Inspecting policing in the **public interest**

Report on an unannounced inspection visit to police custody suites in

Leicestershire

by HM Inspectorate of Prisons
and HM Inspectorate of Constabulary

8–17 September 2014

Glossary of terms

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Section 1. Introduction

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

In January 2014, the Home Secretary asked HM Inspectorate of Constabulary (HMIC) to undertake a thematic inspection in 2014/15 on the welfare of vulnerable people in police custody. It was decided by HMIC and HM Inspectorate of Prisons to use the existing rolling programme of police custody inspections to facilitate the principal fieldwork. The inspection of police custody suites in Leicestershire forms part of this fieldwork, and the findings will inform the final thematic report which is to be published in 2015.

Leicestershire Police had established some excellent mental health services, working with the NHS to ensure good responses to detainees' mental health needs. We saw highly innovative police and health care partnerships, including combined police and health care at street level which prevented mentally ill people going into police custody in the first place. This approach also applied to children. Direct access to NHS beds as places of safety for mentally ill people considerably shortened unnecessary stays in custody.

Other areas of health provision in custody were again very positive. Health care practitioners and mental health workers carried out joint assessments, which avoided duplication of questions for vulnerable people. Clinical records were of a high standard and pertinent to the safety and welfare needs of the detainee. Substance misuse services were also of a good standard, and available from 7am to 10pm. Children were referred or signposted to specialist services.

This focus and momentum toward partnership working was unfortunately lacking in other services for children. Staff told us that there was no local authority secure accommodation for children charged and refused bail, and very limited availability of foster care or similar accommodation for children who could be bailed, but could not go home. However, staff were proactive in ensuring that children were not detained in custody overnight by providing bail options, but in some instances, children had to wait long periods for an appropriate adult to become available, especially at night. We knew of children who were fingerprinted, photographed and had DNA samples required without the presence of an appropriate adult which was not in accordance with the Police and Criminal Evidence Act (PACE).

We found custody staff to be generally polite and courteous but gender imbalance in teams, where sometimes an all-male team was on duty, hindered appropriate care for women and girls in custody.

Risk assessments for detainees arriving into custody were variable. Some were thorough and skilful but others were mechanistic, overlooking basic questions. In some instances, serious risks were taken. For example, we observed some very poor practice where there were inadequate checks for intoxicated detainees and poor handovers, with custody sergeants unaware of individuals on constant supervision or in handcuffs in their care. Use of force in custody was not recorded separately, so there was no analysis which hindered accountability.

There was no evidence that custody specific refresher training was available for staff to update their skills and knowledge. We were disappointed there was no auditing, monitoring and learning from serious or adverse incidents for the organisation or individuals which might help and improve practice. The current definition for adverse incidents did not comply with the Association of Chief Police Officers guidance and College of Policing Authorised Professional Practice.

Alternatives to arrest were available in the form of voluntary attendance, and detention periods were generally kept to a minimum, although more could have been done to progress investigations further, to minimise the length of detention in police custody.

In summary, Leicestershire police had made considerable efforts working with other organisations to provide an excellent mental health and police combined service. It was one of the better services we have seen. Health care was clearly an area of good practice, however, services to children in custody would benefit from the same focus and attention. Areas of weakness requiring improvement included: aspects of risk management, limited accountability in how force was recorded and monitored, and weak arrangements to allow learning from adverse incidents.

We noted that, of the 41 recommendations made in our previous report after our inspection of 24–26 August 2009, 17 recommendations had been achieved, nine had been partially achieved and 15 had not been achieved.

This report provides a number of recommendations to assist the force and the Police and Crime Commissioner to improve provision. We expect our findings to be considered for an action plan to be provided in due course.

Sir Thomas P Winsor
HM Chief Inspector of Constabulary

Martin Lomas
HM Deputy Chief Inspector of Prisons

March 2015

Section 2. Background and key findings

2.1 This report is one in a series relating to inspections of police custody carried out jointly by HM Inspectorates of Prisons and Constabulary. These inspections form part of the joint work programme of the criminal justice inspectorates and contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorates of Prisons and Constabulary are two of several bodies making up the NPM in the UK.

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

2.3 This was the second inspection of Leicestershire police, the first being in August 2009. There had been considerable changes to policing since the previous inspection. Leicestershire now had three full-time custody suites and one stand-by suite, comprising 79 cells in total. The designated custody suites and cell capacity of each was as follows:

Custody suite	**No. of cells**
Beaumont Leys	14 cells
Euston Street	36 cells
Keyham Lane	17 cells
Wigston (stand-by suite)	12 cells

Strategy

2.4 There was a clear senior line-management structure. The assistant chief constable (ACC) was the strategic lead on custody issues and custody was centralised as part of the Delivering Justice Directorate (DJD). There were no immediate or medium-term custody estate plans.

2.5 Staffing was not always sufficient to meet the needs of all detainees and there were some significant delays in booking-in detainees (see paragraph 2.13). Dedicated resource planners were responsible for providing cover in absences by moving staff around, and a pool of custody-trained response and neighbourhood sergeants were also available. Custody sergeants told us that they were empowered to decline further detainees when the

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

custody suite had reached capacity, determined by numbers of detainees and identified risks.

2.6 There was a strategic partnership board but it was not geared to specific criminal justice issues. The ACC was the co-author for a proposal to establish a forum to address these concerns. There was a programme board for liaison and diversion of mental health patients through the street triage service, which was working effectively.

2.7 The Police and Crime Commissioner (PCC) was responsible for the provision and coordination of independent custody visitors (ICVs). The ICVs reported a good relationship with custody staff and had prompt access to custody suites, and there was consistent police representation at ICV team meetings. A good regime for induction and refresher training was offered to ICVs.

2.8 Training and quality assurance were areas of weakness. There was no current plan for refresher training. Quality assurance processes, including auditing, monitoring and learning from serious or adverse incidents, were not evident. The force used the health and safety definition for adverse incidents which was not compliant with the Association of Chief Police Officers (ACPO) guidance and the College of Policing Authorised Professional Practice. These had negative implications for the safety and welfare of staff and detainees alike.

Treatment and conditions

2.9 Staff were polite and courteous to detainees and an adequate standard of care was provided. However, many detainees were kept in holding cells for excessively long periods. Arresting officers often took up to 20 minutes to input information onto a computerised form, some of which was then re-entered by the custody sergeants.

2.10 Provision for privacy was poor, particularly in relation to the booking-in of people with vulnerabilities and sensitive disclosures. Most teams we saw were all male and in one case a female detainee who needed to go to the toilet had to wait 45 minutes before she could be escorted by a female member of staff. Detention officers (DOs) knew to ask transgender detainees about their preferences in relation to being searched by a male or female officer. Facilities for those with disabilities were variable but limited overall. There was no specific provision or policy in the care of children in custody, but we saw a few examples of excellent care.

2.11 The quality of initial risk assessments was mixed across all custody suites; some were thorough and involved de-escalation of difficult situations, but most involved asking questions in a mechanistic manner and staff routinely removed cords from detainees' clothing, regardless of whether there was a good reason to do so. Staff did not ask supplementary questions or probe responses further. Custody sergeants were expected to administer an evidence-based 'PolQuest' mental health screening questionnaire, which was a good initiative but not all used it, which may have led to detainees' mental health needs being overlooked.

2.12 For ongoing risk management, standards of observation were variable, with some good interactions. Our custody record analysis (CRA) and observations showed that rousing checks were not always recorded or carried out. This practice led to unacceptable risks being taken with intoxicated detainees. Some close proximity observations were good but we also saw potentially unsafe practice in the handover of close proximity observations without the sergeant being present.

2.13 There were delays in answering cell call bells because staff on duty were busy, suggesting that there were not enough staff to deal with the demand. Non-custody staff were given keys to collect detainees from cells, to relieve the workload of busy custody staff.

2.14 Shift handovers were mostly unsystematic and poor, and did not include health care practitioners (HCPs). Detention officers and custody sergeants had separate handovers, potentially leading to missed information about risks. In one instance, the incoming sergeant was not briefed about a detainee in a cell who had been handcuffed overnight.

2.15 Pre-release risk assessments (PRRAs) varied greatly in quality; we saw some good PRRAs for vulnerable people, but most were inadequate and often completed with little or no discussion with the detainee. There was little detail about PRRAs on the detention logs, even when vulnerabilities had been identified. Sometimes it was unclear how people got home, especially at night, although we saw arresting officers issuing travel warrants and taking people home. There were leaflets about support agencies available but we did not see them being issued.

