Criminal Justice Joint Inspection

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

24 – 29 August 2015

by HM Inspectorate of Prisons and HM Inspectorate of Constabulary

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This inspection was carried out in partnership with the Care Quality Commission.

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 was the second inspection of North Yorkshire police custody cells, the first being in February 2010. Since our last inspection, the custody estate had reduced by two custody suites. There had been notable progress in working with partners to reduce how often a police cell was used as a place of safety for people with mental ill-health requiring specialist health care. It was also encouraging that new collaborations were planned, with York University, to explore new approaches to supporting those with mental health issues. Unfortunately, while progress was good, the numbers held were still high, and the force needed to do more.

Local authority provision of suitable accommodation for children was mixed. Secure accommodation was not always available but safe accommodation had been provided. In general, however, we saw good efforts to try and ensure children got bail.

Staff and detainee interactions were generally polite and courteous, although the individual needs of some detainees were not always met. We considered the use of anti-rip clothing was too often disproportionate to the apparent risk and officers need to demonstrate greater understanding for the needs and welfare of women in custody.

Where initial risk assessments were completed these were reasonable, but the subsequent care plans did not always correlate with the risks identified for the individual. Observation levels were often too low, not adhered to or reduced without adequate rationale. Similarly, some pre-release risk assessments did not correspond with the risks logged in the detention log.

There was insufficient oversight of the use of force in the custody suites. Officers did not always complete use of force forms, and those we reviewed lacked details to make any meaningful judgements. Analysis of trends or staff accountability in the use of force on detainees was inadequate.

Individual rights of detainees were explained to them when they arrived in the custody suite. Custody sergeants were confident in refusing detention when it was not merited. Voluntary attendance, as an alternative to arrest, was well used.

The youth offending service provided a good appropriate adult service for children although this was only available up to 10pm. The local authority service provided outside these hours was inadequate and prolonged detention unnecessarily for children.

Vulnerable adults also relied on the local authority to provide appropriate adults, during and outside office hours. It was reported this service was consistently poor.

Detainees reported, and we saw, courteous, appropriately skilled and experienced health care practitioners delivering a good standard of health care. Difficulties arose if a forensic medical examiner was required, as there was only one covering the county, which led to significant delays. Substance misuse services were reasonable.

Overall, North Yorkshire police had demonstrated some significant improvements in some areas since the last inspection, but more was required. Useful strategic oversight and some good work with partners was leading to some positive outcomes. While the report is critical of police cells being used as a place of safety, there is recognition of the progress made to date. Our main concerns

relate to the treatment of detainees, with the disproportionate use of anti-rip clothing, inadequate oversight of the use of force and some risk-averse practices.

In our inspection we noted that of the 27 recommendations made in our previous report after our inspection of February 2010, 13 recommendations had been achieved, 11 had been partially achieved and three had not been achieved.

This report provides a number of recommendations to the force and the Police and Crime Commissioner. We expect our findings to be considered and 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

November 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 North Yorkshire police, following up on our inspection of February 2010. The designated custody suites and cell capacity of each were as follows:

Custody suites	Cells
Harrogate	16
York	24
Northallerton	9
Scarborough	17

[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 for North Yorkshire police. Since the previous inspection in 2010, the force had rationalised its custody estate and closed the suites in Selby and Skipton. Management of the custody suites was centralised and a chief inspector had operational responsibility within the criminal justice portfolio.

2.7 Current custody staffing levels offered limited opportunity for staff breaks and little flexibility to cover sickness or other absences at short notice. There were significant differences in the throughput of detainees between the suites, yet Northallerton and Scarborough operated at the same minimum staffing levels even though Scarborough had double the throughput.

2.8 The assistant chief constable had responsibility for the custody portfolio in force with the deputy chief constable as the main police lead for external partnerships, including use of the Mental Health Act (section 136) and children in detention. The assistant chief constable chaired a custody strategy meeting, which discussed issues such as staffing, use of force, provision of health care and the custody estate.

2.9 The deputy chief constable was part of the local criminal justice board with an active approach to influencing other organisations to improve detainee care – such as mental health needs of detainees and local authority responses to children in police custody. The force also met with the health provider, with effective monitoring and challenge through these meetings. There were some demonstrable improvements but also some areas that required further development.

2.10 The independent custody visitor (ICV) scheme was well supported by the force, and the inspector of each suite held quarterly meetings with the ICV volunteers, who made regular visits to custody suites.

2.11 The force conducted its own self-assessment of custody, with visits to custody facilities and relevant checks on the standard of the estate and some of the work processes. There was good record sampling to assess the treatment of detainees, with over 10% of detainee records reviewed by custody inspectors. However there was no cross-referencing against CCTV and other documentation.

2.12 The content of staff training was relevant and the programme was well attended, with largely positive feedback from participants. A custody section on the force intranet stored all relevant policy and procedures, including a custody bulletin, and was easily accessible to staff.

Treatment and conditions

2.13 Staff were generally polite to detainees, although there were some issues about the treatment of children and women. Children were not always spoken to in language that was age-appropriate or allowed them to understand the process. However, we saw good efforts to ensure children were bailed rather than kept in custody.

2.14 Some custody suites lacked sufficient privacy to book in detainees and some custody staff had become inured to the sensitivity and confidential nature of allegations, discussing cases in front of other detainees.

2.15 We had some concerns about the treatment of women, specifically when they were forced to wear anti-rip suits (to prevent the use of clothing as ligatures). There was not always enough consideration to maintaining the dignity of women - in one case when a woman was

left in inappropriate clothing, and in another, male officers were in a woman's cell while she was being put into anti-rip clothing when their presence was not appropriate.

2.16 Detainees were asked their religious beliefs as part of the booking-in process, and a range of religious texts were available.

2.17 Not all suites provided adequate facilities for detainees with disabilities although there were wheelchairs at all four suites.

2.18 Staff had good interactions with detainees during risk assessments, which were focused and enhanced by supplementary questions. Initial risk assessments were generally dynamic; however, subsequent care plans were not always appropriate. We found levels of observations were sometimes set too low, not adhered to or the rationale for reduction was not always recorded.

2.19 There was disproportionate use of anti-rip clothing. It was often used as a control measure for detainees who did not comply with the risk assessment. It was also used automatically if there was a risk of suicide or self-harm when higher levels of observations would have provided greater dignity and safety for the detainee.

2.20 Staff shift handovers should include all staff, but we saw individual groups of staff handover to their own peers separately rather than as a whole group. However, handovers were generally well conducted and properly focused on risk and case progression. A relatively detailed printout with relevant information about each detainee was provided for each handover.

