Report on an inspection visit to police custody suites in North Yorkshire Police

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

27 June–8 July 2022

Contents

Fact page

Note: Data supplied by the force.

Force

North Yorkshire Police

Chief constable

Lisa Winward

Police and crime commissioner

Zoë Metcalfe

Geographical area

North Yorkshire

Date of last police custody inspection

2015

Custody suites

- York: 24 cells
- Harrogate: 16 cells
- Scarborough: 17 cells

Annual custody throughput

11,727 between 1 June 2021 and 1 June 2022

Custody staffing

- 1 chief inspector
- 2 inspectors
- 24 custody sergeants
- 28 detention officers

Health service provider

Leeds Community Healthcare NHS Trust

Summary

This report describes our findings following an inspection of North Yorkshire Police custody facilities. The inspection was conducted jointly by HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS), HM Inspectorate of Prisons (HMIP) and the Care Quality Commission (CQC) in June and July 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.

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

We have also highlighted a further 16 areas for improvement. These are set out in section 6 of this report.

Leadership, accountability and working with partners

There are clear governance structures for custody services in North Yorkshire, with good arrangements to oversee the safe and respectful provision of custody. The force welcomes external scrutiny and has made good progress in some areas since our last inspection.

Custody services are provided by three custody suites based in York, Harrogate and Scarborough. The custody estate is dated and some facilities don't meet detainee needs.

We saw that there were generally enough staff on each shift to provide custody services. However, staff were over-stretched when the suites became busy. They weren't always deployed in the most effective way, and it wasn't always clear who was responsible for which tasks. This sometimes adversely affected detainees, for example, leading to delays in booking them into custody, and to late welfare checks.

The force has adopted the College of Policing's Authorised Professional Practice. It also has its own policies and guidance. But it isn't always following either of these, especially in the area of risk. We found some gaps in staff knowledge and some staff told us they felt they could be better trained. However, we found that the Police and Criminal Evidence Act 1984 (PACE) and its codes of practice and other legislation were generally followed.

Performance monitoring arrangements are generally good. Performance data is comprehensive and routinely monitored.

The force's governance and oversight of the use of force in custody isn't good enough. Although there is some scrutiny and quality assurance of incidents, the information that supports this scrutiny is inaccurate. This means North Yorkshire Police can't show that when force is used in custody it is necessary, justified and proportionate. Our review of incidents on CCTV found that they weren't always managed well, and techniques weren't always used correctly. This is a cause of concern.

The quality of recording on custody records is often poor. Important information is sometimes missing, including the reasons for decisions such as the removal of clothing. There are quality assurance arrangements in place, but these aren't always identifying concerns, and the force isn't using findings from these arrangements to make improvements.

The force understands its responsibilities under the public sector equality duty. It collects information on ethnicity, age and gender to help assess whether the outcomes of some custody processes, for example, strip searches, are fair for detainees.

There is a clear priority to divert children and vulnerable adults away from custody. The force works well with partners to achieve this. There are several schemes to keep children out of custody and the criminal justice system. There are arrangements with mental health partners to support people with mental ill health both in and out of custody. There are regular meetings to discuss these arrangements, but outcomes for these individuals could be better.

Pre-custody – first point of contact

Frontline officers consider whether a person is vulnerable when deciding whether to arrest them. They explore all other options before arresting children, and there is some good support from other organisations to help divert children away from custody.

There isn't always enough support for officers when dealing with incidents involving people with mental ill health. Mental health professionals in the force control room give good advice and assistance. But when they aren't on duty, help is more limited for officers who are trying to decide the most appropriate action to take.

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

Custody staff interact respectfully with detainees, and are patient and reassuring. They ensure privacy for detainees as best they can, usually by dealing with one detainee at a time in the booking-in areas. Detainee dignity is generally protected, but some practices are disrespectful, particularly when detainee clothing is removed.

Custody staff recognise detainees' individual and diverse needs. We found these needs were properly met for most detainees.

The identification of detainee risk is generally good, but it isn't always managed well enough. Custody officers generally set observation levels that reflect the risk

posed, but this isn't always the case for detainees under the influence of alcohol and/or drugs (who should be on 30-minute checks with rousals). Welfare checks aren't always carried out on time. Custody staff routinely remove detainees' footwear and any clothing with cords, rather than carrying out an individualised risk assessment to decide whether this is necessary. Anti-rip clothing is used frequently and there aren't always good enough reasons for its use. Shift handovers don't always include all outgoing and incoming custody staff, and healthcare practitioners are rarely involved in them. The approach to risk management isn't always ensuring the safety of detainees. This is a cause of concern.

Custody officers generally book detainees into custody promptly and authorise their detention appropriately. Sometimes arresting officers don't explain the necessity and proportionality for detention (as required by PACE Code G) well enough, but detention is refused if custody officers aren't satisfied by this.

Detainees are given good explanations about their rights and entitlements in custody. Cases are usually dealt with as quickly as possible, so detainees don't spend longer than necessary in custody. Reviews of detention are generally carried out on time and in person with the detainee, although some aspects of them don't meet the requirements of PACE Code C. Detainees are released on bail or under investigation appropriately.

In the custody cell, safeguarding and healthcare

The three suites are well maintained, and overall cleanliness is good. However, there are potential ligature points in all of them, mainly due to the design of toilets and fit of doors.

The safeguarding of children and vulnerable adults in custody is getting better. As a result of the findings of our recent national child protection inspection, the force is introducing additional training and measures to increase safeguarding arrangements. We found custody officers were more involved in identifying concerns and overseeing referrals to other organisations.

There isn't always prompt support for children and vulnerable detainees from an appropriate adult, to help them understand their rights, entitlements and other custody processes. However, children are generally cared for well in custody. They are released as soon as possible to minimise their detention time. Very few are charged and refused bail.

The standard of care custody staff offer to detainees is very good. Detainees spoke positively about the care they received, and most were aware of the facilities and care available to them. We found that food and drinks, along with other care, such as showers, were regularly offered and provided.

Competent, experienced and caring healthcare practitioners see detainees promptly and provide good care to meet their physical health needs. The liaison and diversion team provides good support for detainees with mental ill health, and a wider range of help for vulnerable detainees who have, for example, housing, social, drug and/or alcohol problems.

Detainees can wait a long time if they need a Mental Health Act assessment in custody, and then often wait again for transfer to a mental health facility. Information on the number of assessments carried out and waiting times is available, so that outcomes for these detainees can be monitored at appropriate partnership and oversight meetings.

Release and transfer from custody

Custody staff engage well with detainees when completing pre-release risk assessments and make sure detainees can get home safely. Detention officers complete digital person escort records for detainees who are attending court or recalled to prison, but we found some records had important information missing. Custody officers have little involvement with or oversight of the release of these detainees.

When detainees are remanded, they are generally transferred promptly to the next available court. The force has good working relationships with the courts, which means detainees don't generally spend longer than necessary in police custody.

Causes of concern and recommendations

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 limitations in the way quality assurance is carried out means 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

The force should scrutinise the use of force in custody to show that when force 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: managing detainee risks

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

- Custody officers don't triage queues to risk assess detainees 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 frequently carried out by different members of custody staff, making it difficult to assess changes in a detainee's behaviour.
- Detainee welfare checks aren't always on time, carried out properly, or recorded accurately.
- Level 4 (close proximity) watches aren't always conducted or recorded in line with Authorised Professional Practice (APP) guidance. Bespoke briefings to officers aren't recorded, and custody staff don't carry out welfare checks or rousals of detainees on this level of observation.
- All custody staff routinely remove cords and footwear from detainees without an individualised risk assessment.
- Anti-rip clothing is used too often, sometimes without justification or rationale. It is sometimes removed by force, which can lead to an escalation in risk.
- Handovers between shifts aren't attended by all custody staff, and staff taking over don't always visit the detainees in their care.
- Not all custody staff carry personal-issue anti-ligature knives.
- Custody staff don't always keep control of cell keys.