2.16 Most detainees were not handcuffed on arrival; if they were, their handcuffs were removed promptly, and we saw several examples of staff de-escalating difficult situations. If force was used in custody, this was recorded on the detention log but a use of force form was not completed, contrary to management expectations, making it difficult to identify trends.

2.17 Most suites were clean and had little graffiti, although Euston Street had some ingrained dirt in the cells and was in need of a deep clean. All suites had showers. Wash facilities were available in only some of the suites. At Beaumont Leys, staff said that they were often too busy to facilitate showers.

2.18 Most mattresses were very thin and there were no pillows. All suites had a good stock of tracksuits, plimsolls and foam slippers, and blankets were provided. A wide range of microwave meals was available, catering for a range of diets. Detainees could have extra meals on request.

2.19 Exercise yards were clean and we saw them being used. All suites had a stock of reading materials but there was nothing available in languages other than English.

Individual rights

2.20 Custody sergeants generally asked arresting officers to provide a full explanation of the circumstances of an arrest before authorising detention. Alternatives to custody were available in the form of voluntary attendance (VA), street bail and fixed penalties. There was no recording of VA and therefore no management information about its use.

2.21 Custody staff were aware of the need to keep detention periods to a minimum. We saw examples of timely progression of cases but some detainees were held in custody too long because their cases were not progressed promptly. Immigration detainees were usually moved on to other detention facilities within a maximum of two days.

2.22 We were told by custody staff that there was no local authority secure accommodation available in Leicestershire for children who could not be bailed. Some staff recalled non-secure accommodation being available in the past; however, from the data supplied, local authorities had not provided accommodation for such cases in the previous 12 months.

2.23 The local authority provided appropriate adults (AAs) for children and young people during working hours on Mondays to Fridays but there were gaps in cover from midnight to 8.30am. The proactive approach of custody staff not to detain children overnight helped to mitigate some consequences of not having an AA service for them. When parents acted as AAs, they were provided with little guidance on their role; there was a guidance leaflet in one suite but it was out of date and staff did not use it.

2.24 We saw vulnerable adults and children being fingerprinted and photographed without an AA being present, which was a breach of PACE.

2.25 Interpreters were available by telephone and in person; staff reported some difficulties in accessing telephone interpreters for some languages but no difficulties with the services provided by the face-to-face interpreting service.

2.26 Most custody staff were able to access rights and entitlements information for detainees in a range of different languages but few were aware of the availability of an easy-read version.

2.27 Solicitors were contacted promptly and detainees were able to have private and early consultations. We saw face-to-face PACE reviews taking place at all the custody suites, although our CRA showed that several of these had taken place far too early.

2.28 Leicester Magistrates' Court did not usually accept detainees after 2.30pm on weekdays and 9am on Saturdays, which was too early and could result in detainees being held in custody overnight for longer than necessary. For detainees travelling to court, additional information in the form of charge sheets, property sheets and medical information was attached to person escort records (PERs) in the form of loose-leaf documentation, which might have become detached and lost (see also paragraph 2.38).

2.29 If a detainee indicated that they wished to make a complaint, they were given the option of either accessing the force website or being issued with an Independent Police Complaints Commission (IPCC) complaints booklet, to make the complaint at a later date. Both options could have had the effect of reducing the number of complaints made, as detainees would be less likely to make a complaint in their own time than while in custody.

Health care

2.30 The contracted health care provider, Medacs, scrutinised professional credentials, and provided induction, mandatory training and financial support for clinical training. Working relationships between custody staff and HCPs were very positive, and HCPs and mental health workers carried out joint assessments.

2.31 Each custody suite had an emergency bag containing essential medical equipment, an automated external defibrillator (AED) and oxygen, usually sited at the custody desk. Drugs for emergency use were securely stored but accessible. The equipment was checked regularly.

2.32 The management of clinical records complied with legal and professional requirements, and the lead nurse sampled records to ensure consistency of quality. The storage of medicines, stock management and disposal of discarded medications were very good, with clear audit trails.

2.33 Detainees were treated respectfully and sensitively. They expressed satisfaction following consultations and custody officers were satisfied with health care practitioners (HCP) contacts. The police made reasonable attempts to collect prescribed medications from detainees' homes.

2.34 Clinical records were of a high standard. HCPs copied pertinent parts of electronic clinical records onto the police custody records system called Niche, and then asked the custody sergeant if explanation was required. Niche clinical entries were good, although some contained too much detail.

2.35 Substance misuse services were good. Two arrest referral workers were present in the custody suites from 7am to 10pm and offered prompt support for adults with drug and alcohol issues. Detainees under the age of 18 were signposted or referred to specialist children's services if indicated.

2.36 All custody staff had received training in mental health awareness as part of their induction but none had received refresher training. The partnership arrangements had produced good outcomes for detainees with mental health needs and those detained under section 136 of the Mental Health Act (1983). [2] Detainees requiring formal assessment under the Mental Health Act were seen by emergency duty teams (EDTs). Custody officers said that EDT responses were reasonable.

2.37 The presence of mental health liaison and diversion workers on site enabled them to provide prompt support. They had access to NHS beds, enabling admission from the custody suites and street triage. This considerably shortened the pathway into care for voluntary patients. These workers attended with the police at street events to provide support to children and adults alike.

2.38 We saw a person escort record (PER) with a mental health assessment record attached to it. This was of some concern as this delivery system for mental health reports was not sufficiently secure.

Main recommendations

2.39 The force should implement quality assurance processes to assess the standards of custody provision, with a greater emphasis on qualitative performance, and ensure positive outcomes for detainees.

2.40 The quality and consistency of initial risk assessments should be improved and regularly monitored as part of the quality assurance process for training, staff development and safe outcomes for detainees.

2.41 Custody sergeants should exercise appropriate supervision over the recording of use of force in custody. Leicestershire Police should collate use of force data from custody and examine them for trends, in accordance with the Association of Chief Police Officers' policy and College of Policing Guidance.

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

2.42 The Police and Crime Commissioner and the Chief Officer Group should engage with the local authorities to instigate an immediate review of the provision of local authority accommodation for children under section 38(6) of PACE (1984). They should monitor performance data to ensure that children are not unnecessarily detained in police cells. Custody staff should only fingerprint and photograph children, and take DNA samples from them, in the presence of an appropriate adult.

Section 3. Strategy

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

Strategic management

3.1 An ACC provided strategic leadership on custody issues, with a centralised custody function delivered through the DJD. There was a chief superintendent, who was the head of the DJD, with a clear line-management structure down to the chief inspector, who was head of custody.

3.2 Since the previous inspection, the estate had reduced from four full-time and two stand-by suites to three full-time and one stand-by suite. There were no immediate or medium-term custody estate plans. Leicestershire Police was part of the four-force East Midlands Criminal Justice Service Collaboration programme, which may yield some longer-term plans on custody provision collaboration.

3.3 Detainees were generally conveyed to the nearest custody facility to their place of arrest. We were told that custody sergeants were empowered to decline further detainees when their custody suite had reached capacity. This was determined on the basis of the risks of the detainees they were managing, and was communicated to the dedicated custody inspectors, referred to as 'PACE' inspectors.

3.4 Staffing in custody suites was not always sufficient to meet demand and contributed to long delays in booking in. Staffing comprised of permanent custody sergeants and detention officers (DOs) employed by Leicestershire Police. Dedicated resource planners were responsible for ensuring that rota absences were covered by moving staff between suites. There was also a dedicated pool of response and neighbourhood sergeants who had received initial custody training to provide cover when needed.

3.5 There were six PACE inspectors, under the line management of the head of custody. They provided 24/7 custody management, including PACE coverage for the custody suites. They line-managed the custody sergeants at their respective custody suites. Custody sergeants had operational line management of DOs, who looked after the care and welfare of detainees; however, DO tasks varied between suites.

3.6 There was an internal meeting structure whereby custody matters were discussed and reviewed. The PCC held the ACC to account for performance at the strategic assurance board meeting, where the ICV report had recently been presented. The head of custody chaired a bimonthly management meeting with the PACE inspectors.

3.7 Monthly performance data were available and discussed at these meetings but there were insufficient qualitative data to provide reassurance to managers and chief officers of the standards of custody provision (see main recommendation 2.39). There was no forum at which custody sergeants and DOs could meet with managers, raise issues and share good practice.

