detainees about the retention and destruction of any DNA samples that have been taken. Notices are displayed in the processing rooms explaining how detainees can apply for their DNA to be removed from the database.

DNA samples are stored securely in metal boxes and collected regularly. However, they aren't stored in freezers. The force informed us the forensic laboratory asked for them not to be stored in freezers because the samples had defrosted by the time they reached the South West Forensics collaboration. This contradicts the guidance by the Faculty of Forensic & Legal Medicine.

Area for improvement

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

- always providing the easy-read version of rights and entitlements to children and other detainees who may need help to understand their rights; and
- recording on custody records when incommunicado is no longer required, and making sure detainees have someone informed if requested.

Reviews of detention

Reviews of detention are generally carried out well, but not all aspects comply with PACE and its codes of practice.

We observed some good reviews where detainees were spoken to courteously, given good explanations of how the investigation was progressing, reminded of their rights and entitlements, and asked about their well-being. This included being asked whether they had been given enough food and drink and had any other needs met. We found some good detail of this recorded on the custody records.

However, reviewing inspectors do not place enough importance on assessing the progress of the investigation to make sure it is dealt with expeditiously. We observed two reviews of children where continued detention wasn't authorised because the reviewing officer wasn't satisfied the investigation was expeditious. The children were released on bail. But this was a second review, so the children had already been in custody for a significant time.

We found some detainees in custody for over six hours who didn't have their detention reviewed. This is a breach of section 40 of PACE.

Not all reviews are carried out on time. When they are early or late there is often no clear explanation in the record outlining the reasons for this.

When reviews take place while the detainee is asleep, they are usually told about this at the earliest opportunity as required by PACE Code C paragraph 15.7. However, we found some reviews had taken place outside the recognised rest periods when the detainee should have been woken and spoken to.

Reviewing officers make good use of the live link video facility when they cannot attend in person. This means they can see as well as speak with the detainee during the review and is line with the requirement of PACE code C paragraph 15.9b.

Area for improvement

The force should improve its approach to reviews of detention by making sure:

- reviewing inspectors place enough importance on assessing the progress of the investigation to make sure it is dealt with expeditiously;
- reviews of detention are carried out on time, and when this isn't possible clearly recording the reasons why it is early or late; and
- reviews while the detainee is asleep are only carried out in recognised rest periods.

Complaints

Notices outlining the procedure for detainees to make complaints are prominently displayed at the custody suites. Information about how to make a complaint is also in the rights and entitlements leaflet.

Independent Office for Police Conduct leaflets providing contact details about making a complaint to them aren't available. We were informed during the inspection these had been ordered.

Custody staff we spoke to were aware of the procedure and what to do if a detainee makes a complaint. We saw that custody staff contacted an inspector when a detainee asked to make a complaint.

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 in Dorset has two full-time designated suites at Bournemouth and Weymouth, and a contingency suite at Poole. The suite at Poole isn't always operational and is used when one of the full-time suites closes for a period of time. The suites at Weymouth and Poole are Private Finance Initiative buildings and maintained through a contracted service. Dorset Police owns the suite at Bournemouth.

There are potential ligature points across the custody estate, mostly at Weymouth and Poole. These are mainly in cell bunk vents, around door frames, and drain covers for showers and exercise yards. During the inspection we gave the force a comprehensive report detailing these and conditions in general.

Overall, cleanliness at Bournemouth and Weymouth is good, although there is considerable staining on floors, particularly in corners of cells. There is natural light in most cells, and no graffiti.

Several cell doors have glass fronts to assist detainees who are anxious or suffer from claustrophobia. There are discrete booking-in facilities at all three suites. All cells have sinks and toilets and there are communal showers and washing facilities at each suite. There is a disabled toilet at Bournemouth.

Custody staff carry out and record daily and weekly safety and maintenance checks of the physical environment well. We were told repairs are usually completed quickly.

There are good arrangements at suites for custody staff to monitor detainees on CCTV and monitors can't be seen by those in the communal areas. Officers observing detainees on level 3 constant observations do so in an area without distractions.

However, CCTV doesn't cover all the areas in the suites. Not all cells have CCTV, except Poole. This limits the ability to manage risk at Bournemouth and Weymouth when busy. Not all communal areas are covered and there are some blind spots, although the force is aware of these. The quality of CCTV footage is generally poor, which makes it difficult to review.

Notices saying CCTV is operating weren't prominently displayed at either suite as required by PACE Code C paragraph 3.11. They were put up during the inspection.

