Report on an unannounced inspection visit to police custody suites in

# Hertfordshire

by HM Inspectorate of Prisons
and HM Inspectorate of Constabulary

**18–22 May 2015**

**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.

This is the second inspection of Hertfordshire Constabulary, following on from the first on 26–28 January 2009. Broadly the same criteria were used in this inspection and we found some areas had achieved significant success while others had declined.

We found that while there was a strong strategic direction for the future, there were gaps in the current management of custody. Custody was a centralised function within the criminal justice portfolio with a single management structure. Despite this alignment of staff and structure there was insufficient oversight in custody, such as monitoring use of force and supervision of adequate provision of health care. We also found weaknesses in monitoring staff performance and quality checks to ensure Hertfordshire Constabulary was providing a consistent and effective service to detainees in custody.

There were some significant successes; it was commendable that in working with health care partners Hertfordshire Constabulary had avoided using police cells as a place of safety under the Mental Health Act (1983) for a period of three years.

We observed treatment of detainees to be professional and polite and the general physical conditions of the custody suites were good. Detention officers undertook the booking-in of detainees, risk assessments and set levels of observations to ensure the safety of detainees. Custody sergeants, who were ultimately responsible however, did not always supervise or monitor the booking-in process.

Provision for children in detention was generally poor. The force did not collect data on the number of times it had requested accommodation from the local authority for children who had been charged and not bailed. Some children could be placed in safe accommodation with extended family or foster care, but were not. We were not assured that all staff understood the different requirements for secure accommodation or when alternative safe accommodation would be appropriate. Children's needs when booked in were not always distinguished from those of adults.

Detainees were sometimes placed in anti-rip clothing as a standard response when they did not cooperate with the risk assessment process or were too drunk to comply. In some cases anti-rip clothing was used as an unsafe and inadequate alternative for vulnerable detainees, who would otherwise benefit from close proximity observation. While staff handovers between shifts were well conducted, relevant and focused, pre-release risk assessments of detainees were often poor, although we did also see some better practice.

The recording, monitoring and analysis of use of force, and of strip-searching, was a concern. We knew of occasions when force had been used, but found no record of this. Hertfordshire Constabulary needs to reassure itself that all use of force in custody was and is reasonable, proportionate and lawful.

Detainees' individual rights were supported, and custody sergeants were confident in refusing detention where appropriate. The police used alternatives to arrest and detention, such as voluntary attendance, street bail and fixed penalty notices, which was positive. The appropriate adult service for vulnerable adults and children was good, but relied on a few volunteers and did not operate during the night, causing unnecessary delays for some of the most vulnerable detainees.

It was good to see dedicated officers were employed to support the introduction of video courts at Watford, Stevenage and Hoddesdon. Despite these facilities being available, staff still reported some difficulties in getting the remand court to accept detainees later than 1 or 2pm, leading to unnecessary and prolonged detention.

Health provision was fragmented with significant staff vacancies which caused delays. Hertfordshire Constabulary was not managing this service effectively or adequately. In some cases, the force was unaware of very long delays in health care practitioners seeing detainees - the longest we encountered was 12 hours. Despite the commitment and competence of individual nurses and health care practitioners, who were often covering for vacancies, the overall outcome was ineffective health care causing additional risks for detainees and custody staff.

Mental health services were provided by the Criminal Justice Mental Health Team, part of the Hertfordshire Partnership University NHS Foundation Trust. They provided support to custody staff as well as acting as a liaison and diversion scheme for courts. Staff screened detainees, identifying those for further referral to the approved mental health practitioner (AMHP) for formal assessment under the Mental Health Act. However, a shortage of AMHPs and problems with access to specialist mental health units for patients meant that vulnerable people in mental health crisis remained in police custody for longer than necessary.

We noted that of the 46 recommendations made after our inspection of January 2009, 25 had been achieved, 12 had been partially achieved, five had not been achieved and four was no longer relevant.

Hertfordshire Constabulary has had some significant successes: effective work with partners has meant that police cells have not been used as a place of safety under the mental health act; the appropriate adult service for children and vulnerable adults was good, although it needed to be more available at night; and good use was made of video court facilities in some suites. Interactions between individual staff and detainees were good. Good use of alternatives to detention were made when appropriate. Other areas needed greater management oversight and monitoring. Alternatives to detention for children were not sufficiently pursued, use of force and anti-rip clothing were not adequately managed and the management of the health service was weak. We hope this report will assist in making the further improvement necessary.

**Sir Thomas P Winsor**
HM Chief Inspector of Constabulary

**Nick Hardwick**
HM Chief Inspector of Prisons

August 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's *Authorised Professional Practice - Detention and Custody* at force-wide strategies, treatment and conditions, individual rights and health care. They are also informed by a set of *Expectations for Police Custody*[1] about the appropriate treatment of detainees and conditions of detention, developed by the two inspectorates to assist best custodial practice.

**2.3** A documentary analysis of custody records is conducted as part of all police custody inspections. The analysis provides case examples illustrating the level of care detainees receive, the quality of risk assessments and care arrangements, and access to services such as healthcare and legal advice.

**2.4** Records are randomly selected from approximately four weeks prior to the inspection and the sample contains a minimum of five young people (aged 17 years and under). The number of records sampled from each custody suite is proportional to throughput at those suites, i.e. more records are sampled at suites with a higher throughput and fewer from suites with a lower throughput. Where this information is unavailable, proportional sampling is based on the number of cells in each suite. Due to the small sample size, samples are not representative of the wider detention throughput. As part of this inspection a total of 30 records were sampled.

**2.5** This was the second inspection of Hertfordshire Constabulary, following up our inspection of January 2009. In the previous inspection, custody was a devolved function. There had been some improvements since the previous inspection, but also some aspects had deteriorated. The designated custody suites and cell capacity of each was as follows:

| Custody suites | Cells |
|---|---|
| Hatfield | 30 |
| Hoddesdon | 16 |
| Stevenage | 24 |
| Watford | 16 |

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

## Strategy

**2.6** There was a clear management structure up to assistant chief constable (ACC) level in Hertfordshire Constabulary. Custody was a central function within the criminal justice portfolio. However, management information was poor and performance management needed significant development.

**2.7** Hertfordshire Constabulary had four custody facilities across the force area. We observed only one sergeant at each facility most of the time. There was no capacity for breaks and little flexibility in the event of sickness or other absence at short notice. In addition, the custody suites operated below capacity for detention officers (DO) which affected timely responses to cell call bells and detainee care, especially at Watford. At busy times we also observed operational officers, rather than custody trained officers, taking keys to alleviate the demands on custody staff, which was inappropriate.

**2.8** The force operated a 25-year-old computer system, supplemented by handwritten records, and this was due to be replaced in early 2016. In addition, the completion of documentation in the custody department ranged from good to poor.

**2.9** We were concerned at the frequency of strip searches of detainees, particularly as incidents where force was used were not monitored.

**2.10** There were inadequate arrangements for monitoring shortfalls in partner organisations and commissioned services. Performance and management data was weak and did not provide the opportunity to hold partners to account, especially local authorities and the health care provider. We had considerable concerns about the health care provider - there was no robust monitoring or analysis of the performance data it submitted to assess safe and timely outcomes for ill or vulnerable detainees.

**2.11** Hertfordshire Constabulary had achieved significant success in positive outcomes for people subject to section 136 of the Mental Health Act,[2] who had not been brought into police custody as a place of safety for three years.

**2.12** Children who were charged and had bail refused were almost exclusively held in custody after charge due to a lack of alternative accommodation The force did not collect data on the allocation of local authority secure beds for children who had been charged and could not be bailed, which would have allowed meaningful dialogue when dealing with local authorities.

**2.13** The independent custody visitor (ICV) scheme was under review. Several new volunteers were due to be in place by September 2015 who would more closely reflect the diversity of the population. The force supported the scheme and provided training for visitors. On average each custody suite received one visit a week from an ICV.