Many of these practices don't follow APP guidance and place detainees at an increased risk of harm.

Recommendation

The force should take immediate action to mitigate the risks to detainees by making sure its risk management practices are safe, follow APP guidance, and are consistently carried out to the required standard.

Introduction

This report is one in a series of inspections of police custody carried out jointly by HMICFRS, HMIP 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 joint HMICFRS/HMIP/CQC 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. HMIP 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 North Yorkshire Police, we analysed a sample of 106 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

There are clear governance structures for custody services in North Yorkshire, with established arrangements to oversee the safe and respectful provision of custody. There is also oversight from the police and crime commissioner. Senior managers show a keen interest in custody and the force has made good progress in some areas since our last inspection in 2015, for example, in healthcare for detainees. It also responded quickly to our feedback during the inspections and started making some improvements immediately.

An assistant chief constable oversees custody, supported by the head of criminal justice. A chief inspector and two inspectors are responsible for the day-to-day management of custody services. Another inspector is responsible for custody policy and development.

A clear meeting structure provides good oversight and management of custody services. The meetings include:

- fortnightly custody meetings, chaired by the chief inspector, which examine all aspects of custody provision;
- quarterly custody strategy group meetings, chaired by the head of criminal justice, which oversee important areas of custody. For example, staffing, changes to the estate, and complaints and professional standards;
- regular meetings, which consider out-of-court disposals and the use of bail; and
- regional custody meetings, where the head of criminal justice represents North Yorkshire.

There is effective scrutiny and management of the healthcare contract.

Custody services are provided by three custody suites, based in York, Harrogate and Scarborough. The custody estate is dated, and some facilities don't meet detainee needs. The force knows the suite at York needs improvement and has included this on its risk register. However, there has been little investment in the

custody estate since our last inspection in 2015, and some of the deficiencies we noted then remain.

The force has 24 dedicated custody officers and 28 detention officers. At the time of inspection, an additional custody officer and an additional detention officer were also in post. There were no vacancies.

We saw there were generally enough staff on each shift to provide custody services. However, staff were overstretched when the suites became busy. This adversely affected detainees, because it led, for example, to delays in booking them into custody and to late welfare checks. And there weren't always female staff on duty, which made it difficult to meet the needs of women and girls.

There are often only three custody staff members on duty (either two custody officers and one detention officer or the other way round). The staff work as a team to cover custody duties, but this sometimes means they carry out duties they shouldn't be responsible for, or that are more suited to others. For example, we found custody officers conducting cell checks and rousal visits instead of detention officers, and detention officers overseeing the release of detainees to court or prison when custody officers are responsible for this. We also saw arresting officers escorting detainees to cells when detention officers should do this.

It also sometimes leads to a duplication in effort, and to responsibilities becoming blurred. On one shift, we saw rousal checks of detainees under the influence of alcohol not completed on time because it wasn't clear who was supposed to be doing them.

Initial training for both custody officers and detention officers follows the national programme. The training is carried out by the in-force training team. All custody staff attend a three-week course, followed by a shadowing period before staff start their duties. Officers complete a performance booklet, which is signed off by custody managers. The force rotates staff in and out of custody, and runs the training annually so that they are professionally competent. However, this approach can lead to a lack of experienced officers in the suites, as several may be new in post at the same time.

One day of continuous professional development training is provided by the force annually. Recent topics have included awareness of neurodiversity and mental health. But some staff told us they couldn't attend the training because of annual leave or other commitments, and said there were no arrangements to let them do it at a later stage.

There is a force bulletin that shares information and includes learning from any incidents in custody. Guidance is also available on the force intranet.

Staff told us they felt that training could be better. In our discussions with them in the suites, we identified some gaps in staff knowledge, including of some basic custody processes. For example, not all custody officers were aware that they should visit and speak with the detainees in their care following the shift handover.

The force has adopted the College of Policing's APP guidance, but there are areas where it isn't always followed, particularly when managing risk. For example, not all staff carry personal-issue anti-ligature knives, and clothing with cords is frequently

removed without an individualised risk assessment. The force also has its own policies and guidance, but, again, it doesn't always follow these.

The Police and Criminal Evidence Act 1984 (PACE), its codes of practice, and other legislation are generally followed. For example, we found detainees were usually given their rights and entitlements in line with PACE Code C, and translated documents were provided when needed, in line with Annex M of PACE Code C. Some improvements are needed for the force to consistently meet the requirements of PACE Code G to show the necessity for arrest, and to consistently meet some aspects of reviews of detention.

The force records adverse incidents appropriately (any incident that, if allowed to continue to its ultimate conclusion, could have resulted in death or serious injury to any person). It shares learning from incidents with staff. There have been no deaths in custody suites in North Yorkshire since our last inspection. One detainee died after being released from custody and this matter was referred to the Independent Office for Police Conduct, in line with guidance.

Areas for improvement

- The force should make sure that custody and detention officers are deployed in the most effective way to meet the needs of detainees and keep them safe.
- Training should support custody and detention officers to carry out their role, and any gaps in knowledge should be identified and addressed.
- The force should consistently follow APP guidance.

Accountability

The force regularly monitors comprehensive performance information, but it isn't always clear how the findings are used to improve services.

Performance data is comprehensive and monitored at fortnightly custody meetings chaired by the chief inspector. The areas monitored include:

- the number of detainees entering custody;
- children in custody;
- strip searching;
- Mental Health Act assessments and detentions in custody;
- waiting times for appropriate adults; and
- PACE reviews.

However, some data is inaccurate. For example, the time detainees arrive in custody isn't always accurately recorded. This means performance is assessed on the wrong information. And some data is difficult to extract, for example, data on the use of restraint equipment in custody isn't readily available. Some of the concerns we raised during our inspection aren't being identified by the force, despite it monitoring information about them.

The force's governance and oversight of the use of force in custody isn't good enough. Use of force is considered at both the custody strategy and chief inspector meetings, and there is some quality assurance of incidents. However, use of force isn't always properly recorded on custody records and sometimes it isn't recorded at all, and not all staff involved in an incident complete the required use-of-force forms. This means the information used by North Yorkshire Police to support effective scrutiny is inaccurate.

In our CCTV review, we found that use-of-force incidents weren't always managed well. In four cases we had concerns, including the poor use of techniques. We referred these to the force for its own review. It isn't clear how the type of concerns we identified are picked up by the force's quality assurance arrangements.

North Yorkshire Police can't show that when force is used in custody it is necessary, justified and proportionate. This is a cause of concern.

The quality of recording on custody records is often poor. Important information is sometimes missing, such as the justification for the removal of clothing and the reasons for strip searching. Sometimes the provision of food and drink isn't recorded at all. The recording of welfare checks often relies on either standard text entries or uses identical text to the previous entry. This is poor practice and makes it difficult to assess any improvement or deterioration in a detainee's condition.