2.21 Pre-release risk assessments involved the detainee and were focused on their safe release. However, some records did not indicate that all risks and vulnerabilities were considered before release. A helpful support leaflet was automatically generated for all detainees on their release.

2.22 There was evidence that officers did not always complete use of force forms when force was used. There was no monitoring or analysis of use of force trends and data for training or to ensure staff accountability. Some of the forms we reviewed were of poor quality with limited information, and we found cases where force had been used but no corresponding form had been submitted. Handcuffing of detainees in custody was proportionate and we rarely saw detainees in handcuffs, and strip searching was properly authorised and used sparingly.

2.23 Overall physical conditions were adequate. Cleanliness and general maintenance of some custody suites was good but a few required more thorough cleaning. There was a clear process for the cleaning and checking of cells. Showers and some toilet areas were dirty and not sufficiently private.

Individual rights

2.24 Custody sergeants booked in detainees and authorised detention appropriately, and were confident in refusing detention when it was not merited. They told us that operational officers had a good understanding of the necessity to arrest criteria in the relevant PACE code. Voluntary attendance as an alternative to custody was used well, although the custody suites were still used for this; there were plans to use other facilities for voluntary attendees and divert them from custody suites.

2.25 Custody staff reported, and force data confirmed, that although few immigration detainees were held, they could sometimes be in custody for up to 48 hours, which was too long.

2.26 Staff understood the different requirements for safe and secure accommodation for detained children. Staff told us that for children who were charged and not bailed, they had not known the local authority to provide secure accommodation. However, they were able to confirm alternative accommodation, such as foster care, was sometime available.

2.27 Custody staff said there was a good service from the Youth Offending Service. Its staff acted as appropriate adults (AAs) for children, from 9am to 10pm. Outside these hours the local authority provided the AA, and children could wait a long time for someone to attend. The force also arranged AAs for vulnerable adults in custody, which was not efficient, and vulnerable detainees could wait longer than necessary to have an AA, even during office hours.

2.28 Detainees were offered up-to-date rights and entitlements leaflets. Most staff knew how to access these in foreign languages, but none were aware that an easy-read format was available on the Home Office website. The leaflets were available in Braille at all the suites.

2.29 PACE codes of practice were offered to detainees, and legal advisers were given copies of their custody record. There were not enough consultation and interview rooms at York and Northallerton to meet demand at busy times.

2.30 PACE reviews took place either face-to-face or over the telephone and were timely and thorough. However, in some instances there had been telephone-only reviews of detained children, which was inappropriate.

2.31 Custody staff said it was difficult to get detainees accepted by the remand courts in the afternoon, and that the courts were unlikely to accept any detainee after 2pm, resulting in detainees remaining in police custody for longer than necessary.

2.32 Most custody staff indicated that if a detainee wished to make a complaint, they would advise the critical incident inspector accordingly, who could take the complaint while the detainee was still in custody.

Health care

2.33 North Yorkshire Police directly commissioned Leeds Community Healthcare to provide medical services in police custody suites. Health care professionals (HCPs) had appropriate skills and training, and worked in a safe, professional and caring manner.

2.34 Detainees were satisfied with their medical care and were able to see an HCP of the gender of their choice, which sometimes involved a longer wait. The HCPs we observed were courteous in their interactions with detainees.

2.35 Nurses were available 24 hours a day at Scarborough and York, with a nurse deployed between Harrogate and Northallerton suites. There was just one forensic medical examiner (FME) on duty for the whole of North Yorkshire. Custody staff told us that nurse response times were good, but the FME response was slower due to the coverage of a large geographical area.

2.36 Custody staff told us that organisations offering services to detainees with alcohol or substance misuse problems were helpful and supportive. Detainees were offered the services of a drug or alcohol arrest referral worker as appropriate, and were referred to community drugs or alcohol teams as necessary. Drug workers contacted the custody suites daily, and some visited them. Services were only available during office hours.

2.37 Mental health support services were provided through the Tees, Esk and Wear Valley NHS Trust, York City Trust, a crisis resolution and home treatments team (CRHT) at Harrogate, Northallerton and Scarborough, and York City provided a similar service. The police custody Leeds Community Health nurses could not directly refer to the CRHT and required the FME to attend, which delayed the referral process for vulnerable detainees.

2.38 Street triage had been introduced in Scarborough and York and been credited with diverting many vulnerable people from police custody.

2.39 There were positive interactions and meetings between the police and mental health services in providing reasonable outcomes for detainees, including joint approaches to care. However, we were told there were long delays in mental health assessments requiring an approved mental health practitioner.

2.40 North Yorkshire Police had demonstrated significant progress in reducing the number of detainees in police custody under section 136 of the Mental Health Act.[2] However, police cells had been used as a place of safety on 23 occasions in the three months to the end of June 2015, which was unacceptable.

Main recommendations

2.41 Custody staff should be more aware of the individual needs of vulnerable detainees, including women and children, and how to meet them in custody and on release.

2.42 All staff should complete use of force documentation after such force has been used in custody.

2.43 North Yorkshire Police should engage with their counterparts in the local authority to 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.

2.44 The force should continue its partnership work to ensure that police custody is not used as a place of safety for detainees under section 136 of the Mental Health Act, except in exceptional circumstances.

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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 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.

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 There was a clear management structure up to assistant chief constable, who provided the strategic lead for custody in the North Yorkshire police force. Custody was a centralised department within the criminal justice portfolio headed by a police staff lead. A chief inspector custody manager provided the operational lead. There was one inspector each to lead at Scarborough and York, and a third had dual responsibility for Northallerton and Harrogate. There was also an inspector who led on policy and procedure.

3.2 There were four custody facilities and four custody inspectors. Since the previous inspection, North Yorkshire had rationalised its custody estate and closed facilities in Selby and Skipton. The staffing of the custody suites meant that there was little opportunity for staff to have breaks during a 12-hour shift, and little capacity or flexibility if staff became unavailable at short notice – staff often travelled long distances at the beginning of their shift to provide cover at a custody suite.

3.3 There was a significant difference in throughput of detainees between the custody suites – for example, Scarborough had double the throughput of Northallerton, yet operated with the same minimum staffing levels.

3.4 The custody suites had sufficient cell capacity to manage the number of detainees held, although there were not enough support facilities, such as consultation rooms, in the busier locations (see paragraph 5.18).