**2.14** There was an initial and refresher training programme for all custody staff. The force disseminated learning from its sampling of case records and other management processes. However, the process of sampling was inadequate, and not enough cases were sampled and cross-referenced with evidence.

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

**2.15** The force produced *Custody Matters*, a newsletter that identified learning opportunities and provided feedback on incidents in the force and nationally.

## Treatment and conditions

**2.16** Custody staff were polite and considerate in their interactions with detainees, but did not explore their diverse needs sufficiently. Staff did not always ask detainees if they had, or were, carers or had any religious or dietary needs and, too often, women detainees were not given the option to speak to a female member of staff. We observed there were mostly only male custody staff on shift, although female colleagues could be requested to attend to respond to the welfare needs of women detainees.

**2.17** The care and support offered to detained children was similar to that offered to adults. Staff did use age-appropriate language and children assessed as low risk were usually placed on no less than 30-minute observations. Children were given no additional care acknowledging their vulnerability.

**2.18** Custody suites were well equipped with religious materials and books for detainees who wished to make use of them.

**2.19** Not all custody suites had sufficient holding rooms for detainees waiting to be booked in to custody, at Hoddesdon the holding space was an uncovered caged area, and in Hatfield we saw people waiting outside in police vehicles for nearly 30 minutes.

**2.20** The force had a basic electronic risk assessment tool. There were significant variations in the assessments; some included good supplementary questioning, while others took a mechanistic approach that did not address the specific needs of the detainee. Some detainees were not asked if it was their first time in custody.

**2.21** Detention officers were not always adequately supervised during the risk assessment process or while devising the care plan. Too often custody sergeants were briefed about the risk assessment and level of observations applied after the detainee was located in the cell, even though, primarily, this was the sergeants' responsibility. We found inconsistent practices where differing levels of observations were applied to similar cases and we also found that staff did not always comply with levels that were set.

**2.22** We observed several detainees who were placed in anti-rip clothing with little rationale provided; their clothing was not always returned after their level of risk had been reduced. Anti-rip clothing was often used inappropriately as a standard response when there was a perceived risk of self-harm, and sometimes as an unsafe and inadequate alternative to close proximity observation. The automatic removal of detainees' corded clothing and footwear without assessment was disproportionate.

**2.23** Management and control of cell keys in most suites was sometimes chaotic during busy times. Operational officers, rather than trained detention staff, had access to keys and collected detainees, which was inappropriate.

**2.24** The staff shift handovers we observed were generally well conducted, providing relevant information focused on risk and case progression, with case and detainee details completed for each handover.

**2.25** Despite a few examples of good pre-release risk assessments, they were often poor, and custody staff did not consistently assess the needs of detainees on their release. Detainees were given a support leaflet without explanation. Stevenage had piloted a pre-release risk

assessment form that required custody staff to assess the detainees' needs throughout their detention and in discussion with them, which was appropriate.

**2.26** The recording, monitoring and analysis of use of force was a concern. Although force was used, a lack of records meant we were unable to say how frequently this occurred. We identified several occasion when it had been used but no use of forms had been submitted. Oversight and governance of the use of force were inadequate. We were not assured that force was monitored and that officers were held accountable for its use or that managers were aware of its use in the custody suites. Authorisation of strip searches was not always recorded and in some instances they were conducted in the absence of a robust risk assessment.

**2.27** The cleanliness and general maintenance of the custody suites was good, except at Watford where there was graffiti. There was a clear process for cleaning and checking cells. Mattresses and pillows were provided for detainees but not always cleaned between uses - in Watford we saw staff cleaning the mattress with the floor mop. Clean blankets were generally provided but toilet paper and handwashing facilities were mostly provided on request.

**2.28** Cell bells were mostly answered promptly, except in Watford where there were not enough staff to undertake all duties; this could affect the safety and welfare of detainees in an emergency.

**2.29** A range of reading materials was available, some in foreign languages, but there were no books for children. Detainees could use the exercise yard in some suites, which was positive. However, custody staff at Watford told us it was unlikely that detainees would go out to use the exercise yard as they did not have time to supervise them.

## Individual rights

**2.30** Custody sergeants reported that operational officers did not always have a good understanding of PACE code G – 'the necessity for arrest'. We observed custody being refused on several occasions, with a custody record opened and endorsed with the grounds for refusal.

**2.31** Periods in detention had reduced for some groups of detainees. The average length of detention for immigration detainees had fallen from 25.48 hours in 2013-14 to 21 hours in 2014-15. Voluntary attendance was well used as an alternative to custody, and its use had doubled between 2013-14 and 2014-15.

**2.32** Custody staff at all the suites said there was a good service from Hertfordshire Appropriate Adult Scheme (HAAS). However, this service did not operate between 11pm and 8am, and there was heavy reliance on a very few volunteers, potentially prolonging custody for vulnerable detainees.

**2.33** Custody staff said they had never known the local authority to provide appropriate accommodation for children who had been charged and could not be bailed. We were not assured that all staff understood the different requirements for 'secure' and 'safe' accommodation, and staff told us they would only request secure accommodation in the event that bail was refused after charge. In the previous 12 months, 35 children had been charged and held overnight in police custody cells.

**2.34** Rights and entitlements leaflets were available but were not always offered to detainees, and staff varied in how they explained rights to a detainee.

**2.35** PACE codes of practice were not routinely offered to detainees, and staff did not ask or note on the custody record the reasons for detainees declining the services of a legal adviser. Detainees had access to private telephone consultations with solicitors in all the custody suites, and solicitors reported good relations with custody staff. The lack of signage at Watford on the use of CCTV in the suite went unnoticed until the inspection team pointed this out. It was then rectified that day.

**2.36** There were 'virtual' (video-enabled) courts at Watford, Stevenage and Hoddesdon, operated by dedicated court officers. Despite these facilities, custody staff still reported difficulties in getting detainees accepted by the remand court later than 1pm or 2pm, although there was some flexibility on occasions.

**2.37** There were variations in the force's approach to detainee complaints. Mostly detainees were advised to submit a complaint after they left the custody suite.

## Health care

**2.38** The health care provided to detainees was fragmented, operating with significant vacancies and delays, although when a practitioner was available, the quality of patient care was generally good. There was clear evidence that detainees were not always seen promptly, which presented a significant risk to their safety and welfare.

**2.39** Custody staff also reported major health staffing problems, and leadership of the G4S team, which provided physical health services, was weak. Health care performance was considered at quarterly meetings chaired by the police, but G4S did not attend and so clinical performance was not effectively reviewed.

**2.40** Substance misuse services were effective, and the community-based substance misuse team offered good support to detainees with drug or alcohol problems. Team members were available in the suites and responded to need when alerted by custody staff or other health professionals.

**2.41** Police custody suites had not been used as a place of safety under the Mental Health Act for three years, which was positive. However, there were significant delays in in-custody Mental Health Act assessments for detainees who displayed erratic behaviour after arrest. The in-custody mental health support was provided from the Hertfordshire Partnership NHS Foundation Trust, although very limited at evenings and weekends, leading to prolonged detention of very vulnerable patients.

**2.42** A shortage of approved mental health practitioners had led to delays in accessing mental health assessments and obtaining a bed when need was identified. Transport by ambulance also created delays, as a result, detainees were held in police custody when they needed specialist inpatient mental health care.

## Main recommendations

**2.43** **There should be sufficient staff in custody suites at all times to ensure the safety and well-being of detainees.**

**2.44** **Hertfordshire Constabulary should collect and analyse management information, including quality assurance processes, to ensure robust assessment of standards of custody provision.**

**2.45 Hertfordshire Constabulary should reassure itself that use of force is in accordance with the College of Policing guidance and ensure it records and monitors use of force data to establish trends, training needs and staff accountability.**

**2.46 The Force should engage with their counterparts in the local authority, instigate an immediate review of the provision of local authority accommodation for children under section 38(6) PACE 1984, and monitor performance data to ensure that children are not detained unnecessarily in police cells.**

# 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 assistant chief constable (ACC) was the strategic lead for custody in Hertfordshire Constabulary. Custody was a centralised function that was part of the criminal justice portfolio, and there was a clear management structure.