There are quality assurance arrangements. Custody inspectors dip sample approximately 90 records each month from all 3 suites and check them against a very detailed set of indicators. Despite this, some of the concerns we found hadn't been identified by the force. It isn't clear how any quality assurance findings, especially when they show themes or trends, are used to make improvements.

The force understands its responsibilities under the public sector equality duty, and has policies and guidance to reflect these. Training for custody staff on equality, diversity and inclusion relies mainly on online learning, although some topics such as neurodiversity have been included in the continual professional development training.

The force collects information to help it assess whether outcomes for detainees are fair. It breaks down arrests, strip searches and any use-of-force incidents in custody by ethnicity, gender and age. Assessments of the information haven't identified any specific concerns about disproportionality, but the force intends to include this information in future custody overview reports, to see if any trends emerge. However, detainees' ethnicity isn't always recorded, which limits the accuracy of any assessments made.

The force is open to external scrutiny from the independent custody visitor (ICV) scheme. ICVs visit the suites regularly and report good working relationships with custody staff, who respond quickly to any issues raised. The ICV scheme contributes to custody staff induction training to help their understanding of the ICV role. Feedback from visits is reported to quarterly ICV panel meetings, which are attended by the custody inspector. Any recurring concerns are discussed and dealt with.

There is external scrutiny by North Yorkshire's office of the police and crime commissioner. The police and crime commissioner's public accountability meeting recently considered custody arrangements throughout North Yorkshire. The force

gave comprehensive information to the meeting about custody, including on how the suites were staffed and how risks were managed. These meetings also regularly consider some aspects of custody performance including detentions under section 136 of the Mental Health Act 1983.

The force invited a leading academic for custody provision to examine how detainees were treated in North Yorkshire and how their dignity was maintained. It intends to use the findings from this study to make improvements.

Areas for improvement

The force should improve the quality of recording on custody records, and its quality assurance arrangements by:

- including all information about a detainee's time in custody so it is clear what has happened, and how they have been treated and looked after;
- consistently recording important decisions and the reasons for them; and
- using quality assurance to assess important areas of custody and, where trends emerge, make improvements.

Working with partners

There is a clear priority to divert children and vulnerable adults away from custody. The force works well with partners to achieve this.

There is a strong commitment by the force and its partners to work together to keep children out of custody and the criminal justice system. The force, its partners and other organisations have several schemes to achieve this. They include Operation Choice, Crossroads, and No Wrong Door, all of which offer support to children to help prevent further offending.

The force works with mental health partners to offer alternatives to custody for people with mental ill health. There are regular meetings with mental health services, and mental health professionals work in the force control room to help deal with incidents involving those with mental ill health. But when these professionals aren't available, alternative arrangements are limited, and outcomes for individuals with mental ill health could be better.

The liaison and diversion team provides valuable support to vulnerable detainees in custody as well as on release so that they can get help to try and reduce further offending.

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 how a person may be vulnerable. They take this into account when deciding whether to make an arrest or find another way of dealing with the incident. They consider factors such as age, mental ill health, drug and alcohol use. They also consider the circumstances a person might find themselves in, and the risks they may face, such as child sexual exploitation.

There has been some training for officers on recognising vulnerabilities. However, officers told us that apart from the training received when they became police officers, most of this was online. More recently, training on the needs of children has been given and more is planned.

Officers told us that call handlers in the force control room (where calls from the public are answered) gave them enough information about incidents and the people involved in them to help them decide what to do. The call handlers pass on any information held on the force's IT systems and find out more information if asked. Officers can also access information from their phones or laptops if they have time. Overall, officers felt able to make informed decisions.

Frontline officers explore all other options before taking children to custody. If arresting officers can't show the necessity for arrest is robust, custody officers refuse to authorise detention. Instead of arresting children, officers consider:

- taking a child back to their parents and discussing the incident;
- taking a child to other family members if a situation needs calming down;
- arranging voluntary attendance interviews; and
- using community resolutions where the child and injured party agree remedial action.

There is also some good support from other services and organisations to keep children out of custody. Frontline officers refer children to the youth service's triage and diversion scheme, where workers support the child to try and prevent them from

further offending. They also make referrals to other schemes such as Change Direction, which helps children through support and diversionary activities, or to children's social services' early help team, which supports both the child and their family. There is also work in schools through Operation Choice – a scheme aimed at helping children involved in drug offences.

Frontline officers don't always feel they receive adequate levels of support when dealing with incidents involving people with mental ill health. Officers told us that the mental health professionals in the force control room gave good advice and assistance to help them decide what to do when dealing with a person with mental ill health. But officers also said that when these staff weren't on duty it could be difficult for them to get advice.

The mental health professionals are only available from 10.30am to 11.00pm. When they aren't on duty, officers ring the mental health crisis teams instead. They reported difficulties in getting through to speak with someone. This often leaves them trying to manage the risk and deciding to detain the person under section 136 of the Mental Health Act 1983 for the detainee's safety or that of others.

Some officers told us that occasionally a mental health professional attended incidents to deal with the person directly, but most officers weren't aware this could happen.

Long wait times for ambulances to take section 136 detainees to a mental health suite are common. Often there is then more waiting with the detainee at the mental health suite before a Mental Health Act assessment can take place. This is a poor outcome for the person in mental health crisis and a poor use of police officer time.

When officers attend an incident where an offence has been committed, they consider the circumstances before deciding whether to arrest or to find a health solution. If it is necessary to arrest, the person is taken to custody and any mental health concerns are dealt with there. The investigation continues unless a Mental Health Act assessment determines the person needs to go to a mental health suite. Occasionally detainees in mental health crisis are further detained in custody under section 136, so they can transfer from custody to a health facility.

Detainees are usually transported to custody using police vans. This is for the safety of both detainees and officers.

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. To ensure privacy, they usually deal with one detainee at a time for booking in and other custody processes. When busy, the suites can be noisy, which can make it difficult for custody officers and detainees to hear each other.

There are no separate, discreet booking-in areas at the York and Scarborough suites for detainees to discuss any sensitive matters, and the one at Harrogate custody suite isn't used. But detainees are told they can speak to a member of staff in private.

Detainee dignity is generally protected. Detainees are usually suitably dressed when moving about the suite or attending interviews. Strip searches are conducted in cells, and staff make sure CCTV monitors are switched off to protect the detainees' dignity during the search. But some practices are disrespectful, particularly when detainee clothing is removed. Sometimes detainees are left naked in cells with little encouragement to put replacement clothing on.

Some CCTV monitors in the custody area can be seen by detainees or others in the suite. Their positions need adjusting. Staff tell detainees that CCTV operates in the suite and cells, and explain that cell toilets are pixelated and can't be seen on the monitors.

Shower locations and screens aren't private enough, as they can be seen from corridors. Staff try to mitigate this through discreet supervision and by restricting access to corridors when showers are in use.

Meeting diverse and individual needs

Custody staff recognise and do their best to meet detainees' individual and diverse needs. They told us they had received little training to help them with this, but we found that most detainee needs were properly met.

Detainees are routinely asked if they have any caring responsibilities that need to be considered during their detention.

The design of the older suites makes it difficult to meet the needs of detainees with physical disabilities. There are no adaptations in cells, for example, no lowered call bells, and few thicker mattresses to raise the height of low benches. However, there are adjustments and arrangements available, including:

- ready access to a wheelchair;
- ramps for access to exercise yards in two of the three suites;
- an adapted shower and toilet at Harrogate, and an adapted toilet at Scarborough;
- coloured bands on cell walls to help detainees with sight impairments; and
- legal rights and entitlements available in Braille and in easy-read format.