Recommendation

3.8 **Leicestershire police should assure itself that the current staffing model in custody suites allows for safe detention and reduces the time that detainees spend waiting to be booked in.** (Repeated recommendation 3.17)

Housekeeping point

3.9 The force should introduce a forum to enable custody sergeants and DOs formally to meet with managers.

Partnerships

3.10 The strategic partnership board met quarterly and was attended by the chief constable, local authority chief executives and the Chief Crown Prosecutor. The ACC custody lead had recognised the limitations of the current strategic partnership structures and was the co-author of a paper proposing the establishment of a 'local criminal justice board-type' executive group with business area-specific subgroups.

3.11 There was a programme board for liaison and diversion, which included the mental health street triage service. This was a national pilot which included nine other sites and was working effectively, as evidenced by the small number of detainees held in police custody under section 136 of the Mental Health Act 1983 since the beginning of the scheme.

3.12 The PCC was responsible for the provision and coordination of the ICV scheme. There were three ICV teams, coordinated by the head of governance within the PCC's office. It was an active scheme, providing a regular schedule of visits. The ICVs reported a good relationship with custody staff, were admitted to custody suites quickly and were appropriately challenging in holding the force to account for custody provision. We were told by the coordinator that there were no current trends causing concern and that ad hoc issues were dealt with effectively. There was regular and consistent police representation at ICV team meetings, and a good regime for induction and refresher training was offered to ICVs.

Learning and development

3.13 All custody sergeants and DOs had undergone an initial four-week custody-specific training course before undertaking custody duties, but there had been no custody refresher training for the preceding nine months and there was no plan to provide such training.

3.14 There was no corporate structured quality assurance process for dip-sampling custody records; ad hoc sampling took place, with feedback at an individual level. Consequently, the force could not evidence a robust audit trail of organisational learning from such processes, which should also have included person escort records (PERs), cross-referencing to closed-circuit television (CCTV) and sampling of shift handovers (see main recommendation 2.40)

3.15 There was no specific adverse incident process, and custody sergeants were vague about information on near misses and adverse incidents. The force used the health and safety near-miss process, which was not compliant with ACPO guidance and the College of Policing Authorised Professional Practice (APP) guidance. There was no management

information, analysis or audit trail to further improve service delivery in connection with adverse incidents.

3.16 The force intranet site included a link to the IPCC website, which included the 'learning the lessons' bulletins. However, due to the lack of refresher training, there was limited evidence as to how these were communicated to staff; most custody sergeants were aware of them but some did not know how to obtain them and not all recalled seeing them regularly. There was a criminal justice newsletter, but this was not used sufficiently well to provide information on learning and development in custody provision.

3.17 The force did not have a custody policy and we were told that APP was the standard against which custody was being delivered. However, a regional policy for custody had been developed and was waiting to be approved and implemented, and would provide standard operating procedures for staff, which conflicted with what we were told. There appeared to be some confusion about the policies followed by staff to ensure safe treatment of detainees.

Recommendations

3.18 **Custody refresher training should be provided to all staff who work within the custody environment as a matter of course, including topics such as safer custody and child protection.** (Repeated recommendation 3.18)

3.19 **A process for adverse incidents, in line with the College of Policing Authorised Professional Practice (APP) guidance, should be implemented and staff should receive regular information about learning from incidents.**

3.20 **Operating procedures for custody which align with the College of Policing APP guidance, should be developed, published and communicated to staff to ensure safe treatment of detainees.**

Housekeeping point

3.21 The criminal justice newsletter should be used to provide information on learning and development in custody provision.

Section 4. Treatment and conditions

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

Respect

4.1 DOs provided an adequate standard of care for detainees, and all custody staff were professional, friendly and courteous in undertaking their role. However, many detainees were kept in holding cells for excessively long periods, waiting to be booked in; during the inspection, a detainee waited one hour 50 minutes at Euston Street and another waited two hours 27 minutes at Beaumont Leys. Following their arrival in the custody suite, it often took arresting officers 20 minutes to input information onto the computerised 'occurrence form'. The custody sergeant then had to re-enter some of it onto the Niche custody system before booking-in started, which added to the delays. We saw detainees becoming frustrated about long waits in the cramped holding rooms, particularly at Euston Street (see recommendation 3.8).

4.2 The booking-in areas at all suites afforded little privacy. At Euston Street, there was a second booking-in desk that could have been used to provide some privacy when booking in a potentially vulnerable teenager. At Beaumont Leys, the booking-in area was small. We saw a 16-year-old girl being booked in there beside an adult male being charged, who showed interest in the responses she gave to the risk assessment questions. She was subsequently placed in a cell without the officer giving her any reassurance, even though it was her first time in custody. At the same custody suite, we witnessed a delay in arranging for a woman to go to the toilet (she had been in the holding room for 45 minutes) while the all-male staff obtained the assistance of a female officer. However, commendably, the custody sergeant cleared the crowded booking-in area of all staff later, when the woman was reticent about answering health-related questions. We saw all-male teams on duty at the smaller suites on a number of occasions (see section on strategy and recommendation 3.8).

4.3 Girls of 16 or under were not allocated a female officer to care for them. Women were not routinely asked if they might be pregnant and few were offered the opportunity to speak to a female officer.

4.4 There was no specific provision for children, but we saw a few examples of excellent interaction between custody staff and young detainees. At Keyham Lane, the custody sergeant bailed a 14-year-old boy with learning difficulties. When he returned the next day, he was not placed in a cell and both his parents were allowed to be present for his interview, after which he was bailed again.

4.5 There was an adapted toilet for detainees with disabilities at Euston Street but the cells were unsuitable for those with mobility difficulties as all the bed plinths were low. The force told us they recognised this and that adaptation was part of ongoing development. At Keyham Lane, custody staff told us that they had allowed detainees with disabilities to use an adapted toilet outside the suite. Only at Euston Street was there a hearing loop, and no suites had any information in Braille.

4.6 Provision for religious observance was limited. All suites had Bibles, Qur'ans and prayer mats but, with the exception of Keyham Lane, had no reliable means of determining the direction of Mecca. Custody sergeants did not routinely ask detainees about religious observance. At Euston Street, we heard a detainee complaining that she had asked for a Bible on two occasions and this had not been facilitated.

4.7 Images of toilets were obscured on the CCTV monitor, but detainees were not told about this. A cell had been taken out of use at Euston Street because the pixilation of the toilet area on the CCTV image had failed.

4.8 DOs told us that they would always ask a transgender detainee about their preferences in relation to being searched by a male or female officer.

Recommendations

4.9 Booking-in areas should afford privacy to detainees.

4.10 Cells adapted for use by detainees with disabilities should be provided. (Repeated recommendation 4.24)

4.11 Girls aged 16 or under should be in the care of a named female officer at all times.

Housekeeping points

4.12 Female detainees should be asked if they might be pregnant and if they wish to speak to a female officer.

4.13 A hearing loop and information in Braille should be available in all custody suites and staff should know how to access it.

4.14 Staff should ask detainees if they wish to undertake any religious observance while in custody and provide items for religious observance, subject to risk assessment, when requested, including identifying the direction of Mecca.

4.15 Detainees should be told that the toilet area is obscured on the CCTV coverage.

Safety

4.16 We had serious concerns about risk management, from booking-in through to pre-release risk assessments (PRRAs). Custody sergeants told us that their training included the use of the Niche risk assessment questionnaire, but we observed that many did not demonstrate robust risk assessment skills.

4.17 At Euston Street, custody sergeants asked the risk assessment questions in a mechanistic manner, making little effort to explain terms like 'mental illness', ask supplementary questions or probe detainees' responses further. At this suite, custody sergeants were expected to administer an evidence-based 'PolQuest' mental health screening questionnaire to establish the need for a fuller assessment by an HCP. This was a good initiative but not always completed and some sergeants admitted that they had forgotten about it, which may have led to detainees' mental health needs being overlooked. We saw some detainees at this suite disclosing health problems but custody sergeants making little

effort to explore the nature of their recent contact with health services. At all suites, few detainees were asked about any dependants (see main recommendation 2.39).

4.18 Elsewhere, the risk assessment during booking-in was better. We saw an excellent assessment at Beaumont Leys, where a custody sergeant succeeded in gaining the cooperation of a very distressed and non-compliant man with learning difficulties. The detainee refused to get out of the police van. The sergeant talked to him at length in the van, finally leading him gently into the suite. During booking-in, he explained the meaning of complex terms and checked that the detainee understood, immediately arranging assessments for fitness to detain and pre-release planning.