**3.2** There were four custody facilities – at Watford, Hoddesdon, Hatfield and Stevenage – with sufficient cell capacity and no immediate plans to change the custody estate.

**3.3** Staffing levels at some of the suites were inadequate. Most suites operated with only one sergeant, which did not allow for any breaks in the working day or short notice absence, such as sickness. There had been a longstanding shortage of detention officers (DOs) across the force, although recent recruitment meant that only two of the 55 posts were currently vacant, with plans to fill these positions. However, the lack of DOs during the inspection affected detainee care, especially at busier times in Watford (see section on detainee care and main recommendation 2.42).

**3.4** The custody computer system was nearly 25 years old and due to be replaced in early 2016. The current system allowed computer recording on the initial reception, authorisation of detention process and risk assessment, but many further decisions about detention and treatment were recorded on a handwritten log. This caused difficulty when searching for information about a specific detainee or on force trends. There was also a risk that papers were not completed, as there was often no computerised prompt, or that they became detached from the main detention log.

**3.5** There were five custody inspectors for the force. Each was aligned to a shift pattern and regularly worked alongside the same custody sergeant and detention officer colleagues across the four custody suites. Two additional inspectors in the department had a policy and support role. The departmental structure allowed for regular custody inspectors meetings with the chief inspector, although there had been none since November 2014.

**3.6** The ACC chaired an operational support group meeting that involved all relevant departmental heads, although the minutes showed that while staffing and recruitment in custody had been raised, some other pressing issues had not been highlighted and dealt with (see section below on partnerships).

**3.7** There was an inconsistent approach to the completion of documents on the use of force, risk assessments and PRRA, ranging from good to poor. Management information was poor and performance management needed significant development (see main recommendation 2.44).

**3.8** Governance of the use of force was poor. We found some cases where force had been used but the required documentation was not completed. Hertfordshire Constabulary could not, therefore, monitor use of force and provide reassurance that it was used proportionately, reasonably and lawfully in all cases (see main recommendation 2.46).

**3.9** There had been 239 strip searches of detainees between October 2014 and March 2015. The force could not provide data fully to satisfy itself of the proportionality and legitimacy of these searches (see paragraph 4.27).

## Recommendation

**3.10 The force should ensure that use of force forms are completed correctly when detainees are subjected to force while in custody.**

## Partnerships

**3.11** Arrangements for monitoring shortfalls in partner organisations and commissioned health services from G4S were inadequate, and were not strong enough to monitor, evidence and challenge the delivery of services, especially by local authorities and the health care provider. We had considerable concerns about the health care provider, and there was no robust monitoring or analysis of submitted data to confirm safe and timely outcomes for detainees. The current system for reporting and tracking concerns about the health care provider's targets and attendance was not effective in providing management information needed to ensure positive outcomes for vulnerable or ill detainees.

**3.12** Hertfordshire Constabulary had worked well with partners to ensure police custody had not been used as a place of safety under section 136 of the Mental Health Act 1983[3] in the last three years; this was a significant achievement.

**3.13** There were few regular partnership meetings at strategic level that discussed custody issues. The ACC chaired the Local Criminal Justice Equalities Board but this forum did not focus on custody matters.

**3.14** There had been 35 occasions in the last 12 months when children were held in police custody overnight after they had been charged and had bail refused. The force had no record of how many requests had been made to the local authority to provide secure or safe beds, and custody staff believed that the local authority did not provide such accommodation. The force did not have data to allow meaningful dialogue with the local authority about the allocation of beds for children after they were charged.

**3.15** The independent custody visitor (ICV) scheme was being revitalised through the office of the Police and Crime Commissioner. Some longstanding volunteers had left the scheme and were being replaced by volunteers who would more closely reflect the population of the force area. The force provided strong partnership support to this scheme and assisted with training and attending meetings. On average, ICVs visited each custody facility once a week.

## Recommendation

**3.16 There should be an effective partnership arrangement that enables robust monitoring of the quality and performance of health providers to ensure safe and timely outcomes for ill or vulnerable detainees.**

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

## Learning and development

**3.17** There was a comprehensive initial training programme for custody staff, including work-based assessment for detention officers. The initial training programme covered policy, procedure and practice, including the management of strip searches, drugs awareness, vulnerability and risk assessment. The force's five-week rotational shift pattern also allowed each member of staff to attend a training day every five weeks that was relevant to their role in custody, which was good. The force disseminated learning from custody record samples and other management processes, but the process of sampling were inadequate.

**3.18** Custody inspectors sampled 15 custody records each month from all teams, not just the team they managed. Staff were offered feedback individually when required, and there was thematic feedback through a *Custody Matters* newsletter. Technological problems prevented sampling to be completed alongside viewing the audiovisual record of the detainee in some cell blocks , which had not yet been introduced. The force corporate service department also audited some records. However, too few records were reviewed, and the reviews were not sufficiently detailed. Quality assurance would also have been improved through the inspector or audit team viewing the audio and visual record of the booking-in process as well as 'real time' observations of practice at the custody suites. (See main recommendation 2.44.)

**3.19** The *Custody Matters* newsletter contained national themes for learning from the Independent Police Complaints Commission (IPCC), as well as issues identified from the custody record samples and audits.

## Recommendation

**3.20** **The sampling of custody records should effectively cross-reference the audiovisual record with the written detention log.**

# 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** Staff treated detainees courteously, and detainees told us that they were well treated by staff at the custody suites.

**4.2** At times custody staff were too focused on processing detainees into custody and did not pay sufficient attention to the individual needs of some, or address diverse needs. For example, they did not always ask detainees if they were – or had – carers or had any religious or dietary needs. Too often, women detainees were not given the option to speak to a female member of staff. We mostly observed only male custody staff on shift, although there were arrangements to request attendance from female colleagues to respond to the welfare needs of women detainees.

**4.3** Custody sergeants and detention officers (DOs) were courteous and mostly patient in dealing with detainees, but some booking-in areas were noisy, particularly at Watford and Hatfield, and, despite screening, had insufficient privacy. At Hatfield we observed a sergeant authorising a detainee's detention in the holding room in front of another detainee. By contrast, some detention officers attempted to lower their voice when speaking to the detainees to offer some confidentiality.

**4.4** The care and support offered to children was similar to that given to adults. Staff did use age-appropriate language and children assessed as low risk were usually placed on no less than 30-minute observations. Beyond these interventions, children were given no additional care acknowledging their vulnerability. This gap was further compounded by the lack of an appropriate adult scheme after11pm and no alternative accommodation to prevent children being held in police detention overnight (see section on individual rights).

**4.5** Girls were not routinely allocated a female officer responsible for their care. At Watford a very vulnerable 16-year-old girl was held overnight with no evidence that she had been allocated a female officer, and an appropriate adult was not available until almost 14 hours after her detention commenced (see paragraph 5.10). She was given food, drinks and reading materials but no further consideration of her age-appropriate needs or support.

**4.6** Custody suites were well equipped with religious books, prayer mats and compasses for the direction of Mecca. There were thick mattresses at sites with very low bed plinths (Stevenage and Hatfield) and all suites had a wheelchair available. Hatfield and Stevenage were regarded as the most suitable custody suites for detainees with physical disabilities. We did observe good care for an older detainee at Hatfield who was permitted to have a chair in her cell. All suites had a portable hearing loop.

## Recommendations

**4.7** **Custody staff should ask all detainees if they have any dependency obligations and help to address these.**

**4.8 Custody staff should have a clearer focus on the needs of detainees, particularly women, children and those with disabilities.**

**4.9 Girls under 16 should be allocated a named female officer who is responsible for their care while in custody.**

## Safety

**4.10** Not all custody suites had sufficient holding rooms for detainees waiting to be booked in, and the holding space at Hoddesdon was a caged area open to the elements, which was inadequate. On a busy day at Hatfield, detainees had to wait outside in police vehicles for nearly 30 minutes, which was inappropriate, although in the case of one detainee the custody sergeant went outside to determine if there were any risk issues, allowing the detainee to be prioritised if needed.