Awareness of the needs of neurodiverse detainees is limited, despite some recent training. Distraction activities have recently been introduced in the suites, but aren't yet routinely offered to detainees who disclose neurodiverse conditions, or to others who may benefit from them.

The force meets the needs of women well. In most cases, female detainees are allocated to the care of a female member of staff. However, when female staff aren't available, detainees aren't always spoken to and engaged with. Menstrual care needs are well catered for, but product disposal arrangements are unsatisfactory.

There is good use of telephone interpreting services for detainees who speak little or no English, particularly during booking in. However, we aren't assured this service is used for other important custody processes such as reviews of detention, which potentially limits detainee understanding. Custody staff can access rights and entitlements information in a range of languages. They give these to detainees as needed.

Custody staff have good awareness of the needs of transgender detainees. Many staff we spoke to had recent experience of dealing with transgender detainees and others gave us appropriate descriptions of how they would treat them.

The provision for detainees wishing to observe their faith could be better. Detainees aren't always asked if they have religious needs, but even when needs are identified they aren't always met. The range of religious items is good for detainees observing Islam, but too limited for other religions.

Areas for improvement

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

- making adequate provision for detainees with disabilities;
- making sure female staff contact and engage with the women they are assigned to;
- having satisfactory disposal arrangements for menstrual care products;
- using private telephone interpreting services at all points during detention where important information needs to be given or requested; and
- consistently asking detainees if they have religious needs, and meeting them by providing religious texts and items for the main faiths.

Risk assessments

The identification of risk is generally good, but it isn't always managed well enough to ensure the safety of detainees. Many of the concerns are the same as in our previous inspection, and this is a cause of concern that we expect the force to address immediately.

Detainees are usually booked in promptly, but sometimes have lengthy waits in vehicles or holding rooms. When this occurs, staff told us there was little triage of queues to manage risk or prioritise vulnerable people or children.

Initial risk assessments focus appropriately on identifying risks, vulnerability factors and welfare concerns. Custody officers engage well with detainees and explain the purpose and importance of the risk assessment. There is routine cross-referencing with the information available from previous custody records and the Police National Computer, but arresting officers are rarely asked if they have any other relevant information to add.

Custody officers set observation levels that generally reflect the risk posed. 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. Rousal checks aren't always carried out correctly and checks aren't always well recorded. There is a lack of continuity of staff carrying them out. Continuity is important because otherwise staff may not recognise changes or any deterioration in a detainee's condition.

Level 1 observations are carried out appropriately through an open hatch but aren't always on time or recorded well. There is little or no detail recorded of any communication made with the detainee.

Sometimes checks, including rousal checks, are late because it isn't clear who should be doing them. Custody staff share duties, but we saw occasions where this approach led to confusion, over what had and hadn't been done, particularly at busy times. This creates risks for detainees.

When a heightened level of risk is identified, detainees are placed on level 4 close proximity observations. The officers responsible for level 4 observations should be briefed by the custody officer about the specific risks the detainee presents. These, along with the names of the officers carrying out the observations, should be documented in the custody record. This doesn't always happen. There is guidance for officers about level 4 observations, but this is generic and of limited help. Custody staff aren't always carrying out routine welfare checks or rousing detainees as required when level 4 observations take place. These practices don't follow APP guidance.

As in our previous inspection, regardless of risk, all custody staff continue to routinely remove footwear and clothing with cords from detainees, rather than deciding on an individualised risk assessment. This doesn't follow APP guidance. The justification for removal is often not documented in the custody record.

Anti-rip clothing continues to be used frequently. There isn't always good enough rationale or justification for its use. This was a concern in our previous inspection. It is a risk-averse approach and is sometimes used as a response to behaviour or because the detainee won't answer the risk assessment questions, rather than because any risks are posed. This practice is contrary to APP guidance, increases risk, and can sometimes lead to force being used to remove detainees' clothing. Risks could be better mitigated and managed through higher levels of observation such as level 3 (constant observations via CCTV), which is rarely used by the force, or level 4.

Handovers between custody staff include detailed information and are properly focused on risk. But the way they are carried out doesn't follow APP guidance. They don't always include all outgoing and incoming custody staff, and healthcare practitioners are rarely involved. Following handovers, not all custody officers visit and fully interact with the detainees in their care. However, after giving feedback to the force, we saw some improvement during the second week of our inspection.

Not all custody staff carry personal-issue anti-ligature knives, which limits their ability to respond to an incident if needed and could compromise detainees' safety.

Cell call bells are generally responded to promptly, but the resulting staff interactions with the detainees aren't always recorded.

The management and control of cell keys isn't good enough. We saw keys frequently being given to officers to take detainees to interviews, or to visit cells and make further arrests. This practice diminishes the control that custody staff should have over the suites.

Individual legal rights – detention

Detainees are generally booked into custody promptly. There are sometimes delays when more than one person is waiting as only one detainees is booked in at a time. The arrival times for detainees at the suites aren't always correctly recorded, which makes it difficult for the force to accurately know how long detainees wait.

Detention is appropriately authorised. Arresting officers provide the circumstances of arrests for custody officers to authorise detention. But the grounds for the necessity for

detention as required by PACE Code G aren't always explained well enough. We saw custody officers appropriately refuse detention if there were insufficient grounds.

The force makes good use of voluntary attendance interviews to avoid taking a person to custody. It has a comprehensive policy on dealing with suspects in this way, and has the facilities to interview them outside the custody suites. Information given to us by the force showed that 2,223 individuals were dealt with as voluntary attendees in the year ending 31 May 2022. The force also uses other diversions from custody, such as fixed penalty notices, cautions, restorative justice and community resolutions.

Detainees don't generally spend longer than necessary in detention. Cases are usually dealt with as quickly as possible, with regular communication between custody, investigation teams and response officers to progress them. Occasionally there are delays, which we found were mainly due to waiting for appropriate adults or interpreters.

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 were commensurate to the offences under investigation.

Information given to us by the force shows the number of immigration detainees slightly increased (by nine) in the year before this inspection. The force monitors how long immigration detainees spend in custody before they are transferred to immigration detention facilities, which is an average of 11 hours and 11 minutes in custody after the immigration papers (IS91) are served. Custody staff reported good working relationships with immigration services.

Area for improvement

Explanations for the necessity for detention should be detailed and clear so that the requirements of PACE Code G are fully and consistently met.

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.

They give detainees a booklet called *Remember your rights whilst detained*. This gives detainees detailed information on, for example, how to get information about their detention, and what their entitlements regarding welfare and personal needs are while in custody.

Copies of a recent edition of the PACE Code C book (August 2019) are available at all the suites. We saw staff routinely offer these to detainees when they were booked in, and during reviews of their detention.

When detainees are held incommunicado (delaying their right to have someone informed of their arrest) this is appropriately authorised, and removed when no longer required.

When a detainee declines free legal advice, we expect custody officers to explore the reasons for this. In some instances, we saw custody officers trying to find out the reasons, reminding detainees that legal advice is free of charge and that they could change their mind and ask for it at any time. But this didn't always happen.

We also expect legal representatives to be encouraged to represent detainees in person. During the inspection, we saw one occasion when a legal representative had COVID-19 and wished to represent several clients virtually. The custody officer discouraged this. After much discussion it was decided that the cases would be dealt with in person by the duty solicitor. This showed good attention to making sure that detainees had the benefit of in-person representation.