3.5 There was a range of relevant meetings to set the strategic direction and policies for custody. The assistant chief constable chaired a regular custody strategy meeting that managed issues such as staffing, use of force, provision of health care and the custody estate.

3.6 All policies and procedures relating to custody were clearly accessible through the force intranet site in an area dedicated to custody. The policies were mostly clear and easy to understand, and staff had easy access to those on use of force, how and when to contact an appropriate adult, and how to deal with voluntary attendance as an alternative to detention.

3.7 The use of force policy gave responsibility to every member of staff who had used force in an incident to complete the documentation, but this was not always complied with. This made it difficult for the force to monitor trends and patterns or ensure staff accountability for force used.

Partnerships

3.8 The deputy chief constable was the main strategic partnership lead officer for North Yorkshire police. He was involved in some key partnerships, including the local criminal

justice board. There had been a significant reduction in the number of people detained in the force under section 136 of the Mental Health Act[3] over the last four years. However, the number brought into custody under section 136 was still too high. There were four facilities run by local health trusts across the force area where people detained under the Act could be taken instead of held in custody. An audit report for the Police and Crime Commissioner in March 2015 had highlighted some reasons why police did not always use the alternative facilities. These included difficulty in accepting detainees from other local authority areas, and that not all the facilities could deal with people who were violent or disruptive. (See main recommendation 2.43.)

3.9 Partnership work had resulted in a street triage system run by Tees, Esk and Wear Valleys and York NHS Trusts across two parts of the force area. People with mental health needs who came to the attention of the police had an initial assessment before appropriate action was decided. Everyone we spoke to about this work was positive.

3.10 While the number of children who had been charged with criminal offences and refused bail was reasonably low, many of these children were still held in custody overnight because of a lack of appropriate local authority accommodation. (See main recommendation 2.43.)

3.11 The force had recently changed its health care provider, and we found a robust mechanism for holding the provider to account. There was a regular meeting with the health care company. The force recorded shortfalls in service effectively, and was able to make challenges to improve the service for detainees.

3.12 An independent custody visitor (ICV) system worked across all four custody facilities, and a rota in each area ensured regular visits to the custody suites. The ICVs felt well supported by the force. Each custody inspector held a quarterly meeting with the ICV group for their custody suite, and the force had been visible in providing support and guidance for the visitors.

Learning and development

3.13 Custody sergeants and detention officers attended a three-week training programme covering the law, custody policy and procedure, and IT skills. Custody staff had enhanced personal safety training, although there was no policy on carrying personal safety equipment within custody. An annual refresher training programme was well attended by all staff, and feedback from participants was largely positive. The programme was relevant and included learning from the Independent Police Complaints Commission (IPCC) and national inspection agencies, as well as dealing with some local policies and procedures.

3.14 The force conducted its own self- assessment of custody, with visits to custody facilities and relevant checks on the standard of the estate and some of the work processes. There had been several improvements as a result of these inspections, although staffing levels restricted the number of inspections and the depth of inquiry.

3.15 Each custody inspector sampled a proportion of custody records, amounting to 10% of records across the force. There was good scrutiny of key areas of custody, including review

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[3] 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 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.

of the risk assessment process. However, several of the records needed to be cross-referenced against the audiovisual record and other documentation for improved scrutiny.

3.16 The force produced a regular custody bulletin, which reported relevant national reports and internal policies and procedures.

Recommendation

3.17 The custody records that the force samples should be cross-referenced against audiovisual records and other documentation.

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 Detainees we spoke to, and our observations, confirmed that custody staff engaged politely and courteously with detainees. Some booking-in areas were noisy and had insufficient privacy. Staff did not always ensure confidentiality, and we observed some unacceptable incidents at York where they discussed the cases of individuals in front of other detainees.

4.2 Individual needs of detainees were not always identified or adequately met. Staff generally asked detainees if they were carers, and then gave them the opportunity to make arrangements. However, we saw some poor practice: women detainees were not routinely asked if they would like to speak to a female member of staff; and when men and women were detained in the same corridor, we were not assured that the need to protect women from potential abuse or harm was considered. For example, in York, we found a man accused of rape located opposite a woman, with no consideration of appropriate safeguards to protect her. In a separate case, we observed CCTV footage where a woman had her clothing forcibly removed and was partially naked in the presence of male officers with little, if any, consideration of maintaining her dignity. On discussing this matter with police managers, there was no rational explanation for the presence of these male officers in the cell.

4.3 Custody staff told us that they would try to minimise the time children spent in custody by dealing with them promptly. In our custody record analysis of 30 cases we examined the records for five children, of whom three were held for less than six hours. Children who posed no risk were put on a minimum level of observations at 30-minute intervals. Other than this, there was little acknowledgement of the specific vulnerability of children, and they were offered no other specific support or care. Staff did not use age-appropriate language or always explain the custody process – including in one case we saw of a 14-year-old boy who had never been in custody before and appeared overwhelmed. Custody staff were not always aware that girls under 18 should be routinely allocated a female member of staff responsible for their care.

4.4 Detainees were not routinely asked if they had any religious needs as part of the booking-in process. Although religious items were only provided on request, suites were well equipped with artefacts to allow detainees to practise their religion. These included Qur'ans, prayer mats with compass, Bibles and Jewish texts.

4.5 Harrogate custody suite, the newest, had adequate facilities for detainees with disabilities, including an adapted shower and toilet, wider cell doors and lowered call bells. All suites provided a wheelchair, but there were few other adaptations to accommodate detainees with physical disabilities comfortably and safely. However, all suites had access to hearing loops, and material on detainee rights and entitlements were readily available in Braille.

4.6 Custody staff understood the importance of respecting the requests of transgender detainees, particularly about the gender of the person they were searched by.

Recommendations

4.7 Girls under 18 should be allocated a named female officer who is responsible for their care while in custody.

4.8 All suites should have facilities for detainees with physical disabilities.

Safety

4.9 Custody staff used the electronic risk assessment on the Niche police records management computer system, which was properly focused and enhanced by responsive supplementary questions that custody staff generally asked detainees to clarify their circumstances. We observed custody staff dealing patiently and sensitively with some detainees who were intoxicated and/or vulnerable. Although our custody record analysis indicated limited detail in initial risk assessments, our observations assured us that staff generally identified detainee risks and vulnerabilities well initially, including for those in custody for the first time, with appropriate cross-referencing to police national computer (PNC) warning markers and historic records on the Niche system. Where detention officers booked detainees in there was appropriate oversight from custody sergeants.