**4.11** There had been a positive focus on raising awareness of and responding to vulnerable detainees across the force, through training and the display of notices in all the suites. Despite this, initial risk assessments were of varying quality. The electronic risk assessment form contained basic questions, and a guidance sheet encouraged staff to explore issues further but was referred to infrequently. Some risk assessments were very good and staff explored emerging issues but too many were process driven, and some failed to identify risks and take action to address them. There was little focus on detainees in custody for the first time; one who we spoke to at Watford was scared and anxious and did not know what to expect, but had been given no specific support.

**4.12** Detention officers at most suites completed the booking-in process but were not adequately supervised when conducting the risk assessment and devising the care plan. It was usually some time after the detainee was located in their cell that the custody sergeant was then briefed about the assessment and the level of observations set. We were not assured that all sergeants were active enough in authorising levels of observation, and they too often deferred to the detention officers when this was ultimately their responsibility.

**4.13** We were assured that staff took account of other sources of information during the risk assessment process, such as warning markers on the police national computer (PNC) and local intelligence systems. However, we were not satisfied that levels of observation were always set correctly to manage the risks. In our custody record analysis of 30 people detained between 16 and 20 April 2015, one individual had attempted self-harm by hitting his head on the custody desk, and had PNC markers for self-harm. He was placed on 60-minute observations, which were inappropriate as he should have been on at least 30-minute observations initially, particularly as his risk assessment also noted several mental health problems alongside self-harm.

**4.14** Risk management plans were reviewed regularly, based on ongoing assessments, and changed appropriately, particularly for detainees who arrived intoxicated. Sometimes levels of observation were not adhered to. For example, a 14-year-old boy detained at Hoddesdon overnight was placed on 30-minute observations but we found as long as 55 minutes between recorded observations, which was unacceptable. The routine removal of detainees' clothes with cords and their footwear was unnecessarily risk-averse.

**4.15** There was too much use of anti-rip clothing for inappropriate reasons, with little overall clarity or consistency to offset risks. The rationale for its use was generally inadequately recorded. In some cases anti-rip clothing was used, inappropriately, as a standard response when detainees were uncooperative during the booking-in process. The explanation given was they could be a self-harm risk, even though no previous risk had been recorded. For

example, one custody record recorded: 'Blue suited [anti-rip clothing] as on previous custody visits he is very unpredictable with outbursts of rage and violent is apparent. DP could self-harm and blue suit prevents risk of staff injury by going in when DP is being volatile'. It was unclear how placing the detainee in the anti-rip clothing would prevent harm to staff. In other cases the use of anti-rip clothing was an unsafe and inadequate response when higher levels of observation would have been more appropriate, offering greater dignity and better care for the detainee. Several detainees who were placed in anti-rip clothing with poor rationale did not always have their clothing returned, even when their level of risk had reduced.

**4.16** Close proximity observations were rarely used. At Watford a vulnerable detainee with challenging behaviour attempted self-harm on five occasions during a short period, including trying to choke himself with anti-rip blankets and clothing, swallowing toilet paper and putting his head under the toilet flush. The response was to remove each article he had attempted to self-harm with and ultimately to move him to a 'dry' cell, with no toilet or basin and water, but his observation level was not increased despite the obvious and increased risks.

**4.17** Management and control of keys was sometimes chaotic, especially during busy times. Operational officers, rather than trained detention staff, had access to keys and collected detainees, which was inappropriate.

**4.18** All detention officers and custody sergeants carried anti-ligature knives, and detention officers were aware of the importance of rousing detainees who were intoxicated.

**4.19** Although the staff shift handovers observed did not always involve the whole team, they were generally well conducted, relevant and focused on risk and case progression. The whiteboard with information for staff was consistently completed for each handover and provided relevant detail. However, sergeants coming on shift did not routinely speak to all detainees after the handover.

**4.20** Pre-release risk assessments (PRRAs) varied. We saw some very good plans by one sergeant at Hatfield who had considered all the risks, and at Watford we observed some excellent care to two vulnerable female detainees (one a 16-year-old girl) in trying to make appropriate arrangements for their release. Notwithstanding these good examples, too many PRRAs were often poorly conducted, and custody staff did not consistently assess the needs and demeanour of the detainee on their release. Despite the force's concerted effort to raise awareness of vulnerability, this was not always evident in pre-release risk plans. A leaflet detailing telephone numbers of local support agencies was routinely given out to detainees before release, often without explanation. PRRAs were not completed for detainees who went on to virtual (video-enabled) courts and were released from them. A new pre-release risk assessment form was being piloted at Stevenage. This required custody staff to assess the detainees' needs throughout their detention and in discussion with them, which was appropriate. However, staff needed to understand why PRRAs needed to be completed.

## Recommendations

**4.21 Police vehicles should not be used as a location to hold detainees waiting to be booked in.**

**4.22 Anti-rip clothing should only be used in exceptional circumstances and as a last resort to protect the detainee from harm, with recorded rationale based on a risk assessment.**

**4.23 All risk assessments, including those undertaken pre-release, should include a recorded rationale for any actions taken, ensuring the safety and welfare of detainees during their stay in custody and after their release.**

**4.24 All custody staff should be involved in the same shift handover.**

**4.25 Restrictions on detainees' footwear and clothing should be subject to individual risk assessment, and items should returned to the detainee when their risk level has reduced.**

## Use of force

**4.26** Oversight and governance of the use of force were inadequate. We were not assured that force was monitored, that officers were held accountable or that managers were aware of its use in the custody suites. A use of force form was not always completed after each incident, when it should have been, and none of the forms relating to four recent incidents that we found in the custody records could be provided to us. (See recommendation 3.10.)

**4.27** We identified some cases where detainees were strip searched without clear recorded justification or authorisation, and in some instances in the absence of a robust risk assessment. Although there was a 'BOSS' (body orifice security scanner) chair in each suite, these were not used effectively to justify some strip searches. We were not assured that all strip searches were authorised correctly. During the inspection we observed CCTV of a detainee having his clothes removed forcibly, being made to wear a spit hood, and then an officer appearing to part his buttocks. We were concerned about this practice and referred the matter to the Head of Custody to investigate.

**4.28** Few detainees arrived handcuffed, which was positive, and those that were had them removed soon after arrival.

**4.29** In some suites, most of the sergeants carried PAVA (incapacitant spray), which was disproportionate for the levels of risk we observed. We were not given a reasonable explanation for this practice, although staff told us that they had not been used.

## Recommendation

**4.30 Officers should record decisions about the level of searching applied to detainees, the authorising officer, gender of searching staff and subsequent outcomes in the custody record.**

## Physical conditions

**4.31** The cleanliness and general maintenance of the custody suites was good, except at Watford. Hatfield and Stevenage had the best conditions, and were well laid out and in a good state of repair. Watford was old, spread over two levels - which was not ideal for conducting cell visits, supervising detainees, answering cell call bells, and providing meals and drinks - and was relatively grubby. Cells were mostly clean and well maintained but many in Watford were dirty and had graffiti. Cells were checked between uses and their condition recorded. Detention officers cleaned them during the day if required. There was a clear process for cleaning and checking cells.

**4.32** CCTV operated in all custody suites but there were no signs at Watford to inform detainees of this. The toilet area in one cell at Watford was not pixilated on the CCTV screen, which meant detainees could be observed using it.

**4.33** After booking in, all detainees were escorted to their cell by a detention officer (DO), who explained in-cell equipment, such as the cell call bell, handwashing facility and toilet flush. With the exception of Watford, responses to cell call bells were generally prompt – at Watford, however, we saw a busy detention officer mute the call bells several times before responding to them, which caused a delay.