Posters advertising the right to free legal advice are in the suites, but not in all the languages required by PACE Code C paragraph 6.3. However, new posters were ordered during our inspection.

The custody officers we spoke to were aware of the requirements of PACE Code C Annex M (detainees should receive documents and records on important information about custody processes in a language they can understand). They knew where the translated documents were on the force's computer system, and we saw them routinely give the documents to detainees. This is positive.

There are copies of the easy-read version of rights and entitlements for children and other detainees who may need help to understand their rights. We saw these given to detainees when needed.

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. Legal representatives are given a summary printout of the front sheet of a detainee's custody record when requested.

Custody officers know how to contact the relevant embassies, consulates or high commissions for foreign nationals coming into custody if the detainee requests this.

We saw posters in all the suites explaining the Protection of Freedoms Act 2012 and the retention and destruction of DNA samples. At Harrogate there is separate A4-sized notice that can be given to detainees. However, we didn't see this information being verbally explained to all detainees or the poster being brought to their attention. DNA samples are stored securely and in freezers, to maintain the integrity of the samples. They are regularly collected from the suites.

Areas for improvement

- Custody officers should consistently explore the reasons why a detainee has declined free legal advice and record this appropriately.
- Detainees should be told what happens to any DNA samples they have given.

Reviews of detention

Reviews of detention are generally carried out on time and in person by either the custody or response inspectors. This includes reviewing children face to face as a matter of course (rather than by telephone), which is an improvement since our last inspection.

Before starting their review, inspectors routinely establish the progress of the investigation by speaking to investigating officers or custody staff to find out why continued detention is needed.

In the reviews we saw, detainees were spoken to courteously, with good emphasis on their wellbeing and whether they had had enough food and drinks or other care.

However, detention was sometimes authorised before the detainee was given the opportunity to make any representations, which doesn't meet the requirements of PACE Code C paragraph 15.3.

Detainees weren't always reminded at the earliest opportunity that a review of their detention had taken place while they were asleep, as required by PACE Code C paragraph 15.7, despite clear instructions on the custody record to do so. Some of these reviews occurred outside recognised rest periods. For example, some took place during the day when the detainee should have been woken and spoken to. Some detainees were awake either immediately before or after the review according to some of the custody records we examined, suggesting they could have been spoken to.

Areas for improvement

The force should make sure that reviews of detention consistently meet the requirements of PACE Code C. In particular:

- detainees should always be asked if they wish to make any representations regarding their continued detention before reviewing officers decide to authorise their further detention; and
- detainees should be reminded at the earliest opportunity that a review of their detention took place while they were asleep, reminded of their rights and told that their detention had been further authorised.

Complaints

Notices outlining the procedure for detainees to make complaints are prominently displayed at all the custody suites. There is also a paragraph informing detainees of how to complain in the *Remember your rights whilst detained* booklet. But there are no leaflets to give to detainees that include contact telephone numbers or website addresses.

Custody staff are aware of the procedure if detainees want to make a complaint. However, in the two cases we saw where detainees said they wished to complain, the complaint was taken in one instance but not the other.

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 North Yorkshire comprises three full-time designated suites in Harrogate, Scarborough and York. There are potential ligature points throughout the estate, mainly due to the design of toilets and fit of doors. During this inspection, we gave the force a comprehensive illustrative report detailing these points, as well as the general conditions in the suites. The force acted immediately to remedy some of the concerns we identified.

General conditions in the three suites vary due to their age and the design of the buildings. The suites are well maintained and overall cleanliness is good. However, the facilities don't always meet detainee needs. The older suites at Scarborough and York have benches that are either too high or too low to meet current guidance. There are also no sinks in the cells, no cells with glass-fronted doors, and no discrete booking-in area or closed-visits room. Space for level 3 CCTV monitoring in these two suites is limited as the CCTV monitors are immediately adjacent to custody staff workstations.

APP guidance requires daily safety maintenance checks of the physical environment, including cells and communal areas, be carried out, but these aren't always done. We were told that repairs were mostly completed quickly.

CCTV covers most of the suites and all the cells. During our review of CCTV footage, we found some concerns, such as poor images and audio recording. Notices that CCTV is in operation aren't always prominently displayed where detainees can see them, and there are no notices in any of the cells.

Custody staff are aware of emergency evacuation procedures and there are enough handcuffs to evacuate cells if needed. Few of the staff we spoke to had taken part in a physical evacuation in the past year to make sure the procedures work in practice. Force data shows that there has been an evacuation or evacuation drill at each

building in the past year, but this data doesn't always identify the custody staff who took part.

Areas for improvement

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

- identifying all potential ligature points and, where resources don't allow them to be dealt with immediately, managing the risks so that custody is provided safely;
- making sure CCTV systems offer good visual and audio coverage throughout the suites;
- prominently displaying notices throughout the suites advising that CCTV is in operation; and
- making sure all custody staff are trained and involved in the procedures to be followed in the event of a fire or other emergency requiring the custody suite to be evacuated, as per APP guidance.

Use of force

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

We reviewed 19 cases of use of force on CCTV. In the cases we examined, we saw some good communication, with officers de-escalating situations well and avoiding the need to use force. But when force was used, incidents weren't always managed well, and custody officers didn't always provide enough direction and oversight.

Restraint techniques weren't always often deployed correctly. Not all techniques were used correctly, or successfully applied. We saw instances where poor control techniques escalated incidents, leading to more force being used and an increased risk of injury to the detainee.

In the cases we reviewed, force was often used to remove detainees' clothing. It wasn't always clear from the custody records, or from our observations on CCTV, why the removal was necessary and justified. In our view, the removal led to use of force that could potentially have been avoided. In addition, officers didn't always maintain the detainees' dignity well when removing their clothing.

We referred four cases to North Yorkshire Police for learning. All cases involve the use of poor techniques, and in three of the cases the force used may have exposed the detainee to the risk of injury.

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 notices in the suites reminding them to do this. We asked for use-of-force forms for the incidents we reviewed, but didn't receive the number we expected.

Use-of-force incidents are usually noted on the custody record, although we found some that weren't. The details recorded were sometimes limited and didn't always reflect what we saw happening on the CCTV footage.

Custody inspectors view some use-of-force incidents on CCTV footage to quality assure and learn from them. Our own review of incidents identified concerns such as poor control techniques. The force needs to make sure that its own quality assurance is robust enough to identify and address all concerns that may arise when officers are using force on detainees.

Limitations regarding both accurate recording of incidents and quality assurance arrangements make it difficult for North Yorkshire Police to show that when force is used in custody it is necessary, justified and proportionate. Our analysis of custody records shows force is used more often in North Yorkshire custody suites than in other forces, so it is important that North Yorkshire Police can clearly show why this is.

Handcuffs aren't always removed quickly enough from compliant detainees. The reasons why handcuffs have been used aren't recorded, and the time at which handcuffs are removed isn't recorded.

The strip searches we reviewed were generally managed well and the dignity of the detainee was considered. However, it wasn't always clear why a strip search was necessary, justifiable and proportionate. In our analysis of custody records, we found that the force had a high percentage of strip searches in custody compared to other forces we have recently inspected. The reasons for this aren't clear, and the force needs to understand better why this is the case.

Most custody officers and all custody detention officers are up to date with their officer safety training. Training is scheduled for those who need it.

Detainee care

The standard of care custody staff offer to detainees is very good. Detainees spoke positively about the care they received, and most were aware of the facilities and care available to them.

Custody staff explain the range of care available to detainees during booking in. Detainees are frequently offered care during welfare checks, and by inspectors when conducting reviews.