4.10 Although initial risk assessments were generally dynamic, this was not reflected in care plans for the management of risk. We reviewed detention logs and CCTV records and found levels of observations were sometimes set too low, not adhered to or the rationale for reduction was not recorded.

4.11 We reviewed the custody record for a man at York that indicated previous self-harm markers, including that he had been in hospital only that evening as he tried to hang himself, rendering him significantly high risk. His clothing was replaced with anti-rip clothing (shorts and a top made from material that is more difficult to rip to use as a ligature), but his level of observation was set at only 30-minute intervals, which we deemed low for the considerable risk posed. In another case reviewed, we found a 15-year-old girl at Harrogate who was due to be monitored every 30 minutes but on several occasions this did not happen – including one 55-minute gap between recorded observations.

4.12 Most detainees who were initially assessed as needing anti-rip clothing or were placed in them because they did not, or could not, cooperate with the risk assessment then stayed in these clothes until they were released. This did not reflect an ongoing risk assessment - in some cases, people had cooperated with the risk assessment, and in others the risks had reduced but their clothes had not been returned to reflect these changes.

4.13 Anti-rip clothing was often used routinely when risk assessments were not completed because detainees were either uncooperative or unable to cooperate, through intoxication, and sometimes when there was no apparent risk of self-harm. In some cases anti-rip clothing was used when there was a risk of suicide or self-harm, when higher levels of observation would have been more appropriate and given the detainee greater dignity and better care.

4.14 The routine removal of corded clothing (and sometimes footwear, even when there were no shoelaces or other ligature risks) was also disproportionate, particularly where detainees were assessed as low risk.

4.15 Custody staff carried anti-ligature knives and they were attached to cell keys which non-custody staff had access to when they unlocked detainees and engaged with them for a variety of reasons, including undertaking constant observations; this compromised detainee safety and was poor practice.

4.16 Staff shift handovers did not include all staff, and we saw health care professionals, sergeants and detention officers handing over to their peers separately, rather than as one team. Nevertheless, those we observed were well conducted and focused on risk, detainee welfare and case progression. A detailed printout with relevant information about each detainee was produced for each shift change. Custody sergeants generally visited all detainees following the handover to engage with and check them.

4.17 All detainees released from custody were given pre-release risk assessments. Those we observed involved the detainee and were properly focused on delivering a safe release for them, including checking their means of getting home and explaining bail conditions. However, several custody records we reviewed did not record all identified risks and vulnerabilities before release. For example, the pre-release risk assessment for a vulnerable woman at Harrogate identified suicide and self-harm risks and mental health issues, but recorded that there were no threats of self-harm, no known issues and that she 'appeared in order'. By contrast, we saw some cases where there had been additional efforts with some vulnerable detainees to ensure they had accommodation, support and the means to get home.

4.18 A helpful support leaflet was generated automatically for every detainee who was released, and this was explained more thoroughly when there was identified need. Transport was offered to detainees who needed it, with fares paid in exceptional circumstances.

Recommendations

4.19 Removal of detainees' clothing and footwear should be subject to individual risk assessment.

4.20 Observations of detainees should be set at levels appropriate to the risk posed and should always be adhered to.

4.21 Anti-rip clothing should only be used in exceptional circumstances and as a last resort to protect the detainee from harm, with a recorded rationale, based on a risk assessment, and the detainee's own clothes should be returned to them at the earliest opportunity.

4.22 All custody staff should be involved collectively in the relevant shift handover.

Use of force

4.23 Oversight and governance of the use of force was inadequate. Managers were generally unaware of the level and types of force used in custody suites (see paragraph 3.7). There was a database about use of force incidents but the data inputted relied on officers submitting a use of force form. In 2015 to date there had been 165 recorded incidents involving force in custody suites, but we were not assured this was accurate as we found some incidents in custody records that did not appear on the database and had no supporting use of force forms. Incapacitant spray accounted for eight of the uses of force, which was high considering there were usually enough custody staff to de-escalate a situation. We were unable to access any CCTV footage or use of force forms relating to the use of the incapacitant spray to assess if its use was proportionate. Each officer involved in the use of force was required to complete a use of force form, but we found too many gaps where forms were not completed, and those we were able to review mostly contained scant information and were generally of a poor quality.

4.24 All the custody staff we spoke to had been on at least two control and restraint refresher training courses in the previous 12 months. They were aware that force should only be used as a last resort and assured us that they would make efforts to de-escalate situations before applying any use of force. In most incidents we reviewed on CCTV, force was proportionate to the risks posed and was de-escalated reasonably quickly. However, in one incident there were insufficient efforts to de-escalate, and in another a woman detainee was forcibly required to wear anti-rip clothing with insufficient attention to maintaining her dignity and with male staff present when she was partially naked, which was inappropriate and unnecessary. We referred both incidents to the criminal justice chief inspector.

4.25 Detainees were rarely handcuffed when they arrived in custody, which was positive.

4.26 Although force data on strip searching showed that its use was high and, at its own admission, inaccurate, we encountered little strip searching during the inspection. When we observed it, it was properly justified and authorised, and conducted by same-gender staff.

Recommendation

4.27 **Officers of the opposite sex should not be present during the stripping of any detainee unless there is an exceptional and immediate risk.**

Physical conditions

4.28 The environment at the newer suite in Harrogate was very good and, overall, physical conditions were adequate. The cleanliness and general maintenance was mostly good. Detention officers (DOs) conducted daily cell checks and reported any faults or defects, which were generally responded to quickly. Most communal and cell areas were clean with little evidence of graffiti, but a few were dirty and needed more thorough cleaning. Cells were cleaned each day and checked between uses.

4.29 There were comprehensive daily, weekly and monthly checks at each suite which were properly focused on identifying ligature points.

4.30 CCTV operated in all custody suites and prominent signs advised detainees of this. In cells monitored by CCTV, toilet areas were pixellated to ensure privacy.

4.31 It was common practice for non-custody staff to escort detainees to cells after the booking-in process. Custody sergeants actively reminded non-custody staff to explain the cell call bell and to test it to ensure it was working. Responses to cell call bells were generally prompt.

4.32 Each suite had a fire evacuation policy and fire evacuation plans were displayed. Records of all fire drills completed in custody suites were maintained by the health and safety department.

