Report on an unannounced inspection visit to police custody suites in

Dorset

by HM Inspectorate of Prisons
and HM Inspectorate of Constabulary

16–25 February 2016

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 is a positive report. Overall, Dorset Police managed its custodial services well. Detainees were generally treated well, and the conditions they were held in were good. Since the previous inspection significant progress and improvements had been made in a number of important areas. We were particularly impressed at the progress that had been made in relation to mental health provision and we regarded the way information was shared at staff handovers as good practice. Greater effort was still required to ensure that children did not remain in custody unnecessarily. The Office of the Police and Crime Commissioner was actively involved in the delivery of safer detention for vulnerable detainees, especially for children with mental health concerns. There was an active independent custody visitor scheme, with quarterly panel meetings.

The force used performance data and managed staffing resources well. A reserve bank of detention officers helped to maintain resilience and ensure an adequate service was delivered. Managers had a good understanding about the custody operations within the force; however, there were some frailties in the way quality assurance was conducted.

The physical conditions that detainees were held in were good and the treatment they received was appropriate and met their basic needs. We observed a polite and courteous staff, focused on delivering safe custody. Risk assessments were generally undertaken to a high standard and custody records we reviewed highlighted impressive interactions with detainees. Handovers were multi-disciplinary and highly effective. In contrast to this, the quality of pre-release risk assessments we examined were variable and some of them were poor.

Unlike many forces we inspect, the monitoring of use of force was commendable, with each incident recorded on the computer system, reviewed by the Public Order Unit and used to inform training and learning.

Although the provision of alternative accommodation for children in custody who were charged and not bailed was poor, this was not the sole responsibility of Dorset Police. However, the force had only recently begun to discuss this issue with the local authority and no alternative accommodation was available during the course of the inspection.

Individual rights for detainees were addressed appropriately and each detainee was given a clear reason for their arrest and detention. The appropriate adult (AA) scheme for vulnerable adults and children worked well; however, AAs were only required to attend for the interview, which meant that vulnerable detainees spent several hours in custody on their own, which was inappropriate.

Health services were delivered jointly by the force, CRG Medical Ltd, mental health providers, substance misuse services and NHS England, and were good. Detainees were generally seen promptly and clinical records were of a high standard. A drug worker attended the suites daily to see detainees and refer them to specialist support and services. We noted as good practice that clinical rooms were deep-cleaned before forensic testing, that detainees of all ages had excellent access to prompt mental health support, and that children and young people had access to a specialist youth practitioner in the community.

Mental health provision was now extremely good. The strategic partnership with mental health services delivered a significant reduction in the number of people brought into police custody. There

was support from Dorset Healthcare University NHS Foundation Trust, in the form of telephone advice for police officers at each suite, from 7am to 7pm, resulting in fewer vulnerable people arriving in custody.

We noted that, of the 51 recommendations made in our previous report after our inspection of November 2009, 37 recommendations had been achieved, five had been partially achieved, five had not been achieved and four recommendations were no longer relevant.

This report identifies three areas of good practice, makes one recommendation to the force and highlights 13 areas for improvement. We expect our findings to be considered and for an action plan to be provided in due course.

Dru Sharpling CBE
HM Inspector of Constabulary

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HM Chief Inspector of Prisons

June 2016

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 was conducted as part of the police custody inspection. The custody record analysis was carried out on a representative sample of the custody records, across both of the suites in that area, opened in the week before the inspection was announced. Records analysed were chosen at random and a robust statistical formula provided by a government department statistician was used to calculate the sample size required to ensure that our records analysis reflected the throughput of the force's custody suites during that week.[2] The analysis focused on the legal rights and treatment and conditions of the detainee. A total of 118 records were analysed.

2.4 This was the second inspection of Dorset police custody, following up on our first inspection in November 2009. During this inspection, the designated suites and cell capacity were as follows:

Custody suites	**Number of cells**
Bournemouth	37
Weymouth	19
Poole (reserve custody suite)	27

[1] https://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/inspection-criteria/. The inspection of police custody in Dorset was carried out under the previous *Expectations*, published in 2012.

[2] 95% confidence interval with a sampling error of 7%.

Strategy

2.5 There was a clear custody management structure up to assistant chief constable (ACC) level. Current staffing levels were adequate to meet demands. A bank of detention officers (DOs) provided additional resilience when required.

2.6 Besides the two main custody suites, there was also a reserve facility in Poole, which could be used for pre-planned operations or when the main facilities were closed for maintenance. There were two non-designated suites at Blandford and Bridport that could be used to detain people for less than six hours.