Custody staff have a good awareness of emergency evacuation procedures. All the staff we spoke to had taken part in annual evacuation training, and in a physical evacuation practice in the last year. However, there aren't enough handcuffs at either suite to evacuate all cells if required.

Area for improvement

The force should address the safety concerns caused by potential ligature points and, where resources don't allow them to be dealt with immediately, manage the risks to make sure that custody is provided safely.

Use of force

When force is used in custody it is usually proportionate to the risks posed. But incidents aren't always managed well, and some force could potentially be avoided.

We reviewed 11 cases of use of force in custody on CCTV. In most cases it was proportionate to the risk or threat posed. We saw officers patiently and respectfully engaging with detainees and trying to de-escalate situations to avoid the use of force.

In most of the cases, officers clearly recognised the potential risks to detainees when using force. We saw officers minimising the risk of injury to the detainee by protecting their heads. We also saw officers placing mattresses on the floor in custody van docks to help minimise any injury when removing non-compliant detainees from police vans.

But incidents aren't always managed well. Custody officers don't always oversee and direct the use of force well enough.

Restraint techniques weren't always deployed in the best way and sometimes officers failed to appropriately control the situation. Sometimes officers removed handcuffs too quickly from non-compliant detainees, leading to a use-of-force incident that could have been avoided.

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

We referred five cases to Dorset Police for learning. All of them involve the use of techniques that in our opinion could have resulted in injury to the detainee. Two of the cases involved the use of PAVA incapacitant spray when in our view there wasn't sufficient justification. In three cases, we had additional concerns regarding how the detainees' dignity had been considered.

The details of the officers involved, and the type of force used on detainees, is generally well recorded on the custody record. However, the reasons why force is used isn't always well recorded and not all incidents are included on the custody record.

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, despite the force having issued clear instructions to do so. We asked for use-of-force forms for the incidents we reviewed but didn't receive all the forms we were expecting.

The chief inspector for custody reviews the custody records for use-of-force incidents. In addition, custody inspectors review a small sample of incidents on CCTV as well as the custody record to quality assure and learn from them. But this quality assurance hasn't identified some of the issues we are raising.

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

We found that the necessity and justification for a strip search wasn't always clearly recorded on custody records. Strip searches were generally managed well, but the dignity of the detainee wasn't always considered. Sometimes the removal of a detainee's clothing was incorrectly recorded as a strip search. This suggests information on the number of strip searches is incorrect.

Most custody officers and all custody detention officers are up to date with their officer safety training. Training is planned for those who are not.

Area for improvement

The force should improve its approach to the use of force by making sure:

- custody officers direct and oversee incidents to manage them appropriately and prevent any further escalation of force;
- restraint techniques are deployed in a way that minimises risks of injuries to detainees and officers;
- it clearly records why force is necessary, including when it is needed to remove clothing; and
- when force is used, all incidents are recorded and individual use-of-force forms submitted.

Detainee care

Detainees are generally well cared for. The detainees we spoke to were positive about the care they had received.

Custody staff don't always tell detainees about the care available when they are booked in, but it is offered during their time in custody.

The range of food and drink is good, and we saw it offered and provided regularly. All dietary requirements are catered for. Weymouth has a canteen that provides hot freshly prepared food at midday and sandwiches in the evening.

Distraction material such as foam balls, colouring books, word searches and fidget poppers are available. We saw detainees using these.

The range of reading material is extensive with both suites having a large selection of books kept in order on shelving. There are adult and children's books as well as several foreign titles in Russian, Korean, Spanish and Polish. There is also a large print book available for people who are dyslexic.

Showers are offered and we saw these used. Detainees are given toilet paper when they go into their cell. There is a range of toiletries available, including menstrual products, but no shaving products or combs.

Exercise is offered depending on how busy the suite is. Both suites have exercise yards that offer partial coverage for inclement weather. Detainees aren't supervised in person but monitored by CCTV.

There is a good supply of replacement clothing for detainees including underwear and footwear in all sizes. The quality and cleanliness of mattresses is generally good, but they are thin providing little support. Neither suite has thicker mattresses available. Pillows are only given on request. Only safety blankets are available providing little warmth for detainees.

Area for improvement

The force should improve its approach to detainee care by:

- always making detainees aware of the care and facilities available to them;
- improving their comfort by having thicker mattresses and warmer blankets available when needed; and
- having shaving equipment and combs available.