Food preparation areas are generally clean and tidy. Cutlery is sanitised between use. The range of food is reasonable and meets most dietary requirements. It includes instant porridge, cereal bars and, more recently, instant noodle pots. Food and drink is offered and provided regularly. The dietary information for microwave meals is prominently displayed. Food can also be brought in by family or friends, or purchased for detainees who stay in custody for longer periods or for whom custody food is unsuitable.

Showers and exercise are offered and provided regularly. Detainees are generally given toilet paper in their cell without having to ask for it. But the lack of handwashing facilities in cells in Scarborough and York is poor, and detainees aren't routinely offered the opportunity to use the sinks in communal handwashing areas.

There is a reasonable range of reading material such as books and magazines, including material for children and in languages other than English. These are regularly offered and given. Distraction materials have recently been introduced, but aren't always offered to detainees.

There is enough replacement clothing for detainees when their own clothing is removed. Clothing with cords and footwear with laces are routinely removed from detainees. Plimsolls are given as replacement footwear. Footwear is usually kept outside cells, but most detainees wear it when walking around the suite, unless they choose not to.

All cells are equipped with a mattress and a pillow. Some mattresses are in a poor state of repair and most are too thin. Some detainees complained about how uncomfortable they were. Clean blankets are routinely given to detainees.

Safeguarding children and vulnerable people

The safeguarding of children and vulnerable adults in custody is getting better, and the force is making improvements. As a result of the findings of our recent national child protection inspection, the force is introducing additional training and measures to increase safeguarding arrangements.

Some training to improve staff awareness of various aspects of vulnerability, and how to deal with safeguarding concerns, has already been given, and more is planned. This includes recognising neurodivergent needs and understanding the needs of children, for example through 'voice of the child' training, and sessions from external organisations such as The Children's Society.

The force is also strengthening some of its safeguarding arrangements. Custody officers are now expected to check whether arresting or investigating officers have completed safeguarding referrals (public protection notices) to outline possible concerns and notify partner agencies. We saw entries on custody records that suggested this was starting to happen.

The force has also introduced a safeguarding checklist aimed at prompting custody officers to consider how a child might be vulnerable. For example, through involvement in county lines drug dealing or other exploitation risks. However, in the cases we examined, these weren't always completed, and some custody and frontline staff were unclear as to who should complete this checklist or what it achieved. Some weren't aware of it at all.

Children, women and vulnerable adults should always be seen by liaison and diversion (L&D) staff while in custody. This offers an additional safeguarding measure to identify and address concerns. However, staff shortages in L&D mean this doesn't always happen. Although healthcare practitioners (HCPs) don't typically see children, if L&D can't see a child, HCPs are expected to speak with them.

Appropriate adults

Children and vulnerable adults aren't always receiving prompt support from an appropriate adult (AA). This hasn't improved since our previous inspection. Family members are sought as AAs in the first instance. Where this can't be arranged, the local authority emergency duty team or the youth justice service (in the daytime, for children) should provide an AA.

Custody officers generally try to contact and secure an AA as early as possible in a detainee's detention. In our case reviews and observations, we saw examples of this happening. There were also cases when an AA couldn't attend, so the detainee's rights and entitlements were re-read to the individual and the AA listened via telephone. Although this isn't ideal, it shows the importance custody officers attach to getting early AA support.

However, despite custody officers' efforts to arrange early attendance by AAs, we found some long delays before one arrived. Custody staff at all suites told us waits for independent AAs (non-family members) were frequent and often extensive, particularly outside normal working hours and overnight. Sometimes an AA isn't provided at all, and the detainee may have to be released.

The force recognises that AA provision isn't good enough. In particular it recognises that social services don't have any statutory obligation to provide an AA for vulnerable adults. It has improved its monitoring to include the request and arrival times of AAs, and to examine further the reasons for any delays. It will then have a better understanding of its position so it can discuss this with partner agencies.

Custody staff are aware of the need to identify when a detainee is vulnerable and needs the support of an AA. They have received some training to raise awareness of this need. However, in some of the cases we examined, there was information to suggest the detainee was vulnerable, but consideration hadn't been given to securing an AA.

Area for improvement

AAs should always be readily available to support vulnerable adults and children, including at night.

Children

North Yorkshire Police detains few children in police custody. There are schemes to divert them away from custody, and custody officers are robust when considering the necessity to detain a child. We found a good example where detention was appropriately refused for a child. We also found cases where children were released under investigation as soon as their interview had taken place, so they could leave custody at the earliest opportunity and, in some cases, avoid overnight detention.

There is some good care for children in custody. The force has recently introduced a new child-focused entry for custody records, to make sure custody staff routinely consider and take the specific needs of children into account. For example, custody

officers should consider and record whether the child was booked into custody privately, whether a safeguarding referral has been completed, and whether a dedicated member of staff has been assigned as the child's carer. This is a positive change, but it isn't yet consistently working as intended.

In our case reviews we found that, while some entries were good, others didn't always contain enough additional detail to show what had happened, which undermined their value. The force is monitoring how these entries are completed as part of its wider quality assurance procedures for custody. It raises any issues with individual members of staff, to help improve standards.

The force has recently adopted a policy of assigning designated staff members as carers for both boys and girls (though it is only legally required for the latter). During our inspection we saw this generally happened for girls but less so for boys. Some staff weren't aware that this is now force policy. There aren't always female custody staff on duty, so female officers from response (or other) teams are sometimes assigned the role. It was difficult to see from custody records whether assigned carers subsequently spoke to and interacted with the children. The force intends to include these interactions in monitoring arrangements in future.

A selection of distraction items has been introduced to help children and vulnerable detainees during their time in custody. These include fidget toys, foam footballs and puzzles. However, we didn't see these always given to either children or others who could have benefitted from them, and there is little recording on custody records to show if they have been given out.

Very few children are charged and refused bail in North Yorkshire. The force and its local authority partners have a joint protocol agreement governing how these children are managed. This includes joint monitoring arrangements via the Joint Youth PACE Working Group. In the year before this inspection, there were only nine children charged and refused bail. Four of them needed non-secure accommodation and they were moved from custody to this. Four of the children didn't need alternative accommodation, as they were held for breaching court bail. One was taken to court the same day. There is no secure bed accommodation within the force area, which is likely to hamper its ability to move children should they need this.

Healthcare

Leeds Community Healthcare NHS Trust (LCHT) provides physical healthcare support to detainees and carries out forensic testing in custody. HCPs are based in all 3 custody suites, supported by forensic medical examiners and providing healthcare cover 24 hours a day. There are arrangements to call in extra staff if daily staffing levels aren't adequate. Where cover isn't provided when needed, the force can apply 'financial credits' (penalties). The service has some vacancies and recruitment is ongoing.

Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) provides L&D services at all three custody suites. NHS England and NHS Improvement commission L&D services and monitor the contract alongside the force.

The force and its partners work well together. Governance processes ensure a unified approach to monitoring safety, quality and performance. The health providers share data with the force to show how they are meeting the needs of detainees. This data includes HCP response times for seeing detainees, and the use of Mental Health Act legislation prior to and while in police custody.

Information-sharing agreements with health partners ensure the safe and appropriate sharing of information.

There are regular clinical audits of care records, medicines, and infection prevention and control (IPC). Action is taken to improve the quality of care for detainees, if needed.