2.7 There was good collection of management data, especially in relation to use of force.

2.8 There had been a large reduction in the number of people brought into custody under section 136 of the Mental Health Act. The custody mental health lead and the Office of the Police and Crime Commissioner (PCC) for Dorset had made significant progress in improving outcomes for this vulnerable group.

2.9 Dorset Police were in discussions with the local authority on the provision of alternative accommodation for children charged and not bailed. The force had not yet secured any substantive agreements, leading to poor outcomes for children in custody.

2.10 The independent custody visitor (ICV) scheme was well supported by the force, with appropriate interaction and feedback to the force on any issues arising from their visits. The PCC was actively involved in supporting better outcomes for vulnerable detainees.

2.11 Too few custody records were dip-sampled for quality assessment to provide meaningful organisational learning to the force.

Treatment and conditions

2.12 Custody staff had good individual interactions with detainees and were aware of dealing with people with vulnerabilities. The number of children brought into custody had reduced, and they were treated as vulnerable by virtue of their age. Staff had a good understanding of privacy and used discrete booking-in desks when necessary.

2.13 Women's needs were mostly well addressed. All detainees were asked about their religious and dietary needs, and some religious items and books were available. There were no adapted cells for detainees with disabilities.

2.14 The risk assessment contained useful questions about any additional support that the detainee might be receiving in the community, to identify other vulnerabilities. Risk assessments were reviewed regularly and, overall, the detail contained in custody records was of a high standard. In most cases, a rationale was given to support changes in observation levels.

2.15 Enhanced observations and rousing were used effectively and we observed good teamwork between DOs, sergeants and health services staff. The additional use of closed-circuit television (CCTV) and glass-fronted cells helped the monitoring of vulnerable detainees.

2.16 The handovers we observed were excellent. They included all staff, including health care professionals (HCPs). Information was shared on a template which recorded case progression and risks. A nominated custody sergeant took responsibility to update this during their shift.

2.17 The quality of pre-release risk assessments (PRRAs) was variable, from very good to poor. Those we observed being conducted had a clear focus on securing a safe release for detainees. However, for some PRRAs we reviewed there were few references to ongoing help, support or transportation home in cases where it would have been prudent to record extra information. In other records, there was a comprehensive and full account of the issues identified and addressed before release.

2.18 Most detainees arrived at the custody suites in handcuffs but these were removed swiftly. The records and CCTV footage of use of force that we reviewed showed that this had been proportionate, with good efforts made to de-escalate the situation.

2.19 The physical conditions in both suites were good and detainees were looked after appropriately.

Individual rights

2.20 We saw sergeants asking if non-custodial options had been considered. Detainees were given a clear explanation for their arrest. Alternatives to arrest were available but the force had only recently started recording these.

2.21 Custody staff, and data provided by the force, indicated that immigration detainees were moved on promptly.

2.22 The appropriate adult (AA) schemes for vulnerable adults and children worked well, and custody staff told us that there were rarely any serious delays in obtaining support. However, in most cases AAs arrived only in time for the interview, which was inappropriate.

2.23 Staff were not consistent about whether or not they would contact the local authority routinely to request alternative accommodation for children who had been charged but refused bail. Instances where this contact was made were rarely recorded. This meant that children in such circumstances always spent the night in police custody.

2.24 Custody staff were confident about using professional telephone interpreting services. Specialist telephone equipment was available for this purpose but sometimes did not provide sufficient privacy, particularly when used by HCPs.

2.25 Detainees were given a leaflet explaining their rights and entitlements, and had access to their solicitors.

2.26 Courts closed at approximately 2pm on most days but the flexible working and relationships between police and court staff meant that detainees were accepted at courts wherever possible.

2.27 Complaint forms were available in custody suites; however, the process for making complaints was inconsistent between the suites. Staff at Weymouth told us that detainees would need to make complaints after their release, whereas staff at Bournemouth told us that they would receive complaints while detainees were in custody.

Health care

2.28 Joint working between the force, CRG Medical Ltd (CRG), mental health providers, substance misuse services and NHS England was good. Some clinical governance

arrangements, including clinical supervision, audits and appraisals, were underdeveloped but this was being addressed.

2.29 Clinical facilities at Bournemouth were excellent but the Weymouth medical room did not comply with infection prevention and control standards. Cleaning standards were good and the deep-cleaning of clinical rooms before forensic testing was good practice.

2.30 Detainees were generally seen promptly and the quality of care provided was good. Clinical records were completed to a reasonable standard and were stored appropriately. Custody staff and HCPs worked collaboratively.