4.19 Custody sergeants looked for risk markers on the police national computer before booking-in. They routinely removed detainees' shoes and cords from their clothing, regardless of their risk assessment.

4.20 Most detainees were made subject to an appropriate level of regular observation, which in most instances was conducted in a timely manner. However, custody sergeants failed to identify, and DOs did not undertake, rousing checks when their need was indicated. Unacceptable risks were taken with intoxicated detainees. At Euston Street on a Saturday night, a highly intoxicated young woman was brought into the suite and struggled to provide coherent responses to questions. In her cell, she appeared to fall asleep immediately, wrapping her blanket around her head. She was not made subject to rousing checks and, despite our prompting, staff made no attempt to move the blanket away from her face. In our CRA, five of the 30 detainee records we examined showed that the detainee had been intoxicated on arrival and detained overnight, yet none of them had been subject to rousing checks.

4.21 At Beaumont Leys, an officer undertaking close proximity observations gave the detainee his full attention and chatted with him. However, with the exception of Keyham Lane, officers undertaking close proximity or constant watch generally handed over without a briefing from the custody sergeant, which was potentially unsafe. There was no field on the Niche system to indicate when constant watch should be accompanied by rousing checks.

4.22 In our CRA, two detainees held at Beaumont Leys had disclosed that they had attempted suicide within the previous six months, yet both had been placed on 60-minute observations. The risk assessments should have reflected the recent self-harm and vulnerability, and required shorter intervals for observations. Across the suites we saw delays in answering cell call bells, sometimes by up to 10 minutes, because the custody sergeant and DO on duty were busy, suggesting that there were not enough staff to deal with the demand. At all the suites, we also saw non-custody staff being handed keys to collect detainees from cells, to relieve the workload of busy custody staff (see also section on strategy and recommendation 3.8).

4.23 Observations were conducted as specified in the care plan but our CRA confirmed that information about revisions was not always described in the detention log, and was not noted in the plan. The CRA also established that, while care plans were generally of a good quality, subsequent entries in the custody records did not specify the initial risks identified or their management.

4.24 All DOs carried anti-ligature knives on their belts. All the cells were monitored by CCTV cameras, which produced clear images. However, the CCTV monitor at Beaumont Leys was difficult to see from the booking-in desk, even though it was sometimes used for observing detainees on constant watch. At Euston Street, the electronic whiteboards in the DOs' area were faulty, often failing to update promptly when new information about detainees was entered by staff at the booking-in desk.

4.25 Handovers between shifts were unsystematic. Detention officers and custody sergeants had separate handovers, and HCPs were not included. We observed some occasions when not all the incoming staff received a handover. At Euston Street, one handover between DOs focused only on information about which detainees had yet to speak to their legal advisers, and there was no discussion about anything else which might have been relevant. Another involved a custody sergeant handover to one of the two incoming custody sergeants, and important information about risk was mentioned to one sergeant but not the other. On a Saturday night, when both sides of the Euston Street suite were open, custody sergeants received a handover only about detainees on their side of the suite, despite having responsibility for all of the detainees at the suite.

4.26 PRRAs varied greatly in quality, but most were inadequate and were often not discussed with the detainee. Custody sergeants told us that if no risks were evident during detainees' time in custody, they did not need to talk to them before completing the PRRA on Niche. At Euston Street on a Saturday night, a detainee who had slashed his stomach only a month previously and had been on constant watch was released with no PRRA. Another detainee suffering from deep-vein thrombosis was asked by a different custody sergeant on release: '*You fit and well? Yes? Good lad*'. At Beaumont Leys, a sergeant asked: '*I booked you in last night and there were no issues and I assume nothing has changed, right*?' At Keyham Lane, a detainee was told in Urdu, via an interpreter: '*Now, you're not going to do anything silly are you*?' There were some good PRRAs conducted with detainees who had obvious vulnerabilities, but these were notable exceptions to the norm. In 10 of our CRA records, detainees had clear vulnerabilities that did not appear to have been addressed on release, including concerns about self-harm; sometimes it was unclear, especially at night, how people got home.

4.27 Most PERs were not well completed. Many contained vague information that would be of limited use to the recipient, including phrases such as '*historic self-harm*'. One recorded that the detainee '*uses diazepam, previously admitted to Bradgate unit*', without stating the nature of the unit, or if the use of diazepam was illicit or prescribed.

4.28 At all suites there were leaflets about support agencies, but these were available only in English and were mostly kept in medical rooms and cupboards, and we did not see them being issued. Many detainees were given travel warrants or a lift home by investigating officers.

Recommendations

4.29 Detainees' shoes and cords should not be routinely removed.

4.30 Intoxicated detainees should be subject to rousing checks, in compliance with the National College of Policing APP guidance, which should be recorded in the detention log.

4.31 All risk assessments, including pre-release risk assessments, should be undertaken with the detainee and be open to review if circumstances change. Observations should be clearly recorded in the detention log, including actions taken after release.

4.32 All custody staff should be involved in the same shift handover and, wherever possible, this should be away from the booking-in area and recorded.

Housekeeping points

4.33 Closed-circuit television monitors should be situated where they can be clearly seen by custody staff.

4.34 Problems with the electronic whiteboard at Euston Street should be corrected.

4.35 Detainees should be offered information on release about support organisations, and it should be available in languages other than English.

Use of force

4.36 Most detainees were not handcuffed on arrival. Those who were had their cuffs removed in the holding rooms or at the booking-in desk. Handcuffing was mostly proportionate, although at Beaumont Leys we saw a compliant shoplifter being handcuffed when collecting his methadone with arresting officers on his way to the custody suite. We saw several examples of custody staff using good interpersonal skills in calming non-compliant detainees.

4.37 At Euston Street, we found that a detainee had been handcuffed in a cell all night. This fact was not communicated to the incoming custody sergeant, who was unaware that the detainee was still handcuffed until a DO asked if the cuffs could be removed. The detainee had also been placed in his cell in leg restraints but there was no record in the detention log of when they had been removed. No use of force form had been completed (see main recommendation 2.41).

4.38 There was little use of strip-searching. Our CRA showed that when it had been used, it had been properly authorised.

4.39 When force was used during arrest, a use of force form was completed by the officer using the force, usually an arresting officer. The forms were electronic and copies were not held at the suites. Custody sergeants told us that if force was used in the suites by custody staff, an entry would be recorded on the detainee's detention log but a use of force form would not be submitted, contrary to management expectations. Information about use of force was not analysed to identify trends (see main recommendation 2.41).

Physical conditions

4.40 Most suites were reasonably clean, although Euston Street had some ingrained dirt in the cells, was in need of a deep clean and had an unpleasant smell that staff attributed to problems with the drains. The toilets there were heavily stained with limescale. There was little graffiti in any of the suites, except on the backs of the detention room doors at Keyham Lane and the holding cell doors at Euston Street.

4.41 Cell checks were conducted daily and the findings were emailed electronically to the custody inspector. There was a record to show that they were completed at each suite, but there were gaps where the outcomes of repairs needed had not been recorded. Staff at Beaumont Leys told us that repairs were often slow, with cells sometimes out of use for several weeks, but elsewhere staff reported no significant delays in maintenance. All suites had access to an independent contractor for clearing up bodily fluids within a few hours. DOs wiped mattresses with a disinfectant spray between uses.

4.42 At Euston Street, two detainees told us that they were cold. DOs provided them with extra blankets but told us that the temperature could not be adjusted.

4.43 There were no records of any fire evacuations, although staff at Keyham Lane told us that these took place. All suites had sufficient handcuffs reserved for evacuation purposes. At Euston Street, the cuffs were kept in a safe and it took staff five minutes to find the key, which was eventually located in a break-glass case nearby.

Recommendations

4.44 All cells should be clean, well maintained, and properly heated and ventilated. Recording of cell checks should be improved, with clear records showing checks undertaken and repairs completed.

4.45 Emergency practice evacuations should take place regularly and be recorded.

Housekeeping point

4.46 The handcuffs reserved for evacuation purposes should be accessible at all times.

Detainee care

4.47 Most mattresses were very thin and there were no pillows. The bed plinths at Euston Street were too narrow and too low; we saw detainees struggling to get comfortable on them and many moved their mattresses onto the floor to gain sufficient space. There was a good stock of safety blankets but at Keyham Lane clean blankets were stored next to used ones, which could result in contamination; there was an infestation of fleas during the inspection, which could have been spread by poor storage of bedding.