Detainee care

4.33 Detainee care was good overall. In our analysis of 30 custody records, 19 detainees had been offered at least one meal while in custody, four were given a period of exercise and four were offered washing facilities. Mattresses and pillows were provided but were not always cleaned between uses. Clean blankets were offered routinely at all suites, and custody staff also offered jumpers if detainees said they were cold. There were sufficient stocks of

replacement clothing, including underwear. Toilet paper was placed into cells routinely. Women detainees were routinely offered sanitary items, which was positive.

4.34 Food preparation and storage areas were generally clean. Provision of food and drinks was good. A range of microwaveable meals and drinks were offered at regular mealtimes and also provided at other times on request.

4.35 Custody suites had a range of reading materials, generally provided by staff, but they were not promoted well and generally only provided on request. There was not enough material for children, in foreign languages or easy-read format. Not all suites had designated visits facilities and would only facilitate visits in exceptional circumstances.

4.36 With the exception of Northallerton, where the exercise yard was indoors, all suites had outside exercise areas which allowed detainees to access some fresh air. Although we found and saw evidence of their use, this was relatively infrequent, and we were told it was not always possible to facilitate access during busier times.

4.37 Showers were available at all suites and were mostly clean but were not private enough. The communal toilet in the designated children’s cell area at York was dirty and had a bad smell.

Recommendations

4.38 **All suites should hold a stock of reading material in a range of languages and in easy-read format, and books that are suitable for children.**

4.39 **Showers should give detainees sufficient privacy.**

Housekeeping points

4.40 Mattresses and pillows should be cleaned between uses.

4.41 The toilet in the children's corridor at York should be clean and hygienic.

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 and detention officers under supervision booked detainees in, but custody sergeants were responsible for asking arresting officers to provide a full explanation of the circumstances of and the reasons for the arrest before authorising detention. At York, we saw several detainees arriving at the custody suite escorted by G4S staff, who were contracted to convey detainees to custody facilities at peak times; this allowed arresting officers to remain operational on the street. G4S staff handed over a completed custody form, which detailed the circumstances of the arrest, offence details and grounds for arrest. Custody sergeants reassuringly checked the circumstances of the arrest with G4S staff in the presence of the detainee, who they made sure was aware of the circumstances of and reason for the arrest before authorising detention.

5.2 Sergeants told us that they rarely had to refuse detention as officers were aware of the necessity to meet the criteria contained in PACE code G.[4] We saw some officers provide very thorough reasons to justify their necessity to arrest detainees. A few custody sergeants told us they had occasionally refused to authorise detention when the circumstances did not merit it, and they provided details of these cases.

5.3 Alternatives to custody were available in the form of voluntary attendance (VA)[5], fixed penalty notices and community resolution. Data confirmed that voluntary attendance had increased to 2,253 attendees in the year to July 2015, compared with 2,129 attendees in the year to March 2015. The management of voluntary attendees was a protracted process – custody staff had to book in the individual on the custody computer system and complete a risk assessment before they were interviewed. This could result in unnecessary delays while the attendee waited to be booked in alongside detainees and bail returnees, and was contrary to the aim of diverting individuals from police custody. There were VA facilities at Skipton, Whitby and Selby and they were in the process of introducing VA rooms at Harrogate, Northallerton, Scarborough and York to divert attendees from the custody suite.

5.4 All custody staff were aware of the need to keep detention to a minimum, and custody sergeants were clear about their obligation to progress cases quickly. Data supplied by the force showed that the average length of detention was just over 11 hours 40 minutes. This was similar to the average length of detention in our custody record analysis, which was 12 hours five minutes, with 10 detainees held for less than six hours.

5.5 Custody staff reported a good relationship with Home Office immigration enforcement officers. Staff told us, confirmed by data supplied by the force, that although few immigration

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[4] Police and Criminal Evidence Act 1984, code G, is the code of practice for the statutory power of arrest by police officers.

[5] 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.

detainees were held, they could sometimes be in custody for up to 48 hours, which was too long. Force data confirmed that 88 immigration detainees had been held in the year to July 2015, which was fewer than the 101 held in the year to March 2015. However, the overall average time that immigration detainees spent in custody had increased from 23 hours 29 minutes in the year to March 2015 to 27 hours 15 minutes in the year to July 2015.

5.6 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.[6]

5.7 Custody staff told us they had not known local authorities to provide secure accommodation where a child had been charged and could not be bailed, but some staff were aware that local authorities had sometimes been able to provide safe accommodation (such as with foster carers) on request. Force data showed that 12 children had been charged and had bail refused in the 12 months to July 2015. Five requests had been made to the local authorities to provide secure accommodation and six requests for safe accommodation, but only three children were subsequently moved to safe accommodation. We were assured that custody staff understood the different requirements for safe and secure accommodation, and posters displayed in all the custody suites detailed the procedure for the bail, transfer and detention of children (see main recommendation 2.43).

5.8 Custody staff were aware of their responsibilities to contact an appropriate adult (AA) when dealing with vulnerable adults and children under the age of 18. Family or friends were contacted in the first instance, and all custody staff we spoke with were aware of the guidance documents to assist AAs when they supported both detainees and voluntary attendees. These documents were readily available in all the custody suites and we saw them issued to several AAs during our inspection.

5.9 In the absence of family members, AAs were available through the local authorities. Custody staff told us that during the hours of 9am to 10pm the service for children provided by the Youth Offending Service (YOS) was efficient, but there were sometimes delays for vulnerable adults while deciding who to approach to attend – such as the learning disability team, mental health team etc. Outside of these hours, the service was provided by the local authority emergency duty team (EDT), and attendance was inadequate. However, on one evening during our inspection, a member of the EDT attended the Scarborough suite at 7pm to act as an AA for a vulnerable adult who was to be charged, and who had earlier in the day been assisted by an AA from the local learning disability team. Custody staff told us that, where possible, they would bail a detainee awaiting an AA if one was not readily available. However, this was not always possible and led to detainees being held in custody for longer than necessary, as we had found during our last inspection.

5.10 In our custody record analysis, there were five children in the sample aged between 12 and 17. All had an AA present while being informed of their rights and during interview. While it was not always recorded when the AA was contacted, there was only one lengthy wait – of 10 hours 40 minutes – for an AA to attend. In this case, a 17-year-old boy was detained at Northallerton at 11.02pm but the AA (his mother) was not contacted until 00.44am. She had difficulties in travelling to the custody suite so it was agreed that she would attend the following morning, but did not do so until 11.24am.

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[6] 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.