## Recommendations

**4.34** **Cells in all custody suites should be clean and free from graffiti.**

**4.35** **Responses to cell call bells should always be prompt, and bells should not be muted before they are answered.**

## Housekeeping point

**4.36** All toilet areas in cells should be pixilated on CCTV viewing screens.

## Detainee care

**4.37** Detainee care was generally good but was affected because there were fewer staff than required to ensure the safety and welfare of detainees, especially in the busier suites such as Hatfield and particularly Watford. We saw some detainee care devolved to arresting officers when the detention officer was busy, which was inappropriate. The duties required of detention officers, including processing detainees, answering call bells, and conducting cell visits promptly and thoroughly, were sometimes compromised when the suite was busy and when staff were booking in detainees. (See main recommendation 2.42.)

**4.38** Mattresses and pillows were mostly provided routinely but were not always cleaned between use – and at Watford we saw a mattress being cleaned with a floor mop. Clean blankets were offered routinely. There were sufficient stocks of replacement clothing, including underwear, but replacement footwear was not always provided, except at Stevenage. Detainees were not routinely given toilet paper.

**4.39** Food and drinks were generally provided regularly, and outside of mealtimes on request. The food available was microwaveable meals of low nutritional value and cereal bars. Food preparation areas were generally clean and well equipped.

**4.40** All suites had reading material, but not always in a range of languages, and they were not always offered to detainees, although we saw some detainees with reading material in their cells. Suites had rooms to facilitate visits, but these were used infrequently.

**4.41** Custody suites had well-used exercise yards. The one at Hoddesdon was a caged area used as a holding space when detainees were brought to the custody suite, so any detainees exercising in the yard had to be supervised; if the suite was busy, time out in the yard could not be facilitated. Staff at Watford also told us that there were not enough staff to supervise detainee exercise.

**4.42** Showers were available but were not always sufficiently private, and used infrequently, again due to demands on detention officers. Not all women were routinely offered sanitary products.

## Recommendations

**4.43 Replacement footwear should be provided for all detainees if their own footwear is removed or stored outside their cell.**

**4.44 There should be a small supply of toilet paper in each cell, subject to a risk assessment.**

**4.45 All suites should hold a stock of reading material in a range of languages.**

**4.46 There should be appropriate arrangements to facilitate visits in all custody suites.**

**4.47 All custody suites should facilitate exercise periods for detainees.**

**4.48 Women detainees should be offered sanitary products.**

# 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** On arrival at a custody suite, arresting officers completed a form recording the detainee's vulnerabilities and risks, brief details of the offence and the grounds for detention. The custody sergeant then asked the arresting officer, in the presence of the detainee, to provide a full explanation of the circumstances of and the reasons for arrest before authorising detention. Once detention was authorised, detention officers used the information on the form to assist them create a custody record for the detainee.

**5.2** Sergeants told us that operational officers did not always have a good understanding of the 'necessity criteria' in code G of the Police and Criminal Evidence Act 1984 (PACE) – covering the statutory power of arrest by police officers – but sergeants were confident enough to refuse detention when the circumstances did not merit arrest. We saw this happen on several occasions, with a custody record opened and endorsed with the grounds for refusal. Alternatives to custody included voluntary attendance, street bail and fixed penalty notices.[4] Voluntary attendance interviews took place outside the custody suite or in interview rooms on their periphery. Data supplied by the force confirmed the increased use of voluntary attendance, which had risen from 1,050 voluntary attendees between April 2013 and March 2014 to 2,077 in 2014-15.

**5.3** 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 promptly. We saw cases that were progressed quickly, but we also saw some detainees held in custody for longer than necessary when investigations were passed on to case investigation teams or other departments for completion. Data supplied by the force showed the average detention time for the previous 12 months was 12 hours 42 minutes.

**5.4** Custody staff reported a good relationship with Home Office Immigration Enforcement officers. We were told that immigration detainees were usually transferred to immigration removal centres within 24 to 48 hours, although a large number of detainees had recently remained in the custody suites for up to three or four days following an operation that had intercepted three lorries carrying illegal immigrants. Data supplied by the force showed that 546 immigration detainees had been held in the past 12 months for an average period in custody of 21 hours, which was down from 25.48 hours in the previous 12 months.

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[4] 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. 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.

**5.5** 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]

**5.6** Custody staff told us they had not known local authorities to provide safe or secure accommodation when a child had been charged and could not be bailed. We were not assured that staff understood the different requirements for 'safe' and 'secure' accommodation as they told us they would only request secure accommodation.[6] The data supplied by the force showed that 35 children had been charged and had bail refused in the previous 12 months, but the force was unable to identify the number of requests for local authorities to provide alternative accommodation and if any had resulted in children being moved to either secure or non-secure accommodation.

**5.7** We saw two children in custody who were held overnight without charge with no evidence in the custody record that alternative accommodation was sought or considered. In the case of a 14-year-old boy at Stevenage, the custody sergeant gave us a rationale for having kept the boy in custody overnight, although this had not been documented on the custody record by the custody sergeant or the PACE inspector during his PACE review. In our custody record analysis, one child had been detained overnight and there was no record that alternative accommodation had been considered.

**5.8** Custody staff were aware of their responsibilities to contact an appropriate adult (AA) when dealing with vulnerable adults and children under 18. Family or friends were contacted in the first instance, and all custody staff we spoke to were aware of the Home Office guidance document to assist AAs when carrying out this role, which was readily available in all the custody suites.

**5.9** In the absence of family members, AAs for children were available between 8am and 11pm through the Hertfordshire Appropriate Adult Scheme (HAAS), a group of volunteers recruited and trained by the county council's Targeted Youth Services. Custody staff told us that the scheme was very efficient during its operating hours, but when an AA was required outside these times they had to contact the social services emergency duty team (EDT), who (as at our previous inspection) were mostly unable to provide an AA out of hours. Some of the HAAS volunteers were also willing to represent vulnerable adults, but had not received any relevant training. We found a heavy reliance on just a small number of HAAS volunteers providing cover at their local custody suites.

**5.10** In our custody record analysis, we looked at the records for six children aged between 13 and 17. All had an AA present while being told their rights and if they were interviewed. One child came into custody with their parent, but the remaining five children had to wait between one hour and 13 hours 40 minutes to access an AA. In the latter case, the child had spent the night in custody before her mother arrived the following morning – although the police had attempted to telephone the mother and had left a voicemail, it was unclear why the services of another AA were not sought.

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[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.
[6] Under PACE code C note 16D, secure accommodation is only a factor for a child aged 12 or over when other local authority accommodation would not be adequate to protect the public from serious harm from them.

**5.11** During booking in, detention officers advised detainees of their three main rights – to have someone informed of their arrest, consult a solicitor and access free independent legal advice, and consult the PACE codes of practice. Some detention officers went further and gave detainees a summarised explanation of 11 of their rights, as detailed on a written notice setting out their rights and entitlements. However, these notices were not routinely offered to all detainees. All custody staff could access these notices in foreign languages for non-English speaking detainees, and an easy-read pictorial version was readily available in all the custody suites.

**5.12** A professional telephone interpreting service was available to assist the booking-in of non-English speakers through use of double handset telephones. Staff told us that a face-to-face interpreter service was also available for interviews.

## Recommendations

**5.13** **Hertfordshire Constabulary should monitor the time that detainees are kept in detention to ensure that there are no unnecessary delays in progressing their case.**

**5.14** **If a child is held in custody overnight without charge, a clear justification for this should be recorded on the custody record.**

**5.15** **Trained appropriate adults should be available at all times for vulnerable adults and children.**

**5.16** **Contact and attendance times for appropriate adults should be clearly recorded on custody records to enable monitoring.**

## Rights relating to PACE

**5.17** Although we saw detainees being told during their booking in that they could read the PACE codes of practice, these were not routinely shown or explained by custody staff. There were sufficient copies of the up-to-date PACE code C at all suites, and we observed a few detainees who took up the offer and were given a copy to read. The Criminal Defence Service (CDS) posters informing detainees of their right to free legal advice in 24 languages were not displayed at Watford, and in Hatfield and Hoddesdon were only displayed in a limited number of languages.