4.48 All suites had showers. Those at Euston Street offered excellent privacy, but at Keyham Lane the small shower doors were inadequate, particularly for women. At Beaumont Leys, there were no washbasins and there was no hot water, other than in the showers; this meant that detainees could not shave before court, and staff admitted that they were often too busy to facilitate showers. The facilities at Keyham Lane were excellent and included washbasins, hot water and mirrors. At Euston Street, an immigration detainee who had spent a long time on a lorry asked to take a shower during booking-in one afternoon but had still not been offered one at 9.30am the next day.

4.49 At all suites there was a good stock of tracksuits, plimsolls and foam slippers. Detainees who did not want the cords removed from their clothing were offered paper suits rather than tracksuits, which were reserved for detainees going to court or being released.

4.50 Women were not routinely offered feminine hygiene products, although plenty were available at every suite; this meant that women had to ask for them, which may have inhibited them if there were no female staff on duty.

4.51 A wide range of microwave meals was available, catering for a range of diets, and all were in date, although they were of low calorific value. Detainees were offered extra meals on reasonable request. Tea, coffee and orange squash were available, although the squash was decanted into jugs, with no procedures for ensuring that hygiene standards were met. Porridge or cereal bars were provided for breakfast, which might not have been suitable for diabetics. Microwave ovens and food preparation areas were clean.

4.52 All suites had clean exercise yards, monitored by CCTV, although they could only be accessed by steps, making them unsuitable for use by detainees with disabilities. We were told that, subject to risk assessment, detainees could be left alone in them. However, it was only at Keyham Lane that we saw the exercise yard being used.

4.53 There was a stock of newspapers and magazines at every suite, brought in by staff. However, there was nothing available in languages other than English and we saw few detainees being offered anything to read. At Euston Street, we saw many foreign national detainees being kept in custody for over 24 hours, with nothing to do. Social visits rarely took place but were not precluded.

Recommendations

4.54 **Thicker mattresses should be provided.**

4.55 **Pillows should be provided routinely to all detainees.** (Repeated recommendation 4.35)

4.56 **Bed plinths should be at normal bed height, except in cells designated for detainees who are intoxicated, and should be wide enough to enable detainees to sleep comfortably.**

4.57 **Detainees held overnight and those who require one should be offered a shower and showers should afford sufficient privacy, particularly for female detainees.** (Repeated recommendation 4.38)

4.58 **All female detainees should be offered a hygiene pack.** (Repeated recommendation 4.37)

4.59 **Detainees should be offered suitable reading material at all suites.** (Repeated recommendation 4.41)

Housekeeping points

4.60 Clean blankets should be stored separately to used ones, to avoid contamination.

4.61 Appropriate food and hygiene standards should applied to all food and drinks supplied in the suite.

4.62 All detainees should be offered access to an outside exercise area. (Repeated recommendation 4.39)

Section 5. Individual rights

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

Rights relating to detention

5.1 Custody sergeants generally asked arresting officers to provide a full explanation of the circumstances of, and reasons for, an arrest before authorising detention; they told us that the only times they did not ask for an explanation was when the grounds for arrest were implicit. Sergeants told us that they were confident enough to refuse detention when the circumstances did not merit arrest, and provided us with details of such cases. Alternatives to custody were available in the form of voluntary attendance,[3] street bail[4] and fixed penalty notices. Custody staff were unclear about how often voluntary attendance was used and no data were available on the deployment of this alternative.

5.2 All custody staff were aware of the need to keep detention periods to a minimum, and custody sergeants were clear about their obligations to ensure that cases progressed quickly. We saw examples of timely progression of cases but we also saw detainees being held in custody for too long because their cases were not progressed promptly. One day at Euston Street, we came across three detainees who had already been held for 19 hours, 15 hours and 14 hours, respectively, and were still waiting to be dealt with. Staff told us, and we witnessed, that investigations for many detainees were not progressed by arresting officers but were passed on to the following shift or another department for completion. Our CRA showed that the average detention time in custody was 11 hours 25 minutes, with just 27% of detainees held for less than six hours. This was comparable to data supplied by the force, which showed the average detention time across the three full-time custody suites to be 11 hours 26 minutes.

5.3 Custody staff reported a good relationship with Home Office Immigration Enforcement officers and said that immigration detainees who were to be transferred to immigration removal centres were usually moved on within two days, which was an improvement on the situation at the time of the previous inspection. We saw four immigration detainees being moved on well within this timescale. Data supplied by the force showed that the average time in detention for immigration detainees waiting for transfer after being served with a formal warrant of detention (IS91) was 16 hours 58 minutes.

5.4 Staff assured us that the custody suites were never used as a place of safety for children under section 46 of the Children Act 1989.[5] They also told us that they had never known secure accommodation to be made available by local authorities in a case where a child had been charged and could not be bailed, although some staff recalled non-secure accommodation being made available in the past. It was clear from the data supplied by the

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[3] Voluntary attendance is usually used for lesser offences, and involves suspects attending by appointment at a police station to be interviewed about alleged offences. This avoids the need for an arrest and subsequent detention in police custody.
[4] Street bail under section 4 of the Criminal Justice Act 2003 enables a person arrested for an offence to be released on bail by a police constable on condition that they attend a police station at a later date. One of the benefits of street bail is that an officer can plan post-arrest investigative action and be ready to interview a suspect when bail is answered.
[5] Section 46(1) of the Children Act 1989 empowers a police officer who has reasonable cause to believe that a child would otherwise be likely to suffer significant harm, to remove the child to suitable accommodation and keep him/her there.

police that they had requested either secure or non-secure accommodation, as required by section 38(6) PACE 1984, 53 times in the previous 12 months and the local authority had failed to provide accommodation on every occasion (see main recommendation 2.42).

5.5 Custody staff were not always clear on their responsibilities in relation to AAs when dealing with vulnerable adults or children under 18 years of age. At Euston Street, we saw both a vulnerable adult and a 12-year-old boy being fingerprinted, photographed and having a DNA sample taken without an AA being present, which was a breach of PACE. Custody staff at all the suites told us that this was common practice (see main recommendation 2.42).

5.6 Family or friends were contacted in the first instance to act as an AA; when they were not available, the police used a number of different schemes. The local youth offending teams (YOTs) managed a pool of volunteers, who provided AAs for children and young people between 8.30am and 5pm, Monday to Friday. The YOT also contracted The Appropriate Adult Service (TAAS), a private firm, to provide AAs between 5pm and midnight daily, and for cover at weekends and on Bank Holidays. However, there was no AA cover for children and young people between midnight and 8.30am daily (see main recommendation 2.42). Custody staff's proactive approach not to detain children overnight helped to mitigate some consequences of not having an AA service for children. TAAS was also contracted by the police to provide 24/7 AA coverage for vulnerable adults.

5.7 We saw parents being used on a number of occasions to act as an AA; however, custody sergeants, with the exception of one at Beaumont Leys, provided them with little verbal guidance as to what the role involved. Staff at Euston Street were able to show us a guidance leaflet for AAs, but this was not routinely offered to parents acting in that capacity and it was out of date.

5.8 In our CRA, there were five (17%) children in the sample aged between 13 and 17. They had all had an AA present while being re-read their rights and during interview, if this took place. There was no record of when an AA had been contacted or when they had arrived at the custody suites. In two of these cases, it appeared that the children had had to wait around 10 and 13 hours, respectively, for an AA to attend. In both these instances, the children had arrived into custody in the early hours of the morning but neither had been interviewed until later in the day.

5.9 At all suites, interpreting service posters enabled non-English-speaking detainees to indicate their language. A professional telephone interpreting service was available to assist in the booking-in process and we saw it being used on a number of occasions. The custody suites had a double-handset telephone available at the booking-in desk to aid three-way conversations. However, at Beaumont Leys this telephone had been disconnected in favour of a speaker telephone, which staff said that they preferred to use, even though this afforded less privacy for detainees. Staff told us that the telephone interpreting service was often unable to provide interpreters, depending on the language required, and that this had caused delays for detainees while alternative interpreting sources had been considered. In our CRA, one detainee at Keyham Lane had required a Gujarati interpreter but the telephone interpreting service had been unable to provide one. In this case, a police community support officer who was fluent in this language had been able to assist. Staff told us that a good face-to-face interpreting service was available for interviews.