5.11 During booking-in, custody sergeants 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 – and all detainees were offered a written notice setting out their rights and entitlements while in custody. Custody staff could source these notices in foreign languages for non-English speaking detainees, but none who we spoke to were aware of the easy-read pictorial format version available from the Home Office website. An up-to-date version of the rights and entitlements material was available in Braille in every custody suite. A written notice setting out rights and entitlements was also offered to voluntary attendees; the version used at Northallerton was out of date, but this was immediately replaced by a current version after we informed the force.

5.12 A professional telephone interpreting service was available to assist the booking-in process, but this was used via a loudspeaker telephone, which lacked privacy and was noisy when the suite was busy. Staff at some suites said it was easier to use the loudspeaker even when they had the facility to link two telephones together. Staff told us that a face-to-face interpreter service was also available for interviews.

Recommendations

5.13 **Voluntary attendees should not be booked into custody within the custody suite environment.**

5.14 **North Yorkshire police should monitor the average length of detention for immigration detainees to ensure that they are not held in police custody for longer than necessary.**

5.15 **The force should ensure effective provision of appropriate adults for vulnerable adults and children at all times.**

Housekeeping point

5.16 Staff should be made aware of the availability of the easy-read pictorial format of detainees' rights and entitlements information.

Rights relating to PACE

5.17 We saw detainees being told during the booking-in process that they could read the PACE codes of practice, and custody staff routinely explained and offered the codes. There were sufficient copies of the up-to-date PACE code C at all suites. Criminal Defence Service (CDS) posters informing detainees of their right to free legal advice in 24 languages were only available in two suites; the other two suites displayed these in a limited number of languages.

5.18 All detainees were offered free legal representation. If they declined, staff routinely asked them why, while also reminding them that they could change their mind at any time. Detainees who wished to speak to legal advisers could do so in privacy in all the suites through telephones in glass-fronted consultation rooms in the main foyers.

5.19 There were not enough consultation and interview rooms to meet demand at York and Northallerton – at busy periods we saw solicitors and investigating officers queuing to use them, delaying detainee interviews. We saw legal advisers in all the suites given copies of their client's custody record without having to request these. Legal advisers who we spoke

to reported good relations with the police. In our custody record analysis, all detainees were offered legal advice, and 15 accepted.

5.20 We observed detainees being told that they could inform someone of their arrest, which staff facilitated. In our custody record analysis, eight detainees had requested that someone be informed of their arrest, but in only four cases was it clear that this had happened.

5.21 Dedicated custody and critical incident (operational) inspectors carried out reviews of detainees across the force area. Those we observed, which took place face-to-face and over the telephone, were timely and thorough. In our custody record analysis, of the 14 detainees who required a PACE review, 12 were on time and two were slightly early. Ten of the reviews took place when the detainee was asleep, and it was not recorded if any of these had been informed the review had taken place or that they were reminded of their rights and entitlements. Only one of the reviews took place by telephone. Staff told us that telephone reviews had sometimes been used for children in detention, which was inappropriate as this would have failed to take all their needs and vulnerabilities into account. In our custody record analysis, a 17-year-old at Northallerton was subject to an initial review while he was asleep, with no information recorded that he had been told of this on wakening, and his second review was then conducted over the telephone.

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

5.23 Custody staff at all suites told us that local magistrates' courts would not normally accept detainees after 2pm on weekdays or 9am on Saturday, which was too early. Although we were told that there was some flexibility each day, as at the previous inspection, some courts had refused to accept detainees as early as 9am on a weekday because they were too busy, which meant that detainees had to remain in police custody for longer than necessary.

Recommendations

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

5.25 **Custody suites should have sufficient consultation and interview rooms to meet demand at peak times to ensure that detainees do not remain in custody for longer than necessary.**

5.26 **Detention logs should record the outcome when a detainee requests that a nominated person be informed of their arrest.**

5.27 **Detainees should be informed of any reviews carried out while they were asleep, and this should be recorded in the custody record and they should be reminded of their rights.**

5.28 **Telephone reviews should not be conducted with children.**

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

Rights relating to treatment

5.30 Although no information on the complaints process was displayed in the custody suites, details were included in the rights and entitlements notice offered to detainees. Most custody staff told us that if a detainee wished to make a complaint, they advised the critical incident inspector, who would see the detainee in the custody suite, provided this did not hinder the investigation; inspectors confirmed this process. We observed an inspector at York one evening who was made aware of a detainee's wish to make a complaint. The inspector attended the cells and spoke to the sergeant but decided not to progress the matter then due to the detainee's intoxication, but indicated that he would arrange for him to be visited by the dayshift inspector. We were told that the professional standards department circulated a regular organisational learning bulletin with learning points identified from complaints.

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 North Yorkshire police directly commissioned Leeds Community Healthcare NHS Trust (LCH) to provide medical services in police custody since April 2015. Monitoring arrangements were effective with penalties for underperformance. The staffing complement was not yet complete but most staff were in post.

6.2 Detainees were cared for by health care professionals (HCPs) comprising doctors and nurses, with appropriate competences. The HCPs we observed were respectful and careful to preserve the privacy and dignity of detainees. All the detainees we spoke to were complimentary about their care from HCPs. They could see an HCP of the gender of their choice, although this could mean an extended wait.

6.3 LCH clinical governance structures were good and included arrangements for HCP credential checking, training and supervision. Clinical supervision was not yet systematic.

6.4 Clinical notes were stored on SystmOne (electronic clinical record) and subject to audit. The audit cycle was annual, which left too much time in between samples for poor practices to emerge unchecked.

6.5 The LCH ‘quality challenge’, designed to improve and maintain service quality based on the health regulator’s key lines of enquiry, had just been introduced.

6.6 Three of the custody suite health care rooms were only just adequate as they had infection control problems; none were designed for forensic sampling. The fourth suite, at Harrogate, was new, although it also had infection control compliance issues and was dusty. Audits of infection control had been completed and action plans prepared for all suites to return to compliance.

6.7 All equipment (including automated external defibrillators) was ready for use and regularly checked. There were some out-of-date sterile supplies, which were replaced when we pointed them out. All staff had been trained to recognise and respond to medical emergencies and knew where to find the equipment.

Housekeeping point

6.8 There should be frequent clinical audit of medical records to ensure good practice.

Patient care

6.9 Detainees were risk assessed by custody staff on entry to the custody suite, using a standard set of medical questions. In our custody record analysis of 30 cases, seven detainees had a physical injury when they arrived in the custody suite.