Healthcare and L&D staff are given relevant training for their roles and have annual appraisals of their performance. This includes safeguarding training to make sure staff are competent in recognising vulnerabilities in detainees. Supervision is available for all staff, but the recording of completed supervision isn't adequate.

Each custody suite has a medical room that is solely used by HCPs. All medical rooms are compliant with IPC guidance and are cleaned daily. All three rooms are used for forensic sampling and are forensically cleaned before and after examinations. During this inspection, the temperature in the medical room in York was high (28°C). Staff monitored this daily, and discussed with the force how this needed to improve.

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

Healthcare staff have access to interpreters for those detainees whose first language isn't English.

LCHT and TEWV report incidents through their electronic reporting systems. Incidents are investigated and learning is shared with staff through staff meetings, daily 'huddles' (virtual meetings), supervision and bulletins. The outcomes of investigations are shared with the force and commissioners.

Both providers have a confidential complaints process. They have received few complaints in the past year. However, we didn't see information displayed for detainees on how to make a health-related complaint, which we expect.

Areas for improvement

- All clinical supervision should be accurately recorded.
- Information on how to make a confidential complaint relating to a healthcare concern should be available and clearly visible to detainees.

Physical health

Detainees receive prompt clinical assessment and treatment from experienced and competent practitioners. Staff we spoke with and saw were professional and caring during their interactions with detainees.

Staff complete clinical assessments and examinations in appropriately designated rooms. They maintain the privacy and dignity of detainees, and carry out clinical assessments with the door closed unless a risk assessment indicates this might not be safe. The service employs both male and female HCPs, and where possible staff will arrange assessments to be carried out 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.

Staff complete electronic clinical records for detainees. They assess a range of needs including physical and mental health, substance misuse, safeguarding and social needs. The clinical records we reviewed contained a plan of care that reflected the assessed needs of the detainee. Healthcare staff update custody records to make sure custody staff have up-to-date views of the healthcare needs of detainees.

Mental health

The L&D team are commissioned by NHS England and NHS Improvement to provide a service to detainees that covers all types of vulnerabilities, for example, social needs as well as health. It has good working arrangements with other services and organisations, and there is effective oversight from commissioners. However, prompt access to advice, assessment and treatment for detainees needs to improve.

Clinical staff from TEWV and non-clinical staff from Spectrum CIC and Humankind Charity are based in the 3 suites 7 days a week, from 8.00am to 8.00pm. Recruitment difficulties meant at the time of inspection the service was operating reduced hours, from 8.00am to 6.00pm. But more staff had been recruited and were due to start.

The L&D practitioners are well-motivated and skilled, giving good support to vulnerable detainees, ranging from housing, social problems, and drug and alcohol issues through to complex mental health problems. Staff give both telephone and face-to-face support post-release. This support isn't time-bound, and is based on individual need so that detainees can engage with community services.

The L&D service and the force work well together. They have regular meetings to share data and scrutinise information about Mental Health Act assessments. This makes sure outcomes for detainees are monitored.

Custody officers refer detainees for assessment to a central referral point, or verbally to L&D staff in the suite. Between 7.00am and 3.00pm, an L&D navigator screens all detainees using a triage tool to identify any needs and establish any previous contacts with mental health services. Staff use the outcome of the screening to prioritise assessments. Clinical practitioners carry out detainee screenings outside the navigator's working hours, and HCPs carry out screening between 8.00pm and 7.00am. This helps detainees to have prompt access to mental health services. However, most L&D staff don't have access to force's computer systems, so rely on custody staff to record crucial mental health information.

Staff attend twice-daily ‘huddles’ (virtual team meetings) and use a visual communication board to record all information. This helps them to assess risks, make decisions and allocate staff appropriately throughout the custody suites to meet detainee needs. Staff from LCHT attend alongside L&D colleagues. This promotes a shared understanding of detainees’ healthcare.

L&D staff can attend weekly multidisciplinary case conference appointments, where they can discuss detainees with complex needs. This forum focuses on achieving the best outcomes for detainees and supporting staff. In our view it is notable practice.

We examined some clinical records, and found some information about the continuity of care between L&D staff and HCPs was omitted from them. This potentially raises the risk for detainees with mental health problems, particularly overnight when L&D staff aren’t on duty.

Custody isn’t used as a place of safety under section 136 of the Mental Health Act 1983. Custody staff sometimes use section 136 to move detainees with suspected acute mental health problems from custody to a health-based place of safety. It was used on 15 occasions in the year before this inspection. There are only two beds at the health-based place of safety serving the whole county, which can result in delays to detainees getting the support they need.

Detainees sometimes wait a long time for a Mental Health Act assessment in custody, with more waiting for onward transfer to a mental health bed. In the year before this inspection, 21 detainees were referred by staff for an assessment. On average, detainees waited 7.35 hours for an assessment, and then 15 hours for a bed to become available. We found 2 cases where detainees stayed in custody for 28 and 43 hours, respectively, until a mental health bed was found.

In addition to the L&D service, TEWV employs a mental health clinician, who is based in the force control room between 10.30am and 11.00pm, 7 days a week. The clinician has access to both the force systems and the clinical information held by TEWV. This helps them to support frontline officers to decide the best action to take when dealing with someone with mental ill health. Frontline officers welcome this help, but outside the service operating hours they reported difficulties in obtaining advice from mental health crisis teams in the community.

As well as the clinician in the force control room, TEWV provides a first response team between 11.30am and midnight. A small team of clinicians works alongside police officers to help deal with incidents. At the time of this inspection, the provision was limited to three days a week due to a lack of staff.

The lack of advice from mental health professionals can contribute to detaining a person under section 136 of the Mental Health Act 1983 for the detainee’s safety or that of others. Police used their powers under section 136 on 236 occasions in the year before this inspection.

Areas for improvement

- The force should make sure L&D staff can access custody records to record mental health and other information about detainees.
- The force should work with LCHT and TEWV to make sure the continuity of care for detainees continues when the L&D service isn't available.

Substance misuse

HCPs make initial assessments and, where needed, provide treatment for detainees who are experiencing drug and alcohol withdrawal while in custody. HCPs use nationally recognised assessment tools to monitor and inform decision-making regarding withdrawal. When clinically indicated, staff administer medicines to relieve symptoms of withdrawal.

If detainees are already in treatment in the community, HCPs support them by continuing opiate substitute treatment while they are in custody, subject to confirmation of ongoing compliance. There are appropriate patient group directions to help staff in making these decisions.

There is no dedicated substance misuse service in custody suites. However, the L&D team sees detainees with drug and alcohol problems while they are in custody and make referrals to community substance misuse providers (New Horizons in Harrogate and Scarborough, and Changing Lives in York).

L&D staff work with detainees with chronic and complex needs, including dual diagnosis.

Medicines management

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

There are robust governance arrangements to manage medicines. Staff use systems and processes to safely prescribe, administer, record and store medicines. Custody staff store detainees' own labelled medicines securely in the detainees' property lockers.

Staff manage controlled drugs appropriately, and complete regular audits of medicines to identify any potential errors. Staff report medicine errors through the electronic reporting system and investigate these promptly. There is a pharmacy technician to support HCPs in all medicine-related areas, including audit, stock control and incident investigations.

Staff make provision for a detainee's own medicines to be sent with them to court.

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 generally have a clear focus on ensuring detainees are released safely. We saw some good attention and care given to detainees to help them get home.

Custody officers explain 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.

Custody officers are supportive and engage with detainees well when releasing them. We saw detainees present for most of the pre-release risk assessment, and any risks were discussed with them and mitigated as far as possible.