5.10 During booking in, custody sergeants advised detainees of their three main rights (the right to have someone informed of their arrest, the right to consult a solicitor and access free independent legal advice, and the right to consult the PACE codes of practice), and all detainees were offered a written notice setting out these rights and their entitlements while in custody. At Beaumont Leys, we saw a custody sergeant reading the rights and entitlements notice to a detainee who had vision difficulties. Most staff were aware of how

to access these documents in foreign languages for non-English-speaking detainees but not all were aware of the availability of an easy-read pictorial version, which was available on the Home Office website.

Recommendation

5.11 Leicestershire Police should ensure that there are no unnecessary delays in progressing detainees' cases because of investigations being passed on to other officers.

Housekeeping points

5.12 Leicestershire Police should maintain and monitor data on people dealt with through voluntary attendance at police stations.

5.13 Custody staff should ensure that family or friends acting as appropriate adults (AAs) are issued with a relevant written guide to assist them in carrying out this role.

5.14 Contact and attendance times for AAs should be clearly recorded on custody records for monitoring purposes.

5.15 The double-handset telephone at Beaumont Leys should be reconnected, to afford more privacy for detainees when using telephone interpreting services.

5.16 The force should monitor and record details of all occasions when the telephone interpreting service is unable to provide an interpreter, resulting in unnecessary delays for detainees in custody.

5.17 All custody staff should be made aware of the availability of the rights and entitlements information in an easy-read pictorial format.

Rights relating to PACE

5.18 We saw detainees being told that they could read the PACE codes of practice during the booking-in process, but these were not routinely shown or explained by custody staff. At Euston Street, there were only two copies of PACE code C available, in spite of the large capacity of the suite. The Criminal Defence Service poster informing detainees of their right to free legal advice in 24 languages was not routinely displayed in the custody suites.

5.19 All detainees were offered free legal representation and those who declined were told that they could change their mind at any time. Solicitors were contacted promptly and detainees were able to have private and early consultations. There were sufficient consultation and interview rooms where detainees could speak in private with their legal advisers. Telephone calls could be transferred to a portable handset telephone, enabling detainees to speak to their legal advisers while in their cells, and we saw this taking place at all the custody suites. We saw legal advisers being offered access to their clients' paper custody records but they were not allowed to retain them. Solicitors reported no difficulties in accessing the custody suites.

5.20 Reviews of detainees were undertaken by PACE inspectors, who covered the three custody suites across the force area when they were on duty. We saw face-to-face reviews taking place at all the custody suites; however, in our CRA we found that 13 out of 21

reviews had been conducted far too early, when it would have been difficult to determine if detention in custody was still necessary or the person had changed their mind about refusing some entitlements. We saw a number of detainees being reminded that reviews had taken place while they were asleep, but some were not informed of this, despite markers being placed on the Niche computer system to prompt staff to do so. In our CRA, 13 reviews had taken place while the detainee was asleep and, although custody records indicated that the detainees needed to be informed that a review had taken place, it was clear in only three records that this had taken place. We saw a Polish detainee at Beaumont Leys being reviewed by the PACE inspector, who issued him with a notice of review in his native language; the detainee was subsequently reminded of the details of his review when an interpreter attended a short time later. In our CRA, two detainees in our sample had required the services of an interpreter. In one case, it was noted that the detainee had required a written translation of the review, but it was unclear if this had been supplied. In the other case, the detainee had also received a review but, despite an entry in the log stating that the interpreter could translate the review on their arrival, it was unclear if this had taken place.

5.21 The force had good DNA management processes.

5.22 The area remand court at Leicester Magistrates' Court did not usually accept detainees after 2.30pm on weekdays and 9am on Saturdays, which was too early. As a result, detainees who were not charged until late morning remained in custody overnight. PERs were completed for all detainees travelling to court; however, they were sometimes poorly completed (see also section on treatment and conditions) and were accompanied by extraneous paperwork, such as copies of charge sheets, property sheets and medical information (which on one occasion was stapled to the front of them) (see section on health care), which might have become detached or lost.

Recommendations

5.23 Senior police managers should work with the HM Courts and Tribunals Service to ensure that early closure times do not result in unnecessarily long stays in police custody.

5.24 Leicestershire Police should review the practice of adding extraneous paperwork to PERs.

Housekeeping points

5.25 There should be sufficient copies of the PACE codes of practice in all custody suites, and they should be routinely shown and explained to detainees.

5.26 Posters detailing detainees' right to free legal advice, in a range of languages, should be prominently displayed in all custody suites.

5.27 Reviews in custody should be undertaken as per code C, PACE Act 1984.

Rights relating to treatment

5.28 Custody staff said that if a detainee wished to make a complaint, they would give them the option of either accessing the force website or being issued with an IPCC complaints booklet, which would allow them to make their complaint at a later date. Both of these

options could have reduced the number of complaints made, as detainees would be less likely to make a complaint in their own time than while in custody. During the inspection, at Keyham Lane we saw a detainee being given this choice and opting to submit his complaint online after he was released. He indicated that he had been injured during his arrest and was advised by the custody sergeant to visit his GP if that was the case. He was not offered the opportunity of seeing an HCP while in custody in relation to his complaint. At Beaumont Leys, we heard two detainees indicating that they wished to make a complaint. Neither had their complaint noted but IPCC complaints booklets were placed in their property.

Recommendation

5.29 Custody staff should be reminded that detainees who want to make a complaint about their care and treatment should be able to do so before they leave custody.

Section 6. Health care

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

Governance

6.1 Leicestershire police commissioned the medical services, working closely with NHS England with a view to them managing the commissioning in the near future. The service provider was Medacs, although at the time of the inspection the service was out to tender. HCPs, comprising a doctor and one registered nurse, were available to the police 24 hours a day. Medacs scrutinised the HCPs' professional credentials and provided induction, mandatory training and financial support for clinical training. Clinical supervision was available to HCPs.

6.2 A chief inspector was responsible for monitoring service delivery and there were good arrangements for strategic and operational contract management. Performance data were supplied by Medacs, which the police verified. There had been an average of 700–750 calls to Medacs per month in 2014 to date, resulting in around 620 attendances per month. We saw positive working relationships between custody staff and HCPs, and joint assessments between Medacs, HCPs and mental health workers, which avoided duplicating questions directed at the patient.

6.3 Each site had a medical room. Flooring had recently been installed to clinical standard and new equipment was arriving. Some rooms had natural lighting; all had examination lamps, although the one at Beaumont Leys required modernising. A cleaning schedule was displayed and rooms were clean. No room had a clinical work surface suitable for forensic sampling.

6.4 Infection control auditing took place weekly but some fixtures and fittings did not fully comply with minimum standards. For example, some tap fittings were of the wrong type. Toilets had been removed, which meant that some specimens had to be transported across the custody suite for disposal, introducing the potential for spillage in a public area. At the time of the inspection, the custody suite ventilation system was being treated, as a precaution against Legionella (an infection). Medical rooms were often unlocked when not in use and they were sometimes used for other purposes, with the potential for contamination.

6.5 Each custody suite had an emergency bag containing essential medical equipment, an automated external defibrillator (AED) and oxygen, usually sited at the custody desk. Drugs for emergency use were securely stored but accessible. The equipment was checked regularly. All custody staff underwent resuscitation training, including the use of the AED, although there was no custody specific training (see recommendation 3.18). In May 2014, all Medacs medical equipment had been tested and calibrated to ensure accuracy of measurement.

6.6 The management of clinical records (electronic and pictorial) complied with legal and professional requirements; the lead nurse sampled records to ensure consistency of quality.

6.7 The storage of medicines, stock management and disposal of discarded medications were very good, with clear audit trails. Daily and weekly checks were undertaken by HCPs. We noted a controlled drug counting error at Beaumont Leys which had been reported as a serious incident.

6.8 There were patient group directions (PGDs) in each medical room but a copy of the required signatures was not present. PGDs are written instructions for nurses to provide specified medications without referring to a doctor for an individual prescription, and to provide medication according to patient assessment and need. We were told that signatures were available at Medacs head office, as the list had recently been updated and copies were ready for distribution.

Recommendations

6.9 Clinical rooms and practices should comply with relevant standards of infection control, and contemporary standards for preventing contamination and forensic sampling.