Safeguarding children and vulnerable people

Custody staff and police officers have a good understanding of their safeguarding responsibilities for children and vulnerable adults. Training has been given to help them identify safeguarding concerns, for example, on child exploitation.

Arresting or investigating officers make safeguarding referrals to partner agencies for children and vulnerable adults. They had made referrals for children in the cases we examined. Custody officers also take account of any safeguarding concerns during the risk assessment of the detainee.

Most children are seen by the CJLD service and assessed for any support they might need. When a child is in custody when the CJLD team isn't on duty, a worker contacts them the next day. This provides an additional safeguarding measure. However, where a child is already known to children services, they don't visit or engage with them. This limits the opportunity to identify and recognise any current concerns. However, children are routinely seen by an HCP.

Children and vulnerable adults are released safely, generally to the care of their family. Where this isn't possible, they are released to the care of a responsible person. Custody officers consider any safeguarding concerns as part of the release arrangements.

Appropriate adults

Children generally don't wait too long before receiving support from an AA, but this isn't always the case for vulnerable adults.

Custody staff usually request an AA early on in a child's detention. AAs generally arrive promptly but there are sometimes delays before the child receives support. However, requests for AAs for vulnerable adults aren't always made quickly enough and sometimes attendance is arranged for the time of the interview. This means the detainee doesn't always receive early support to understand their rights and entitlements and what will happen to them while they are in custody.

Family or friends are contacted in the first instance to attend as AAs. If this isn't possible other arrangements are made. Staff from the youth justice service attend for children during the day and the local authorities' emergency duty service is expected to provide an AA up to 10pm. The Appropriate Adult Service provides AAs 24/7 for vulnerable adults and after 10pm for children.

Custody staff are aware of their responsibilities to secure an AA when an adult detainee is vulnerable. We found cases where this happened. But in other cases we examined, there was information to suggest that an adult was vulnerable and an AA should have been considered.

A leaflet produced by the National Appropriate Adult Network is available in the suites to provide guidance to AAs about their role in actively protecting detainees' rights.

There are suitable facilities in both suites for an AA to speak to a child or vulnerable adult at any time and in private.

The force closely monitors AA attendance for children. It gathers information monthly on how quickly AAs are called and when they arrive so the child's rights and entitlements can be re-read in the AA's presence. The force also records who acts as the AA, for example, a family member or The Appropriate Adult Service.

Area for improvement

The force should make sure vulnerable adults and children always have prompt support from appropriate adults.

Children

Children are only detained when necessary. The force aims to keep children in custody for as short a time as possible.

However, we saw children held for longer than necessary, including overnight because of delays in investigations. Reviews of detention show little intervention by the reviewing inspector to expedite the investigation. Bail or release under investigation isn't always considered as a way of minimising children's time in custody.

However, there is close scrutiny of children. Every morning a custody inspector monitors overnight child detainees. In addition, the force collects comprehensive information including the type of offences, the length of time in custody and the case outcome.

Children are well cared for in custody, and staff interact with them positively. They generally use discrete areas to book them in, carry out the risk assessment and authorise their detention. Staff give out distraction activities and devices, for example footballs, to help children cope with the environment.

Custody staff understand the requirement to assign a female staff member to care for girls, in line with the Children and Young Persons Act 1933. However, in two cases we examined there was no record of this happening.

Few children are charged and remanded. Those that are, aren't always moved from custody as they should be. Between 1 April 2022 and 31 January 2023, 12 children were charged and refused bail. Accommodation was requested for all of them. Three children were transferred to appropriate alternative accommodation arranged through the local authority, but the rest remained in custody overnight because none was available. There is no secure accommodation in Dorset. Custody officers complete juvenile detention certificates to show why the child remained in custody, and those we looked at gave clear reasons.

The force is working closely with local authority partners to improve the provision of alternative accommodation for children charged and remanded. This has recently led to a scheme to provide overnight foster care. The three children referred to above were all moved as part of this scheme.

Healthcare

Mitie Care & Custody has been contracted to provide physical healthcare to detainees and carry out forensic testing in custody since October 2022.

In the first few months, staff shortages adversely affected healthcare for detainees. However, most vacancies are now filled and an HCP is based at each suite 24 hours a day and the Mitie Care & Custody clinical lead (a registered forensic medical examiner) is on call for both suites. There is additional cover from a senior HCP during peak times. Once fully staffed, a senior HCP will always be on duty.