However, the recording on pre-release risk assessments often lacks important information from the initial risk assessment, or fails to mention issues that have become apparent while in custody. For example, previously disclosed substance misuse and addictions are frequently missing on pre-release risk assessments. Where the L&D team have seen a detainee in custody, there is little or no information to show the result of the team's involvement or whether this has been considered when releasing the detainee.

There is good support agency information available, with leaflets to be handed out on release. But custody officers aren't always telling detainees about the support they can access, or giving the leaflets out.

Where detainees don't have the means to get home, custody officers make good efforts to help them. Options include using petty cash to buy bus and train tickets, researching travel options, and, occasionally and where appropriate, using police vehicles. We were told that children and vulnerable people were always helped to get home safely.

Detention officers complete digital person escort records and arrange transport for detainees who are attending court or recalled to prison. These records aren't always

checked by custody officers, and we found some had important information missing that could help other agencies or court staff. Custody officers don't have much involvement with the release of detainees transferring to court. Instead, detention officers deal with them, with little, if any, oversight from a custody officer. These practices don't follow APP guidance.

Areas for improvement

The force should improve how it releases detainees by:

- making sure all relevant risks identified in initial risk assessments, or identified during custody, are fully recorded in the detainee's pre-release risk assessment;
- advising detainees about the support available and offering support leaflets to all detainees on release; and
- making sure custody officers engage with detainees who are being transferred to court to identify and mitigate risks, that they check that digital person escort records are fully completed, and that they oversee and sign these off before detainees transfer to another agency.

Courts

When detainees are remanded they are generally transferred promptly to the next available court. Detainees appear before local courts in person, although there are virtual court facilities available should they be needed.

Detainees who are remanded or arrested on warrant during the day are sometimes able to appear before the court later the same day. We saw a good working relationship between custody and court staff, and detainees were sometimes able to attend court in the late afternoon. This has improved since our last inspection and 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

Causes of concern and recommendations

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 limitations in the way quality assurance is carried out means 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

The force should scrutinise the use of force in custody to show that when force 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: managing detainee risks

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

- Custody officers don't triage queues to risk assess detainees 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 frequently carried out by different members of custody staff, making it difficult to assess changes in a detainee's behaviour.
- Detainee welfare checks aren't always on time, carried out properly, or recorded accurately.
- Level 4 (close proximity) watches aren't always conducted or recorded in line with Authorised Professional Practice (APP) guidance. Bespoke briefings to officers aren't recorded, and custody staff don't carry out welfare checks or rousals of detainees on this level of observation.
- All custody staff routinely remove cords and footwear from detainees without an individualised risk assessment.
- Anti-rip clothing is used too often, sometimes without justification or rationale. It is sometimes removed by force, which can lead to an escalation in risk.
- Handovers between shifts aren't attended by all custody staff, and staff taking over don't always visit the detainees in their care.
- Not all custody staff carry personal-issue anti-ligature knives.
- Custody staff don't always keep control of cell keys.

Many of these practices don't follow APP guidance and place detainees at an increased risk of harm.

Recommendation

The force should take immediate action to mitigate the risks to detainees by making sure its risk management practices are safe, follow APP guidance, and are consistently carried out to the required standard.

Areas for improvement

Leadership, accountability and partnerships

- The force should make sure that custody and detention officers are deployed in the most effective way to meet the needs of detainees and keep them safe.
- Training should support custody and detention officers to carry out their role, and any gaps in knowledge should be identified and addressed.
- The force should consistently follow APP guidance.
- The force should improve the quality of recording on custody records, and its quality assurance arrangements by:
    - including all information about a detainee's time in custody so it is clear what has happened, and how they have been treated and looked after;
    - consistently recording important decisions and the reasons for them; and
    - using quality assurance to assess important areas of custody and, where trends emerge, make improvements.

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

- The force should strengthen its approach to meeting the individual and diverse needs of detainees by:
    - making adequate provision for detainees with disabilities;
    - making sure female staff contact and engage with the women they are assigned to;
    - having satisfactory disposal arrangements for menstrual care products;
    - using private telephone interpreting services at all points during detention where important information needs to be given or requested; and
    - consistently asking detainees if they have religious needs, and meeting them by providing religious texts and items for the main faiths.
- Explanations for the necessity for detention should be detailed and clear so that the requirements of PACE Code G are fully and consistently met.
- Custody officers should consistently explore the reasons why a detainee has declined free legal advice and record this appropriately.
- Detainees should be told what happens to any DNA samples they have given.
- The force should make sure that reviews of detention consistently meet the requirements of PACE Code C. In particular:
    - detainees should always be asked if they wish to make any representations regarding their continued detention before reviewing officers decide to authorise their further detention; and
    - detainees should be reminded at the earliest opportunity that a review of their detention took place while they were asleep, reminded of their rights and told that their detention had been further authorised.

In the custody cell, safeguarding and healthcare

- The force should improve the safety and environment of the custody suites by:
    - identifying all potential ligature points and, where resources don't allow them to be dealt with immediately, managing the risks so that custody is provided safely;
    - making sure CCTV systems offer good visual and audio coverage throughout the suites;
    - prominently displaying notices throughout the suites advising that CCTV is in operation; and
    - making sure all custody staff are trained and involved in the procedures to be followed in the event of a fire or other emergency requiring the custody suite to be evacuated, as per APP guidance.
- AAs should always be readily available to support vulnerable adults and children, including at night.
- All clinical supervision should be accurately recorded.
- Information on how to make a confidential complaint relating to a healthcare concern should be available and clearly visible to detainees.
- The force should make sure L&D staff can access custody records to record mental health and other information about detainees.
- The force should work with LCHT and TEWV to make sure the continuity of care for detainees continues when the L&D service isn't available.

Release and transfer from custody

The force should improve how it releases detainees by:

- making sure all relevant risks identified in initial risk assessments, or identified during custody, are fully recorded in the detainee's pre-release risk assessment;
- advising detainees about the support available and offering support leaflets to all detainees on release; and
- making sure custody officers engage with detainees who are being transferred to court to identify and mitigate risks, that they check that digital person escort records are fully completed, and that they oversee and sign these off before detainees transfer to another agency.

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 custody records using a representative sample of all records in all the suites in the force area that were opened in the week preceding the inspection. The records we analysed were chosen at random.

We use a government statistical formula with a 95 percent confidence interval and a sampling error of 7 percent to calculate the sample size. By using this formula, we make sure that our records analysis reflects the throughput of the force's custody suites in that week. Our analysis focuses on the legal rights and treatment and conditions of the detainee. Only statistically significant comparisons between groups or with other forces are included in the report.

A statistically significant difference between two samples is one that is unlikely to have arisen by chance alone and can be assumed to represent a real difference between the two populations. To adjust p-values for multiple testing, $p<0.01$ was considered statistically significant for all comparisons. This means there is only a 1 percent likelihood that the difference is due to chance.

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 substantial 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
- 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
- Martine Moore: HMI Constabulary and Fire & Rescue Services inspection officer
- Kellie Reeve: HMI Prisons team leader
- Fiona Shearlaw: HMI Prisons inspector
- Joanne White: CQC inspector
- Dayni Johnson: CQC inspector
- Joe Simmonds: HMI Prisons researcher
- Helen Ranns: HMI Prisons researcher

www.justiceinspectorates.gov.uk/hmicfrs
www.justiceinspectorates.gov.uk/hmiprisons
www.cqc.org.uk