6.10 Nurses were available 24 hours a day at Scarborough and York, with a nurse deployed between Harrogate and Northallerton suites. One forensic medical examiner (FME) was on duty for the whole of North Yorkshire for each 12-hour shift. HCPs were on call at all times, and saw around 450 detainees a month. Custody staff told us that response times were usually good, although FMEs often took too long to travel across the large geographical area. In the four months since April 2015, the average response time by all HCPs was 50 minutes against a target of 60 minutes (an improvement on the pre-April average of 100 minutes). Our custody record analysis indicated waits for HCPs ranging from zero to 181 minutes.

6.11 We sampled clinical records and spoke to HCPs making entries. Records contained standardised assessment tools, and detainee care plans conformed to contemporary clinical guidance. HCP records were of a good standard.

6.12 After seeing a patient, the HCP uploaded a summary on the Niche police records system and shared information as necessary with custody staff. Although the police appreciated the Niche summary, it duplicated HCP activity and some Niche medical records were difficult to follow.

6.13 Treatment pathways were available to guide medical practices, and appropriate medicines were available for prescription by doctors, or by nurses using patient group directions (PGDs), which enabled nurses to supply and administer prescription-only medicine. Nurses also administered over-the-counter medications. Where nurses were not available, medicines for patients were placed in labelled bags and clipped to detainee clipboards, which was not a secure system. Opiate substitution and nicotine replacement therapies were available.

6.14 Medicines supply, storage and administration were generally to a good standard, although we found controlled drug recording and counting errors – these were investigated and miscounts resolved when we visited. Two code-activated key lockers were not working, and at Northallerton the over-ride key was left with the police, which was an unnecessary risk. Variations in temperatures of refrigerators holding heat-sensitive medications had been recorded but actions to rectify problems had not been documented. A pharmacy technician had been employed to improve medicines management, which was positive.

6.15 The police kept a separate stock of inhalers (for detainees with breathing difficulties), which were administered after consultation with a HCP. Detainees' own medicines were stored in their property lockers and administered as directed by the HCPs, which was appropriate.

Recommendations

6.16 Detainees should have access to appropriate and timely responses from the FME.

6.17 Medicines for detainees should be labelled and kept securely.

6.18 Controlled drugs should be stored securely and stock levels checked frequently at all custody suites.

Housekeeping points

6.19 The transcribing of medical information from SystmOne to Niche should be scrutinised to avoid duplication.

6.20 All health care professionals should be aware of the actions required to rectify out-of-range refrigerator temperatures.

Substance misuse

6.21 In our custody record analysis, 12 out of the 30 detainees were intoxicated by alcohol or drugs on entry to police custody. North Yorkshire Horizons provided substance misuse services at Harrogate, Northallerton and Scarborough, and Lifeline in York. Custody staff said that both organisations were helpful and supported detainees with substance misuse and alcohol problems.

6.22 Detainees were offered the services of drug arrest and referral workers, although in our custody record analysis this had not always been documented. Drug workers telephoned the custody suites daily and sometimes visited the suites. Services were only available during office hours. Custody staff would often signpost detainees to relevant services. There was appropriate use of conditions of bail to ensure engagement with services; custody staff and drug workers said it was effective in engaging service users after the bail condition had ceased.

6.23 There was little harm minimisation advice in the custody suites. Needle exchange had recently been relaunched, but not all staff were aware of it. Children were signposted to age-appropriate services.

6.24 Voluntary peer support from Alcoholics Anonymous (AA) was available at York, which was positive. The system for peer engagement through AA was under review.

Mental health

6.25 Tees, Esk and Wear Valleys NHS Trust provided mental health support through crisis resolution and home treatment (CRHT) teams in Harrogate, Northallerton and Scarborough, and York City Trust provided such a team in York. Custody staff had had mental health awareness training, but LCH registered mental nurses were unable to refer patients to CRHT teams, which caused delays while waiting for FMEs to arrive.

6.26 In our custody record analysis, 33% of detainees had told police they had mental health problems. There were visiting mental health professionals at Scarborough but nowhere else. We did not see any mental health professional in a custody suite. Street triage had been introduced in Scarborough and York, and was credited with diverting many mentally ill people from custody (see paragraph 3.9).

6.27 There were good strategic and operational meetings and teleconferences through which the police and mental health providers resolved issues in the effective mental health care of detainees, including joint approaches to care. Out-of-hours Mental Health Act assessments were arranged via approved mental health professionals, but we were told that response times were excessive – up to 24 hours according to some custody staff. We observed two cases where detainees waited longer than six hours to be seen, which was unacceptable.

6.28 Police custody had been used as a place of safety under section 136 of the Mental Health Act 1983[7] on 34 occasions in the three months to the end of June 2015. Use had reduced by 75% in the previous three years, which was very good progress, but too many detainees still entered police custody on section 136. (See main recommendation 2.44.)

Recommendation

6.29 **The force should monitor response times for out-of-hours Mental Health Act assessments, and take action to improve these.**

Housekeeping point

6.30 Leeds Community Healthcare NHS Trust registered mental nurses should be able to refer patients to crisis resolution and home treatment teams for assessment.

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[7] 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 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.

Section 7. Summary of recommendations

Main recommendations

7.1 Custody staff should be more aware of the individual needs of vulnerable detainees, including women and children, and how to meet them in custody and on release. (2.41)

7.2 All staff should complete use of force documentation after such force has been used in custody. (2.42)

7.3 North Yorkshire Police should engage with their counterparts in the local authority to 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. (2.43)

7.4 The force should continue its partnership work to ensure that police custody is not used as a place of safety for detainees under section 136 of the Mental Health Act, except in exceptional circumstances. (2.44)

Recommendations

Strategy

7.5 The custody records that the force samples should be cross-referenced against audiovisual records and other documentation. (3.17)

Treatment and conditions

7.6 Girls under 18 should be allocated a named female officer who is responsible for their care while in custody. (4.7)

7.7 All suites should have facilities for detainees with physical disabilities. (4.8)

7.8 Removal of detainees' clothing and footwear should be subject to individual risk assessment. (4.19)

7.9 Observations of detainees should be set at levels appropriate to the risk posed and should always be adhered to. (4.20)

7.10 Anti-rip clothing should only be used in exceptional circumstances and as a last resort to protect the detainee from harm, with a recorded rationale, based on a risk assessment, and the detainee's own clothes should be returned to them at the earliest opportunity. (4.21)

7.11 All custody staff should be involved collectively in the relevant shift handover. (4.22)

7.12 Officers of the opposite sex should not be present during the stripping of any detainee unless there is an exceptional and immediate risk. (4.27)