Mitie Care & Custody has introduced corporate governance processes to ensure it complies with clinical audits, mandatory training, supervision, and appraisal. This is in its early stages. At the time of inspection, some staff were still being inducted, not all had received the mandatory training required and staff appraisals hadn't started.

Bournemouth and Weymouth medical rooms are compliant with infection control guidelines; an improvement since our last inspection. Depending on the risk, HCPs see detainees in the medical room with the door left ajar rather than open. When the rooms are used for forensic sampling, they are forensically cleaned before and after examinations. However, detainee dignity isn't always protected when intimate samples are taken. Another officer is present, and there is no privacy screen in the Weymouth clinical room.

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

The Mitie Care & Custody clinical lead chairs a governance meeting every two months. HCPs are expected to attend three times a year and review recordings of meetings they don't attend. The clinical lead also provides induction training for staff and investigates clinical incidents.

Dorset Healthcare University NHS Foundation Trust is contracted by NHS England and NHS Improvement to provide CJLD services in the custody suites. The force attends contract review and performance meetings twice a year where the safety, quality and performance of the service is monitored.

The CJLD team has enough staff to provide the service and cover any gaps in the rota. Governance processes ensure good compliance with mandatory training, appraisal and supervisory requirements. There is a lone-working policy to help mitigate the risks of working in the community.

Both providers report and investigate incidents as required and learning is shared with staff. Outcomes of investigations are reviewed and shared with commissioners and the force during the contract monitoring meetings.

Data around the number and demographics of people referred to CJLD, and of those accepting or declining the service, are analysed and used to make sure it continues to meet detainee needs.

Both healthcare providers have a confidential complaints process. No complaints have been received recently. Information about the Mitie Care & Custody complaints process wasn't displayed prominently as we would expect, but this was remedied during our inspection.

Area for improvement

All healthcare practitioners should be compliant with mandatory training requirements.

Area for improvement

The dignity of detainees should always be protected during clinical examinations.

Physical health

At the start of the contract, staffing shortages meant detainees weren't seen promptly, and some weren't seen at all before leaving custody. At the time of our inspection, most HCP vacancies had been filled and the service to detainees had significantly improved.

The contract requires that HCPs attend all requests within an hour. This is monitored rigorously, and response times had risen from 62.8 percent in October 2022 to 85.5 percent in January 2023. The Mitie Care & Custody clinical lead scrutinises any request not meeting the one-hour response time to identify learning opportunities.

HCPs are experienced and competent practitioners who treat detainees respectfully. They carry out comprehensive assessments of their health needs and contribute to decisions regarding risk, fitness to detain, and interview and release arrangements.

Mitie Care & Custody staff told us their induction training had been comprehensive and they had opportunities for further development. Staff have easy access to Mitie Care & Custody policies and procedures. However, not all staff we spoke to were familiar with the contracted response times.

The service employs both male and female HCPs. Where possible, an assessment is carried out by an HCP of the gender requested by the detainee.

The clinical records we reviewed were comprehensive and contained a plan of care that reflected the assessed needs of the detainee, meaning care is safe and appropriate. Staff seek consent from detainees for healthcare interventions and capacity is assessed and recorded clearly where appropriate.

Staff complete paper clinical records for detainees. This limits the opportunities for data collection and analysis and means health information isn't readily accessible. Mitie Care & Custody is implementing an electronic clinical system, but staff aren't yet trained to use it.

HCPs update the custody record so that custody staff have up-to-date information about the healthcare needs of the detainee andare aware of identified risks. This allows custody staff to take account of these when caring for a person during their detention and on release. Custody staff and HCPs work collaboratively, and custody staff we spoke to were positive about the healthcare provided.

Mental health

The CJLD service supports detainees with all types of vulnerabilities. As well as mental ill health, there is support with housing, social problems, and drug and alcohol issues.

CJLD staff are based in the custody suites every day from 7am to 7pm in Bournemouth and from 7am to 4pm in Weymouth. Staff attend a daily meeting to assess risks, make decisions and allocate staff appropriately across the custody suites and in the community to meet detainee needs.

As well as the CJLD workers in custody, there are support time recovery workers and support workers with lived experience who help vulnerable people in the community. Dorset Mental Health Forum provides a peer support programme. These arrangements support detainees both during and after custody.

CJLD staff screen detainees to check if they are known to mental health services and carry out initial assessments. They arrange a Mental Health Act assessment if required. They provide telephone and face-to-face support to detainees after their release, based on individual need, to help them engage with community services.