6.10 Medical room doors should be locked when not in use.

Good practice

6.11 *The practice of undertaking joint assessments between Medacs and mental health clinicians avoided duplicating questions directed at the patient and was very efficient.*

Patient care

6.12 In our CRA, 27% of detainees had been seen by an HCP. From April to July 2014, 98% of detainees, against a target of 95%, had been seen within 60 minutes and our CRA showed that the average attendance time had been 49 minutes (ranging from four minutes to one hour 55 minutes), which was good.

6.13 Detainees were treated respectfully and sensitively. They expressed satisfaction following consultations and custody officers were satisfied with HCP contacts.

6.14 There was a comprehensive approach to medical assessment, and evidence-based guidance materials were available on site. Clinical records were of a high standard. HCPs copied pertinent parts of electronic clinical records onto Niche and then asked the custody sergeant if explanation was required. Niche clinical entries were good, although some contained extraneous detail.

6.15 The police made reasonable attempts to collect prescribed medications from detainees' home addresses. In our CRA, 33% of the detainees had been on medication; subject to authentication, this had been continued. Continuation of opiate substitution therapy during police custody, following verification, and also symptomatic relief were available. Detainees were not permitted to smoke, and nicotine replacement therapy was not available in the custody suites.

Recommendation

6.16 **On an individual assessed basis, nicotine replacement should be offered to smokers.** (Repeated recommendation 4.33)

Substance misuse

6.17 In our CRA, 27% of detainees had entered custody under the influence of alcohol, and 10% were said to have been addicted to alcohol or drugs. Two arrest referral workers were present in the custody suites from 7am to 10pm and offered prompt support for adults with drug or alcohol issues. Custody staff referred detainees with mandated treatment requirements. Additionally, drug workers offered services to all detainees, including assessment, harm minimisation advice and appropriate referral to other support services, such as opiate substitution prescribing, and housing and benefits support. Arrest referral workers followed up out-of-hours referrals and offered clean injecting equipment from the custody suites, although this was rare. Detainees under the age of 18 were signposted or referred to specialist children's services if indicated. Detainees and custody staff were complimentary about the substance misuse services available.

Mental health

6.18 Leicester Partnership NHS Trust offered mental health services. In our CRA, 20% of detainees had entered custody with mental health problems and a further 20% with current or previous self-harm or suicide issues. All custody staff had received training in mental health awareness as part of their induction, but none had received refresher training (see recommendation 3.18). Strategic and operational partnership arrangements between the police and the Trust had produced good outcomes for detainees with mental health needs and those detained under section 136 of the Mental Health Act (1983).

6.19 Mental health liaison and diversion staff were present in the custody suites from 7am to 10pm each day; out of hours, the crisis team offered support. They saw detainees on request and also responded to calls made to them for triage; when necessary, they attended street events to provide support and assessment. They engaged with children as well as adults, which we had not seen before, and this was a positive and welcome development. Mental health workers had admission rights to NHS beds and arranged voluntary admissions directly from police custody or street triage. We were not supplied with any performance data; however, custody staff enthused about the mental health services and the effective partnership working that occurred. Detainees we spoke to were very satisfied with the support they had received.

6.20 Of concern, one PER we saw had a mental health assessment document and recommendation from a mental health practitioner stapled to the front of it. The document was not in an envelope and was not marked 'medical in-confidence', and was not marked for the attention of the court. This system for transporting mental health reports was not sufficiently secure.

6.21 Detainees requiring a formal assessment under the Mental Health Act were seen by emergency duty teams (EDTs). Custody officers said that EDT responses were reasonable.

6.22 Custody staff said that section 136 was used appropriately; only 18 detainees under section 136 had entered police custody in the previous year. Although data were unavailable to us, we were told that most such detainees went directly to the Place of Safety Assessment Unit at Glenfield Hospital.

Recommendation

6.23 The system for transporting mental health reports should be robust, safe and secure to ensure privacy and confidentiality of patient records.

Good practice

6.24 *The presence of mental health liaison and diversion workers on site enabled them to provide prompt support, and their access to NHS beds considerably shortened the pathway into care for voluntary patients.*

Section 7. Summary of recommendations and housekeeping points

Main recommendations

7.1 The force should implement quality assurance processes to assess the standards of custody provision, with a greater emphasis on qualitative performance, and ensure positive outcomes for detainees. (2.39)

7.2 The quality and consistency of initial risk assessments should be improved and regularly monitored as part of the quality assurance process for training, staff development and safe outcomes for detainees. (2.40)

7.3 Custody sergeants should exercise appropriate supervision over the recording of use of force in custody. Leicestershire Police should collate use of force data from custody and examine them for trends, in accordance with the Association of Chief Police Officers' policy and College of Policing Guidance. (2.41)

7.4 The Police and Crime Commissioner and the Chief Officer Group should engage with the local authorities to instigate an immediate review of the provision of local authority accommodation for children under section 38(6) of PACE (1984). They should monitor performance data to ensure that children are not unnecessarily detained in police cells. Custody staff should only fingerprint and photograph children, and take DNA samples from them, in the presence of an appropriate adult. (2.42)

Recommendations

Strategy

7.5 Leicestershire Police should assure itself that the current staffing model in custody suites allows for safe detention and reduces the time that detainees spend waiting to be booked in. (3.8)

7.6 Custody refresher training should be provided to all staff who work within the custody environment as a matter of course, including topics such as safer custody and child protection. (3.18, repeated recommendation 3.18)

7.7 A process for adverse incidents, in line with the College of Policing Authorised Professional Practice (APP) guidance, should be implemented and staff should receive regular information about learning from incidents. (3.19)

7.8 Operating procedures for custody which align with the College of Policing APP guidance, should be developed, published and communicated to staff to ensure safe treatment of detainees. (3.20)

Treatment and conditions

7.9 Booking-in areas should afford privacy to detainees. (4.9, repeated recommendation 4.32)

7.10 Cells adapted for use by detainees with disabilities should be provided. (4.10, repeated recommendation 4.24).

7.11 Girls aged 16 or under should be in the care of a named female officer at all times. (4.11)

7.12 Detainees' shoes and cords should not be routinely removed. (4.29)

7.13 Intoxicated detainees should be subject to rousing checks, in compliance with the National College of Policing APP guidance, which should be recorded in the detention log. (4.30)

7.14 All risk assessments, including pre-release risk assessments, should be undertaken with the detainee and be open to review if circumstances change. Observations should be clearly recorded in the detention log, including actions taken after release. (4.31)

7.15 All custody staff should be involved in the same shift handover and, wherever possible, this should be away from the booking-in area and recorded. (4.32)

7.16 All cells should be clean, well maintained, and properly heated and ventilated. Recording of cell checks should be improved, with clear records showing checks undertaken and repairs completed. (4.44)

7.17 Emergency practice evacuations should take place regularly and be recorded. (4.45)

7.18 Thicker mattresses should be provided. (4.54)

7.19 Pillows should be provided routinely to all detainees. (4.55, repeated recommendation 4.35)

7.20 Bed plinths should be at normal bed height, except in cells designated for detainees who are intoxicated, and should be wide enough to enable detainees to sleep comfortably. (4.56)

7.21 Detainees held overnight and those who require one should be offered a shower and showers should afford sufficient privacy, particularly for female detainees. (4.57, repeated recommendation 4.38)

7.22 All female detainees should be offered a hygiene pack. (4.58, repeated recommendation 4.37)

7.23 Detainees should be offered suitable reading material at all suites. (4.59, repeated recommendation 4.41)

Individual rights

7.24 Leicestershire Police should ensure that there are no unnecessary delays in progressing detainees' cases because of investigations being passed on to other officers. (5.11)

7.25 Senior police managers should work with the HM Courts and Tribunals Service to ensure that early closure times do not result in unnecessarily long stays in police custody. (5.23)

7.26 Leicestershire Police should review the practice of adding extraneous paperwork to PERs. (5.24)

7.27 Custody staff should be reminded that detainees who want to make a complaint about their care and treatment should be able to do so before they leave custody. (5.29)

Health care

7.28 Clinical rooms and practices should comply with relevant standards of infection control, and contemporary standards for preventing contamination and forensic sampling. (6.9)

7.29 Medical room doors should be locked when not in use. (6.10)

7.30 On an individual assessed basis, nicotine replacement should be offered to smokers. (6.16, repeated recommendation 4.33)

7.31 The system for transporting mental health reports should be robust, safe and secure to ensure privacy and confidentiality of patient records. (6.23)

Housekeeping points

Strategy

7.32 The force should introduce a forum to enable custody sergeants and DOs formally to meet with managers. (3.9)

7.33 The criminal justice newsletter should be used to provide information on learning and development in custody provision. (3.21)