7.13 All suites should hold a stock of reading material in a range of languages and in easy-read format, and books that are suitable for children. (4.38)

7.14 Showers should give detainees sufficient privacy. (4.39)

Individual rights

7.15 Voluntary attendees should not be booked into custody within the custody suite environment. (5.13)

7.16 North Yorkshire police should monitor the average length of detention for immigration detainees to ensure that they are not held in police custody for longer than necessary. (5.14)

7.17 The force should ensure effective provision of appropriate adults for vulnerable adults and children at all times. (5.15)

7.18 Posters advertising detainees' right to free legal advice, in a range of languages, should be prominently displayed in all custody suites. (5.24)

7.19 Custody suites should have sufficient consultation and interview rooms to meet demand at peak times to ensure that detainees do not remain in custody for longer than necessary. (5.25)

7.20 Detention logs should record the outcome when a detainee requests that a nominated person be informed of their arrest. (5.26)

7.21 Detainees should be informed of any reviews carried out while they were asleep, and this should be recorded in the custody record and they should be reminded of their rights. (5.27)

7.22 Telephone reviews should not be conducted with children. (5.28)

7.23 Senior police managers should work with HM Courts & Tribunals Service to ensure that early court closure times do not result in unnecessarily long stays for detainees in police custody. (5.29)

Health care

7.24 Detainees should have access to appropriate and timely responses from the FME. (6.16)

7.25 Medicines for detainees should be labelled and kept securely. (6.17)

7.26 Controlled drugs should be stored securely and stock levels checked frequently at all custody suites. (6.18)

7.27 The force should monitor response times for out-of-hours Mental Health Act assessments, and take action to improve these. (6.29)

Housekeeping points

Treatment and conditions

7.28 Mattresses and pillows should be cleaned between uses. (4.40)

7.29 The toilet in the children's corridor at York should be clean and hygienic. (4.41)

Individual rights

7.30 Staff should be made aware of the availability of the easy-read pictorial format of detainees' rights and entitlements information. (5.16)

Health care

7.31 There should be frequent clinical audit of medical records to ensure good practice. (6.8)

7.32 The transcribing of medical information from SystmOne to Niche should be scrutinised to avoid duplication. (6.19)

7.33 All health care professionals should be aware of the actions required to rectify out-of-range refrigerator temperatures. (6.20)

7.34 Leeds Community Healthcare NHS Trust registered mental nurses should be able to refer patients to crisis resolution and home treatment teams for assessment. (6.30)

Section 8. Appendices

Appendix I: Inspection team

Maneer Afsar	HMI Prisons team leader
Vinnett Pearcy	HMI Prisons inspector
Kellie Reeve	HMI Prisons inspector
Fiona Shearlaw	HMI Prisons inspector
Clive Burgess	HMIC staff officer
Anthony Davies	HMIC staff officer
Paul Tarbuck	HMI Prisons health services inspector
Catherine Raycraft	Care Quality Commission inspector
Rachel Prime	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

There should be sufficient custody staff on duty to ensure that detainees' care and welfare needs can be met effectively. (3.10)
Achieved

Clear directions should be issued to formalise the quality assurance of custody records to ensure consistency and equity across the force. (3.11)
Partially achieved

The use of force monitoring form should be amended to capture all available information and to monitor the use of force centrally so that custody managers can identify patterns and monitor trends. (3.12)
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.

Main recommendations

Risk assessments should take into account all the relevant information available to staff, who should actively engage with detainees when booking them in to custody. (2.23)
Partially achieved

The processes for carrying out health and safety, maintenance and cleanliness checks should be reviewed and formalised across the custody estate and the results reviewed by managers. Staff should be provided with appropriate training to allow them to carry out these checks. (2.24)
Achieved

Recommendations

Refresher training on meeting the specific needs of the diverse range of detainees found in custody, including juveniles, women and those with disabilities, should be offered. (4.23)
Partially achieved

Booking-in areas should allow sufficient privacy to facilitate effective communication between staff and detainees. (4.24)
Partially achieved

All cells should be fit for purpose and free of ligature points and custody staff should be trained to identify potential ligature points. (4.25)
Achieved

All staff should carry anti-ligature knives. (4.26)
Partially achieved

Views of in-cell toilets covered by closed-circuit television should be obscured. (4.27)
Achieved

Detainees held overnight should be offered a shower. (4.28)
Partially achieved

All female detainees should be offered a hygiene pack on arrival. (4.29)
Achieved

The food provided should be of a sufficient quality and calorific content to sustain detainees held for long periods. (4.30)
Achieved

Detainees held overnight or for longer periods should be offered outdoor exercise. (4.31)
Partially achieved

Individual rights

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

Main recommendation

Appropriate adults should be readily available to support juveniles aged 17 and under and vulnerable adults while in custody. (2.25)
Partially achieved

Recommendations

Custody staff should ensure that detainee dependency obligations are routinely identified and, where possible, addressed. (5.12)
Partially achieved

The responsible assistant chief constable should work with the equivalent manager of the court service to minimise delays in holding detainees who are to be produced at court. (5.13)
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 delivery of an action plan that addresses the issues. (5.14)
Achieved

Custody managers should ensure that detainees who want to make a formal complaint about their arrest or treatment in custody should be able to do this while still in custody. (5.15)
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.

Main recommendations

Keys to medicine cabinets should be secured and accessible only to healthcare professionals. (2.26)
Not achieved

There should be a liaison and/or diversion scheme that enables detainees with mental health issues to be identified and diverted into appropriate mental health services. (2.27)
Partially achieved

Recommendations

Healthcare professionals should not instruct non-healthcare professionals to administer prescribed medicines. (6.17)
Achieved

There should be clear infection control procedures across all suites and the management of general and clinical waste should be managed more robustly. Cleaning schedules should be monitored. (6.18)
Achieved

Resuscitation equipment should be in place and ready for use at every custody suite and staff should be trained in its use and receive annual training updates. Responsibility for the management of, and determining the need for, equipment should be clarified. (6.19)
Achieved

Weekly checks of drugs held in the forensic medical examiner room should be carried out and recorded appropriately. (6.20)
Partially achieved

All clinical records should be stored in accordance with Caldicott guidelines the Data Protection Act and other relative legislation. (6.21)
Achieved

Access to substance use services should be consistent across the county. (6.22)
Achieved

HM Inspectorate of Prisons and HM Inspectorate of Constabulary are members of the UK's National Preventive Mechanism, a group of organisations which independently monitor all places of detention to meet the requirements of international human rights law.