The CJLD service offers additional support services. All people attending for voluntary interview are contacted and offered support. This has been shared with the national liaison and diversion services in England and Wales as an area of best practice. All women are offered a follow-up phone call for support. A speech and language therapy service is being piloted to help detainees with these needs.

There are good working relationships between custody staff and CJLD workers. Information is shared to understand a detainee's needs. Records we reviewed were clear and included a comprehensive summary of detainees' risks.

The CJLD service and the force no longer meet to consider mental health service provision for detainees, for example, requests for Mental Health Act assessments. This limits their ability to improve outcomes for detainees.

Dorset Healthcare University NHS Foundation Trust professionals at the mental health hospital and the 24/7 telephone helpline provide information and advice to police officers called to incidents involving people with mental ill health. A street triage service has been approved but was not up and running at the time of our inspection. Officers told us there were difficulties in getting mental health advice, and that decisions made under section 136 of the Mental Health Act were sometimes made without any professional advice. There is little monitoring to assess how well the arrangements with mental health services are working and what needs to be done to improve them.

Detainees referred for an assessment under section 2 the Mental Health Act 1983 in custody sometimes wait a long time. There are further waits for detainees to be transferred to a mental health facility if needed. In the 12 months to 31 January 2023, 94 detainees were referred for an assessment, and of these 62 admitted to hospital. However, the time they wait isn't monitored. Custody officers sometimes use section 136 to transfer detainees out of custody and get them the help they need. However, how often this occurs isn't monitored either.

Overall, the arrangements between the force and its mental health services aren't good enough and aren't making sure the best outcomes are achieved for detainees. It is a cause of concern.

Substance misuse

HCPs provide an initial assessment for detainees with substance misuse concerns. Where required, they give treatment to detainees experiencing drug and alcohol withdrawal while in custody. HCPs use nationally recognised assessment tools to monitor and inform their decisions regarding withdrawal. When clinically indicated, staff administer medicines to relieve symptoms of withdrawal, including opiate substitution treatment. This is an improvement since the last inspection. There are appropriate patient group directions to support this.

A community drug and alcohol worker attends each suite daily and sees all adult detainees to discuss whether they need support with drug or alcohol issues. Detainees requiring support are referred promptly to an appropriate service and, with the detainee's consent, drug and alcohol workers share information with HCPs and CJLD staff to help with their care. Custody, CJLD and Mitie Care & Custody staff can also refer detainees to a drug and alcohol service for follow-up after release.

Children are screened by the CJLD service and referred for community substance misuse support if required.

CJLD staff work with detainees with chronic and complex needs, including those with both mental health and substance misuse needs. They can refer these detainees to support time recovery workers who work in the community and offer additional non-clinical support.

Medicines management

Staff provide a range of care and treatment interventions suitable for detainees and consistent with national guidance and best practice in England and Wales. The service has several patient group directions to support staff with decision-making for a range of health issues such as asthma, pain, and acute withdrawal from alcohol and drugs. Custody staff don't have access to any medicines but do administer nicotine replacement therapy.

Custody staff collect a detainee's own labelled medicines from their home address to ensure continuity of care if the HCPs don't stock the medicine and a delay in administration may have a negative effect on the detainee.

There are robust governance arrangements to manage medicines. HCPs use systems and processes to safely prescribe, administer, record and store medicines. Custody staff store detainees' own labelled medicines securely in their property locker, which is an improvement since our last inspection. Medication due to be taken while a detainee is at court is sent with them in the original boxes that contain administration instructions.

Healthcare staff manage controlled drugs appropriately and complete regular audits of medicines to identify any potential errors. No incidents have been reported since Mitie Care & Custody took over the contract. However, the controlled drugs book is a loose-leaf register and not a bound book, which isn't in line with The Misuse of Drugs Regulations 2001.

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

Custody staff have a clear focus on making sure detainees are released safely. We saw some very good care given to detainees during the release process.

Custody officers engage very well with detainees when completing pre-release risk assessments. They use the initial risk assessments and care plans, as well as considering the detainee's behaviour while in custody, to ensure all risks are understood and considered before release. The recording of information on the pre-release risk assessment is also good, although sometimes there isn't enough detail about the involvement of health or CJLD services and how this has been considered in release arrangements.

Custody officers clearly explain to detainees what bail means, any conditions and the consequences of breaching them. Officers also explain what it means to be released under investigation and the possible offences the detainee may commit if they interfere with victims or witnesses.