Treatment and conditions

7.34 Female detainees should be asked if they might be pregnant and if they wish to speak to a female officer. (4.12)

7.35 A hearing loop and information in Braille should be available in all custody suites and staff should know how to access it. (4.13)

7.36 Staff should ask detainees if they wish to undertake any religious observance while in custody and provide items for religious observance, subject to risk assessment, when requested, including identifying the direction of Mecca. (4.14)

7.37 Detainees should be told that the toilet area is obscured on the CCTV coverage. (4.15)

7.38 Closed-circuit television monitors should be situated where they can be clearly seen by custody staff. (4.33)

7.39 Problems with the electronic whiteboard at Euston Street should be corrected. (4.34)

7.40 Detainees should be offered information on release about support organisations, and it should be available in languages other than English. (4.35)

7.41 The handcuffs reserved for evacuation purposes should be accessible at all times (4.46)

7.42 Clean blankets should be stored separately to used ones, to avoid contamination. (4.60)

7.43 Appropriate food and hygiene standards should applied to all food and drinks supplied in the suite. (4.61)

7.44 All detainees should be offered access to an outside exercise area. (4.62, repeated recommendation 4.39)

Individual rights

7.45 Leicestershire Police should maintain and monitor data on people dealt with through voluntary attendance at police stations. (5.12)

7.46 Custody staff should ensure that family or friends acting as appropriate adults (AAs) are issued with a relevant written guide to assist them in carrying out this role. (5.13)

7.47 Contact and attendance times for AAs should be clearly recorded on custody records for monitoring purposes. (5.14)

7.48 The double-handset telephone at Beaumont Leys should be reconnected, to afford more privacy for detainees when using telephone interpreting services. (5.15)

7.49 The force should monitor and record details of all occasions when the telephone interpreting service is unable to provide an interpreter, resulting in unnecessary delays for detainees in custody. (5.16)

7.50 All custody staff should be made aware of the availability of the rights and entitlements information in an easy-read pictorial format. (5.17)

7.51 There should be sufficient copies of the PACE codes of practice in all custody suites, and they should be routinely shown and explained to detainees. (5.25)

7.52 Posters detailing detainees' right to free legal advice, in a range of languages, should be prominently displayed in all custody suites. (5.26)

7.53 Reviews in custody should be undertaken as per code C, PACE Act 1984. (5.27)

Good practice

Health care

7.54 The practice of undertaking joint assessments between Medacs and mental health clinicians avoided duplicating questions directed at the patient and was very efficient. (6.11)

7.55 The presence of mental health liaison and diversion workers on site enabled them to provide prompt support, and their access to NHS beds considerably shortened the pathway into care for voluntary patients. (6.24)

Section 8. Appendices

Appendix I: Inspection team

Maneer Afsar	HMIP team leader
Peter Dunn	HMIP inspector
Vinnett Pearcy	HMIP inspector
Fiona Shearlaw	HMIP inspector
Heather Hurford	HMIC lead inspector
Paul Davies	HMIC associate inspector
Denise Hotham	HMIC staff officer
Vijay Singh	HMIC associate inspector
Paul Tarbuck	HMIP health services inspector
Jan Fooks-Bale	Care Quality Commission inspector
Joe Simmonds	HMIP researcher

Appendix II: Progress on recommendations from the last report

The following is a summary of the main findings from the last report and a list of all the recommendations made. The reference numbers at the end of each recommendation refer to the paragraph location in the previous report. If a recommendation has been repeated in the main report, its new paragraph number is also provided.

Strategy

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

Recommendations

The current staffing model in custody suites should be reviewed to ensure it allows for the care and welfare of detainees to be met. (3.17)
Not achieved (recommendation repeated, 3.8)

Custody refresher training should be provided to all staff who work within the custody environment as a matter of course, including topics such as safer custody and child protection. (3.18)
Not achieved (recommendation repeated, 3.18)

Staff patterns should be reviewed to ensure handovers are factored into all shifts. (3.19)
Not achieved

Treatment and conditions

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

Recommendations

Cells adapted for use by detainees with disabilities should be provided. (4.24)
Not achieved (recommendation repeated, 4.10)

There should be formal policies setting out how staff should deal with juveniles and women held in custody. (4.25)
Partially achieved

Closed-circuit television screens should be located in areas that enable easy monitoring. (4.26)
Partially achieved

All cells should be fit for purpose and free of ligature points. (4.27)
Achieved

Health and safety walk-throughs should take place daily. (4.28)
Achieved

Use of force should be monitored centrally to identify any issues or trends. (4.29)
Not achieved

The reasons for the deployment of incapacitant sprays in custody should be recorded in custody records and centrally. Managers should quality assure such usage and satisfy themselves as to appropriateness, proportionality and any health and safety issues. (4.30)
Not achieved

The physical conditions of suites at Beaumont Leys and Coalville should be clean and in a good state of repair. (4.31)
Achieved

Booking-in desks should not be too high and should afford privacy to detainees. (4.32)
Not achieved

On an individual assessed basis, nicotine replacement should be offered to smokers. (4.33)
Not achieved (recommendation repeated, 6.16)

Mattresses should be cleaned between uses and kept clean. (4.34)
Achieved

Pillows should be provided routinely to all detainees. (4.35)
Not achieved (recommendation repeated, 4.55)

Views of toilets in cells covered by closed-circuit television should be obscured. (4.36)
Achieved

All female detainees should be offered a hygiene pack. (4.37)
Not achieved (recommendation repeated, 4.58)

Detainees held overnight and those who are dirty should be offered a shower and shower areas should afford sufficient privacy, particularly for female detainees. (4.38)
Not achieved (Recommendation repeated, 4.57)

Detainees should be offered access to an outdoor exercise area. (4.39)
Partially achieved (recommendation repeated as a housekeeping point, 4.61)

Detainees held over 24 hours, and young people, should be allowed visits. (4.40)
Partially achieved

Detainees should be offered suitable reading material at all sites. (4.41)
Partially achieved (recommendation repeated, 4.59)

Individual rights

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

Recommendations

Managers should liaise with the UK Border Agency to ensure that immigration detainees are held in police custody for the shortest possible time. (5.15)
Achieved

More posters should be displayed in languages other than English. (5.16)
Partially achieved

Formal pre-release risk management planning should be implemented consistently and any actions taken recorded on NSPIS. (5.17)
Not achieved

Juveniles should be able to receive the services of an appropriate adult when required. (5.18)
Not achieved

Detainees aged 17 years should be provided with an appropriate adult. (5.19)
Achieved

The issues surrounding the lack of quality control systems and processes for taking, storing and submission of DNA and forensic samples should be addressed as an urgent priority, including a referral to the forensic science regulator. (5.20)
Achieved

Detainees' property should be stored securely. (5.21)
Partially achieved

Information about how to make a complaint should be given to all detainees during the booking in process in a format they understand and clearly displayed in the custody suites. (5.22)
Partially achieved

Detainees should be able to make a formal complaint about treatment during arrest or detention while still in custody and all such complaints should be promptly and fully investigated. (5.23)
Not achieved

The number and nature of complaints with a racial element should be monitored by managers and any trends identified acted on. (5.24)
Not achieved

Health care

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

Recommendations

The police should monitor all healthcare contracts to ensure response times and performance indicators are met. (6.37)
Achieved

FMEs and other healthcare professionals should receive ongoing training, supervision and support to maintain their professional registration and development. (6.38)
Achieved

All health services staff should be encouraged to engage in clinical supervision. (6.39)
Achieved

The clinical (medical examination) rooms should be clinically clean, appropriately equipped and fit for purpose at all times. (6.40)
Partially achieved

All medications on site should be stored safely and securely. (6.41)
Achieved

Safe and effective medicines management should be supported by appropriate access to reference information by healthcare staff. (6.42)
Achieved

All equipment, including resuscitation kit, should be ready for use and regularly checked and maintained and all staff (healthcare and custody staff) should understand how to access and use it effectively. (6.43)
Achieved

Female detainees should be able to see a female doctor on request. (6.44)
Achieved

Clinical record systems should be consistent in terms of accessibility, scope and quality and kept confidential at all times. (6.45)
Achieved

Arrangements for detainees with mental health problems should be reviewed and the police should have robust arrangements that are known and agreed by all parties involved, including services for juveniles. (6.46)
Achieved