**5.18** All detainees were offered free legal representation, but if they declined, staff did not routinely ask them why or record the reason why they did not wish to use this service. Detainees were not always told that they could change their mind at any time and accept the offer of free legal representation. Detainees who wished to speak to legal advisers could do so in privacy in telephone booths, holding rooms or visits rooms. We saw legal advisers (and AAs) given custody records and associated documentation to read without having to request this, although not all staff were aware of the need to detach any confidential medical information beforehand (see also paragraph 6.12 and housekeeping point 6.18). In our custody record analysis, all detainees had been offered legal advice and 14 accepted this offer. Some, but not all, records showed when legal advisers were contacted. In three cases it was not clear if legal advisers were contacted, had attended or spoke with detainees on the telephone. Legal advisers told us they had good relations with custody staff.

**5.19** We observed detainees being told that they could inform someone of their arrest, which staff facilitated, but this was not always recorded in the custody records we analysed.

**5.20** Reviews of detainees were undertaken by dedicated PACE inspectors or, in their absence, custody policy and operational inspectors. Custody staff told us that most reviews were carried out over the telephone, and we observed this taking place; this was surprising given the close proximity between the custody suites. Staff also told us that telephone reviews were regularly conducted even when the detainee was a child or a vulnerable adult. In our custody record analysis, 17 of the 20 detainees who required an initial PACE review while in custody had these carried out remotely, and it was unclear in the remaining three cases if they were conducted face-to-face or otherwise. We found no evidence that detainees were routinely reminded of their entitlement to free legal advice while in custody or that they could make representation about their continued detention.

**5.21** There was an effective system for collecting DNA samples taken in custody.

**5.22** A 'virtual' (video-enabled) court was in operation at Watford, Stevenage and Hoddesdon custody suites on weekdays, which allowed detainees to appear remotely at the local remand court at Hatfield Magistrates' Court. The virtual court was staffed by dedicated court officers with one based in each of the three custody suites. Each had five slots daily for the virtual court. If the demand was greater then this, the additional detainees were transported by a local prisoner escort contractor direct to the court, although at Hatfield court staff walked detainees through to the court cells as these were next to the police premises. Custody staff told us that even with the introduction of the virtual court they found it difficult to get the court to accept detainees after 1-2pm, which was too early, although there was sometimes flexibility on this. This situation, which was similar to what we found at the previous inspection, caused unacceptable delays for detainees in remaining in custody.

## Recommendations

**5.23** **PACE reviews should be conducted as set out in section 15 Police and Criminal Evidence Act 1984, code C.**

**5.24** **Contact and attendance times for legal advisers should be clearly recorded on custody records to ensure detainees' rights are complied with.**

**5.25** **Senior police managers should work with HM Courts & Tribunals Service to ensure that early court closure times do not result in unnecessarily long stays in police custody.**

## Housekeeping point

**5.26** Officers should record the reasons why a detainee declines the offer of legal advice in the custody record, and remind them of their right to access such advice while in custody.

## Rights relating to treatment

**5.27** Custody staff gave us a mixed response when we asked how they would handle a complaint, which was similar to our previous findings. Some said they would notify the PACE inspector immediately, while most said they would advise detainees to make a complaint at the front desk on their release. An entry in a custody record that we viewed at Watford said: 'Will not be able to make a complaint until he has left custody'. Such responses could deter

complaints. Some staff said their response would depend on whether the complaint related to a custody matter or something else. There was no information on the complaints process displayed in any of the custody suites, and data on complaints in custody were not routinely circulated to custody staff.

## Recommendation

**5.28 Detainees should be able to make a complaint while they are still in 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** G4S provided the physical health services commissioned by Hertfordshire Constabulary. A team of two health care professionals (HCPs) provided 24-hour cover across the four suites, supported by a forensic medical examiner (FME). However, the service was stretched and there were only four HCPs in post out of an establishment of 12. As a result there were significant delays in detainees being seen by health staff, which could have affected their health outcomes.

**6.2** There were systems to monitor medical and allied health professionals' credentials and revalidation, and G4S provided induction and continuing mandatory training, although supervision for HCPs and professional development opportunities were poor. There was no robust internal mechanism to review providers' performance against their contract. The police held quarterly health care meetings but G4S did not attend these. Clinical governance was generally weak, and collaboration between health providers focused solely on individual cases. (See section on Strategy, paragraph 3.11 and recommendation 3.16.)

**6.3** Service risks were not identified, there was no published health complaints system and policies were unavailable to staff. Although we found evidence of clinical audit and incident management, the outputs were coordinated centrally with limited evidence of learning disseminated to frontline staff.

**6.4** Each site had an identified medical room. Despite established cleaning schedules, the rooms were poorly maintained and did not comply with infection prevention standards. Sharps bins were not correctly assembled, dated or signed, and no suite had a separate facility or surfaces suitable for forensic sampling. Custody staff received mandatory basic life support training and had access to automated external defibrillators. Emergency equipment was appropriate and in date, but there was no clear audit trail to verify that it was routinely checked and maintained.

## Recommendations

**6.5** **The health provider's contract should be enforced to ensure health staffing levels are always at the level required to meet detainees' needs on a 24 hours basis across all four sites.**

**6.6** **Clinical governance arrangements should deliver effective clinical leadership that promotes learning from practice.**

**6.7** **Detainees should be able to complain about health services through a well-advertised and confidential health complaints system.**

**6.8** **Support for frontline health staff should include access to information, regular team meetings, clinical supervision and professional development programmes for all practitioners.**

**6.9 Clinical rooms and practices should comply with relevant standards for preventing infection and forensic sampling.**

**6.10 Routine checking and maintenance of emergency equipment should be fully documented and regularly audited.**

## Patient care

**6.11** Performance data produced by G4S indicated that between January and March 2015 an average of 90% of detainees were seen by a HCP within the contract standard time of one hour. The data returns included telephone consultations. However, we found much longer waits, and this was confirmed by all the custody staff we spoke to. Our custody record analysis also indicated long waits for detainees, with the longest wait around 12 hours and the shortest around two hours, with others ranging between three and nine hours. This was inadequate and in several cases could have had a significant impact on health outcomes.

**6.12** The clinical interactions we observed were sensitively delivered and clinically appropriate. Handwritten clinical records were legible and the samples we assessed were of good quality. HCPs shared information directly with the police by attaching agreed information on to the custody record. However, these medical records could be accessed by non-custody staff, which was inappropriate and breached data protection law and guidelines on the confidentiality of personal health information (see also paragraph 5.18).

**6.13** Medication management arrangements were appropriate, although routine weekly stock checks were undertaken by non-clinical staff and we saw a few discrepancies in stock that had not been investigated.

**6.14** There was a range of patient group directions that enabled health care practitioners to administer an appropriate range of medicines, but these were out of date. Although detainees had access to nicotine replacement therapy through custody staff, which was positive, custody staff and HCPs did not assess or effectively monitor the frequency of administration.

**6.15** Detainees could continue to receive validated prescribed medication in custody. Symptomatic relief was provided for detainees withdrawing from drugs or alcohol, where clinically indicated, and detainees could continue to receive prescribed opiate substitution therapy. However, the generally long waits to be assessed could lead to delays in treatment.

## Recommendations

**6.16 Medicine stock monitoring should be regularly verified and audited by the health care professionals team leader, and all discrepancies appropriately investigated.**

**6.17 Patient group directions should be updated to ensure they remain appropriate, and they should clarify the arrangements for detainees to access nicotine replacement products.**

**6.18 All clinical records should be held in line with the Data Protection Act and Caldicott guidelines on the confidentiality of personal health information.**

## Substance misuse

**6.19** Substance misuse services were provided by Spectrum, part of the Crime Reduction Initiatives (CRI) charity, with a focus on reducing reoffending. The community-based service offered effective support to detainees with drug or alcohol problems. Spectrum workers visited the custody suites daily and spoke to detainees. Practitioners also responded to referrals from custody staff or other health professionals.