There is good information about local support services available and custody officers offer leaflets to detainees on release or transfer to court.

Where detainees don't have the means to get home, custody officers make good efforts to help them. Custody staff research options including train tickets, taxis and sometimes police transport when appropriate. We were told that children and vulnerable adults are always helped to get home safely.

Detention officers complete digital escort records and arrange transport for detainees attending court or recalled to prison. These records are mostly completed well, but we found a few where important risk and medical information had been missed. Custody officers oversee the release of detainees transferring to court as per APP guidance and engage well with them throughout the process.

Courts

When detainees are remanded to court, they are usually collected promptly in the mornings. Detainees appear before local courts in person, although there are virtual court facilities if needed.

Staff told us the court is flexible and accepts detainees in the afternoon when time and capacity allow. This is a good outcome for detainees as it minimises their time in police custody.

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

Cause of concern and recommendation

Cause of concern

The force and mental health services don’t have good enough arrangements to deal with people with mental ill health. Frontline officers called to incidents in public places can’t always get the support they need from mental health professionals. This potentially leads to people being detained under section 136 of the Mental Health Act 1983, when other more appropriate solutions may have been available. Detainees wait too long for a Mental Health Act assessment in custody when required, with further waits before they are transferred to a mental health facility. There is very little information and no monitoring to show how well the needs of people with mental ill health are met, and little joint work to try to improve outcomes for them.

Recommendation

The force should work with mental health services to make sure people with mental ill health are dealt with appropriately and their needs met. This should include collecting and scrutinising information on the numbers of people with mental ill health coming into contact with the police or entering custody and assessing the outcomes achieved for them. This information should be used to improve services.

Areas for improvement

Leadership, accountability and partnerships

The force should make sure all custody procedures and practices comply with PACE and its codes of practice and follow Authorised Professional Practice guidance.

The force should use performance information better to identify and act where improvements are needed.

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

The force should maintain detainee dignity at all times.

The force should improve its approach to meeting individual and diverse needs by:

- providing sufficient religious texts and items in all the main faiths; and
- using interpreting services for all important custody processes.

The force should improve its approach to risk management by:

- making sure there is always enough staff to safely manage the risks and welfare of detainees;
- custody officers adequately justifying and recording why they are reducing the level of observations for detainees under the influence of alcohol or drugs;
- recording in detail in the custody record the briefings given to officers carrying out level 4 close-proximity observations;
- placing children on 30-minute interval checks; and
- making sure handover arrangements between shifts share information with all staff coming on duty and that all custody officers visit the detainees in their care when they come on shift.

The force should make sure detainees don't spend longer than necessary in custody by allocating officers to investigations and interviewing detainees promptly so that cases are dealt with expeditiously.

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

- always providing the easy-read version of rights and entitlements to children and other detainees who may need help to understand their rights; and
- recording on custody records when incommunicado is no longer required, and making sure detainees have someone informed if requested.

The force should improve its approach to reviews of detention by making sure:

- reviewing inspectors place enough importance on assessing the progress of the investigation to make sure it is dealt with expeditiously;
- reviews of detention are carried out on time, and when this isn't possible clearly recording the reasons why it is early or late; and
- reviews while the detainee is asleep are only carried out in recognised rest periods.

In the custody cell, safeguarding and healthcare

The force should address the safety concerns caused by potential ligature points and, where resources don't allow them to be dealt with immediately, manage the risks to make sure that custody is provided safely.

The force should improve its approach to the use of force by making sure:

- custody officers direct and oversee incidents to manage them appropriately and prevent any further escalation of force;
- restraint techniques are deployed in a way that minimises risks of injuries to detainees and officers;
- it clearly records why force is necessary, including when it is needed to remove clothing; and
- when force is used, all incidents are recorded and individual use-of-force forms submitted.

The force should improve its approach to detainee care by:

- always making detainees aware of the care and facilities available to them;
- improving their comfort by having thicker mattresses and warmer blankets available when needed; and
- having shaving equipment and combs available.

The force should make sure vulnerable adults and children always have prompt support from appropriate adults.

All healthcare practitioners should be compliant with mandatory training requirements.

The dignity of detainees should always be protected during clinical examinations.

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 and treatment and conditions 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
- Andy Reed: HMI Constabulary and Fire & Rescue Services inspection officer
- Stephen Matthews: HMI Constabulary and Fire & Rescue Services inspection officer
- Lynda Day: CQC inspector
- Helen Lloyd: CQC inspector

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