**6.20** There was a team of three full-time staff (plus a manager), with two workers visiting two suites each, although only two workers were available at the time of our inspection. As a result initial contacts were sometimes by telephone. Outside of service hours, custody and health care staff submitted paper referrals, which were picked up at the Spectrum worker's next visit. Detainees who arrived in custody after 9pm on Friday were unlikely to have contact with Spectrum before they were released, which was a gap in the service.

**6.21** The Spectrum team maintained contact with detainees who required support in the community for drug and alcohol problems and facilitated access to other services, including clinical treatment, psychosocial support or needle exchange schemes and other confidential services. Young people were seen by the service if requested, but were signposted or directly referred to age-appropriate services.

**6.22** The CRI manager and Spectrum staff attended the quarterly partnership meeting chaired by the police. Governance of the service was appropriate, and the staff were motivated, well trained and effectively supported. The Spectrum team sought consent appropriately from detainees to share information.

## Recommendation

**6.23** **Substance misuse services should be sufficiently staffed to enable daily visits to all custody suites.**

## Mental health

**6.24** Mental health services were provided by Criminal Justice Mental Health Team (CJMHT), part of Hertfordshire Partnership University NHS Foundation Trust. The team comprised three staff who screened all detainees in the suites at the start of their shift (8am-4pm, weekdays only) and any subsequent arrivals. Outside these hours any referrals were made to the local authority emergency duty team. The team also provided a liaison service to courts, virtual courts and proportionate justice suites across the county. The service provided advice to detainees, custody staff, interviewing officers and health care professionals. A 'mentally disordered offender' panel was held monthly for each custody area, which considered detainees with complex needs who could be diverted from custody, and agreed actions.

**6.25** There was a local shortage of approved mental health practitioners, and access to local acute beds and transport were also problematic, which affected the time taken to complete assessments under the Mental Health Act. Although delays were longer at night, we also saw evidence of delays during working hours. This meant that people in mental health crisis were in custody for significantly and unacceptably longer than was necessary, when more specialist health care was appropriate.

**6.26** The CJMHT was contracted as an adult service, although staff told us that they would screen young people in custody. The trust provided a child and adolescent mental health service (CAMHS), although links to this were weak and we received varying views from mental health staff about how young people were referred to the service.

**6.27** The team had provided monthly mental health awareness training for custody staff, and in recent months there had been an intensive weekly programme for a cohort of newly employed staff.

**6.28** We found no evidence that people were detained in police custody suites in Hertfordshire under section 136 of the Mental Health Act,[7] and the suites had not been used for this purpose in the last three years. In the previous 12 months, 216 people had been held under section 136 in the three specialist locations provided by the trust.

## Recommendation

**6.29 Detainees with mental health needs should have prompt access to specialist mental health services out of hours, and those who need an assessment under the Mental Health Act should receive this without delay.**

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

# Section 7. Summary of recommendations and housekeeping points

## Main recommendations

**7.1** There should be sufficient staff in custody suites at all times to ensure the safety and well-being of detainees. (2.43)

**7.2** Hertfordshire Constabulary should collect and analyse management information, including quality assurance processes, to ensure robust assessment of standards of custody provision. (2.44)

**7.3** Hertfordshire Constabulary should reassure itself that use of force is in accordance with the College of Policing guidance and ensure it records and monitors use of force data to establish trends, training needs and staff accountability. (2.45)

**7.4** The Force should engage with their counterparts in the local authority, instigate an immediate review of the provision of local authority accommodation for children under section 38(6) PACE 1984, and monitor performance data to ensure that children are not detained unnecessarily in police cells. (2.46)

## Recommendations

### Strategy

**7.5** The force should ensure that use of force forms are completed correctly when detainees are subjected to force while in custody. (3.10)

**7.6** There should be an effective partnership arrangement that enables robust monitoring of the quality and performance of health providers to ensure safe and timely outcomes for ill or vulnerable detainees. (3.16)

**7.7** The sampling of custody records should effectively cross-reference the audiovisual record with the written detention log. (3.20)

### Treatment and conditions

**7.8** Custody staff should ask all detainees if they have any dependency obligations and help to address these. (4.7)

**7.9** Custody staff should have a clearer focus on the needs of all detainees, particularly women, children and those with disabilities. (4.8)

**7.10** Girls under 16 should be allocated a named female officer who is responsible for their care while in custody. (4.9)

**7.11** Police vehicles should not be used as a location to hold detainees waiting detainees to be booked in. (4.21)

**7.12** Anti-rip clothing should only be used in exceptional circumstances and as a last resort to protect the detainee from harm, with recorded rationale based on a risk assessment. (4.22)

**7.13** All risk assessments, including those undertaken pre-release, should include a recorded rationale for any actions taken, ensuring the safety and welfare of detainees during their stay in custody and after their release. (4.23)

**7.14** All custody staff should be involved in the same shift handover. (4.24)

**7.15** Restrictions on detainees' footwear and clothing should be subject to individual risk assessment, and items should returned to the detainee when their risk level has reduced. (4.25)

**7.16** Officers should record decisions about the level of searching applied to detainees, the authorising officer, gender of searching staff and subsequent outcomes in the custody record. (4.30)

**7.17** Cells in all custody suites should be clean and free from graffiti. (4.34)

**7.18** Responses to cell call bells should always be prompt, and bells should not be muted before they are answered. (4.35)

**7.19** Replacement footwear should be provided for all detainees if their own footwear is removed or stored outside their cell. (4.43)

**7.20** There should be a small supply of toilet paper in each cell, subject to a risk assessment. (4.44)

**7.21** All suites should hold a stock of reading material in a range of languages. (4.45)

**7.22** There should be appropriate arrangements to facilitate visits in all custody suites. (4.46)

**7.23** All custody suites should facilitate exercise periods for detainees. (4.47)

**7.24** Women detainees should be offered sanitary products. (4.48)

## Individual rights

**7.25** Hertfordshire Constabulary should monitor the time that detainees are kept in detention to ensure that there are no unnecessary delays in progressing their case. (5.13)

**7.26** If a child is held in custody overnight without charge, a clear justification for this should be recorded on the custody record. (5.14)

**7.27** Trained appropriate adults should be available at all times for vulnerable adults and children. (5.15)

**7.28** Contact and attendance times for appropriate adults should be clearly recorded on custody records to enable monitoring. (5.16)

**7.29** PACE reviews should be conducted as set out in section 15 Police and Criminal Evidence Act 1984, code C. (5.23)

**7.30** Contact and attendance times for legal advisers should be clearly recorded on custody records to ensure detainees' rights are complied with. (5.24)

**7.31** Senior police managers should work with HM Courts & Tribunals Service to ensure that early court closure times do not result in unnecessarily long stays in police custody. (5.25)

**7.32** Detainees should be able to make a complaint while they are still in custody. (5.28)

## Health care

**7.33** The health provider's contract should be enforced to ensure health staffing levels are always at the level required to meet detainees' needs on a 24 hours basis across all four sites. (6.5)

**7.34** Clinical governance arrangements should deliver effective clinical leadership that promotes learning from practice. (6.6)

**7.35** Detainees should be able to complain about health services through a well-advertised and confidential health complaints system. (6.7)

**7.36** Support for frontline health staff should include access to information, regular team meetings, clinical supervision and professional development programmes for all practitioners. (6.8)

**7.37** Clinical rooms and practices should comply with relevant standards for preventing infection and forensic sampling. (6.9)

**7.38** Routine checking and maintenance of emergency equipment should be fully documented and regularly audited. (6.10)

**7.39** Medicine stock monitoring should be regularly verified and audited by the health care professionals team leader, and all discrepancies appropriately investigated. (6.16)

**7.40** Patient group directions should be updated to ensure they remain appropriate, and they should clarify the arrangements for detainees to access nicotine replacement products. (6.17)

**7.41** All clinical records should be held in line with the Data Protection Act and Caldicott guidelines on the confidentiality of personal health information. (6.18)

**7.42** Substance misuse services should be sufficiently staffed to enable daily visits to all custody suites. (6.23)

**7.43** Detainees with mental health needs should have prompt access to specialist mental health services out of hours, and those who need an assessment under the Mental Health Act should receive this without delay. (6.29)

# Housekeeping points

## Treatment and conditions

**7.44** All toilet areas in cells should be pixilated on CCTV viewing screens. (4.36)

## Individual rights

**7.45** Officers should record the reasons why a detainee declines the offer of legal advice in the custody record, and remind them of their right to access such advice while in custody. (5.26)

# Section 8. Appendices

## Appendix I: Inspection team

| | |
|---|---|
| Nick Hardwick | HM Chief Inspector of Prisons |
| Maneer Afsar | HMI Prisons team leader |
| Fionnuala Gordon | HMI Prisons inspector |
| Vinnett Pearcy | HMI Prisons inspector |
| Kellie Reeve | HMI Prisons inspector |
| Fiona Shearlaw | HMI Prisons inspector |
| Clive Burgess | HMIC lead staff officer |
| Anthony Davies | HMIC staff officer |
| Steve Eley | HMI Prisons health services inspector |
| Jan Fooks-Bale | Care Quality Commission inspector |
| Jessica Kelly | HMI Prisons researcher |
| Alissa Redmond | HMI Prisons researcher |

# Appendix II: Progress on recommendations from the last report

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

## Strategy

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

### Recommendations

The provision of custody services at Watford should be overhauled at the earliest opportunity to ensure the consistent application of corporate standards. (3.23)
**Partially achieved**

An ongoing regime of refresher training should be implemented which addresses core skills and knowledge. This should be centrally managed on behalf of BCUs. (3.24)
**Achieved**

The risk posed by ligature points should be understood by staff, and detainees supervised according to risk while in custody. (3.25)
**Achieved**

BCU policies which offer local guidance should be validated to ensure that they do not conflict with force policies. (3.26)
**No longer relevant**

Specific policies in relation to the treatment female detainees and young people under 18 years of age should be introduced. (3.27)
**Not achieved**

The roles of custody sergeant and detention escort officer should be dedicated for a reasonable length of time and staff specially selected for the role based on motivation and suitability. (3.28)
**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

A clear protocol for transferring detainees from police to court cells should be agreed with the escort contractor and adhered to in all custody suites, maximising the use of both sets of cells. (4.93)
**No longer relevant**

All custody suites should be refurbished and deep cleaned where necessary, with regular cell fabric checks, and removal of graffiti and any ligature points. (4.94)
**Partially achieved**

Seating should be provided in all cells. (4.95)
**Achieved**

Toilets in all custody suites should be adequately screened and blocked out on closed-circuit television (CCTV) screens. (4.96)
**Achieved**

Detainees should be offered showers and exercise at regular intervals when held for more than 24 hours. All custody suites should provide an adequate number of showers. (4.97)
**Partially achieved**

All cells should have en-suite hand washing facilities, and towels and soap should be provided when risk assessments allow. (4.98)
**Partially achieved**

All custody suites should have exercise areas cleaned at least daily. (4.99)
**Partially achieved**

Detainees should be offered regular meals. More substantial meals, with a higher nutritional value, should be available for detainees held more than 24 hours. The policy regarding food being sent in should be clarified for all staff. (4.100)
**Achieved**

Underwear should be available when detainees require changes of clothing. (4.101)
**Achieved**

A greater range of reading materials, particularly books, should be available and offered to detainees as a matter of course. (4.102)
**Not achieved**

Female cells should never be located at a distance from the main cell area. (4.103)
**No longer relevant**

Visits should be facilitated in all custody suites, and visitors only strip searched when intelligence and risk indicate that this is necessary. (4.104)
**Not achieved**

The booking-in area in all custody suites should offer sufficient privacy. (4.105)
**Achieved**

Specified observation levels for detainees should always be adhered to, and observations should be carried out in person and not through CCTV systems. (4.106)
**Achieved**

Staff in all custody suites should routinely explain to new detainees that in-cell CCTV monitoring will take place. (4.107)
**Not achieved**

All staff should be issued with and carry anti-ligature knives. (4.108)
**Achieved**

Staff in all custody suites should attend refresher suicide and self-harm training, at least every three years. (4.109)
**Achieved**

Staff in all custody suites should routinely explain to new detainees how the cell call bell system operates. (4.110)
**Achieved**

Staff in all custody suites should undergo fire safety training, fire evacuation arrangements should be on display and there should be regular fire drills. (4.111)
**Partially achieved**

Staff in all custody suites should not use personal mobile telephones while on duty other than in exceptional circumstances. (4.112)
**Achieved**

# Individual rights

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

## Recommendations

All custody staff should have training in child welfare/ protection matters. (5.120)
**Achieved**

An effective appropriate adult scheme, including out-of-hours arrangements, should be available in all custody suites. (5.121)
**Partially achieved**

Newly arrived detainees should routinely be asked about any childcare issues resulting from their detention. (5.122)
**Partially achieved**

Newly arrived detainees should be told how to make complaints, including about a racist matter, and the complaint procedures should be displayed in all custody suites. (5.123)
**Partially achieved**

Discussions should be held with HM Court Service to ensure that cut-off points for accepting detainees are not too early and thus result in people spending too long in police custody. (5.124)
**Partially achieved**

If female detainees are not initially seen by female custodial staff, they should have access on request to a female member of staff. (5.125)
**Partially achieved**

# Health care

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

## Recommendations

The forensic medical examiner (FME) contract with H-FERN should be reviewed, to include: assurance from H-FERN that FMEs on call for a 24-hour period maintain their professional competencies throughout that period; confirmation that clinical records are stored safely and securely at all times in its custody suites and in the possession of FMEs; a policy relating to the sharing of information between health professionals; and evidence of annual checks of professional registration, professional appraisals and maintenance of their professional development. (6.42)
**Achieved**

The management of medicines held in custody suites should be reviewed to ensure that appropriate quantities of medicines are held. Advice should be sought from a qualified pharmacist for the introduction of a proper medicine management system, to include: the safe custody of medicines; the appropriate recording of medicines administered; regular stock checks and balances; and disposal of-out-of date medicines. (6.43)
**Achieved**

A professional health-related cleaning company should be introduced to ensure that FME rooms across the force meet infection control guidelines and maintain high levels of cleanliness in clinical areas. Custody staff and FMEs should ensure that the FME room is clean and tidy after every usage. (6.44)
**Not achieved**

The force should urgently review how it takes, stores, tracks and submits all DNA and forensic samples taken from detainees, volunteers and victims. The review should identify gaps in policies, training, storage facilities and destruction audit trails. The review should have a senior officer responsible for the delivery of an action plan which addresses the issues. (6.45)
**Achieved**

A programme of regular mental health and substance use updates should be introduced for all staff involved in the primary management of detainees. (6.46)
**Achieved**

The services of the local health provider should be commissioned to undertake an infection control audit of its custody suites to ensure that infection control measures are in place and inspected regularly. (6.47)
**Partially achieved**

FMEs should always sign entries made into clinical records. The name and designation of the writer should be legible. (6.48)
**Achieved**

The constabulary should work with its mental health partners to ensure that the quality of mental health provision is consistently good across all police custody suites. (6.49)
**Achieved**

All custody reception areas should provide privacy for detainees being interviewed about their medical history. (6.50)
**Achieved**

The role of the custody assistant (CA) should be developed, and CAs should be given basic training in care skills similar to that of the role of NHS healthcare assistants. (6.51)
**No longer relevant**

Mental health awareness training for detention and escort officers and CAs should be initiated and updated at least annually. (6.52)
**Achieved**

The needle exchange programme should be reintroduced under the guidance of the drug support teams. (6.53)
**Achieved**

All necessary repairs to FME rooms should be made. (6.54)
**Achieved**

Clinical waste bins should be in working order and conform to waste regulations. (6.55)
**Achieved**