2.31 Detainees had good access to symptomatic relief for drug and alcohol withdrawal in custody but these medications were not sent with detainees to court, which presented potential risks to their health.

2.32 Detainees in both suites had appropriate access to drug and alcohol services. A drug worker attended the custody suite and saw all adult detainees with documented substance misuse issues. Custody staff could also refer detainees to the drugs service after release.

2.33 Mental health provision had improved considerably and was excellent. The street triage service and a revised multi-agency policy had markedly reduced the number of detainees being detained in police custody under section 136 of the Mental Health Act and mental health assessments generally occurred promptly.

2.34 All children were screened by the mental health liaison and diversion practitioners and were referred to appropriate services for support, including a specialist youth practitioner in the community.

Areas of concern and recommendations

Area of concern

2.35 When bail for children was denied post-charge, it was unclear if alternative accommodation was sought through the local authority, as required statutorily. Records indicated that this was rarely the case. Additionally, and while discussions were taking place, the force had not yet secured a protocol with the local authority to provide accommodation. This meant that such children were being detained unnecessarily in police cells.

Recommendation

Dorset 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.

Section 3. Strategy

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

Strategic management

3.1 An ACC was the strategic lead for custody. Custody was a centralised function within the criminal justice and custody portfolio, with a clear management structure up to the ACC. The force custody manager was a chief inspector, who dedicated most of his time to custody duties and also had an on-call firearms commander role. One custody support officer worked directly under the custody manager.

3.2 Staffing levels were adequate to meet the demands, with a total of three inspectors, 24 sergeants and 36 DOs working across the custody estate. Good resilience was provided by a bank of DOs and custody-trained frontline police officers, who could be called on to provide cover.

3.3 Data provided by the force showed a reduction in the number of people taken into custody over the previous two years. The two main custody suites had sufficient cell capacity to manage the number of detainees held. There was also one reserve custody facility in Poole, which could be used for pre-planned operational reasons, or when the main facilities were closed for building and maintenance work, and two non-designated suites at Blandford and Bridport that could be used to detain people for less than six hours.

3.4 The force generally collected a good level of management data to inform custody operations. Governance on the use of force was excellent, with a clear system for recording, monitoring and learning from the deployment of techniques in custody (see section on use of force). Data routinely collected through the force's custody computer system (Niche) was analysed by Dorset's Public Order Unit. This was then used to inform training and learning.

3.5 Figures provided by the force demonstrated a large reduction in the number of people brought into custody under section 136 of the Mental Health Act (see paragraph 6.23). The force was also able to show that, overall, the number of children detained had decreased year on year for the previous two years (see paragraph 4.2). However, they were unable to demonstrate how many requests were made to local authorities for accommodation for children charged and not bailed.

Partnerships

3.6 The mental health lead for custody had worked closely with the Office of the PCC for Dorset to ensure that custody was not used as a place of safety. Partnership working between the force and mental health providers was producing positive outcomes for people with mental health issues. A shared protocol between the force and substance misuse providers was also in place to ensure timely referrals to drugs and alcohol misuse services (see paragraph 6.19).

3.7 At the time of the inspection, the force was discussing with the local authority alternative accommodation for the transfer of children who had been charged but refused bail. The outcome of these discussions formed part of the force's wider children and young people

delivery plan, led by a superintendent. However, the force had not yet secured a protocol with local authorities, setting out their expectations in relation to children in custody and the duty placed on local authorities to provide appropriate accommodation for them, and this was leading to poor outcomes for such children (see area for concern 2.35 and paragraph 5.5).

3.8 The ICV scheme was well supported by the force. Quarterly panel meetings were held between the force, the Independent Custody Visiting Association coordinator from the Office of the PCC, and the ICVs. Visitors felt confident in their ability to raise issues with the force at these meetings. Each of the custody suites received regular visits, and both the coordinator and a visitor we spoke to reported easy access to custody suites. The PCC was actively involved in supporting better outcomes for vulnerable detainees.

Learning and development

3.9 There was an approved training programme for all new custody staff. Designed and delivered by Dorset's neighbouring forces in Avon and Somerset, and Devon and Cornwall, the initial training for custody officers lasted three weeks and was based on both the College of Policing's authorised professional practice for detention and custody, and the national Custody Officer Learning Programme. Custody sergeants also completed 100 hours of shadowing and were allocated a mentor before they took up a primary position in custody, which ensured that they were properly prepared for the role. New DOs were trained separately from sergeants and were also assigned a mentor, and all custody staff carried out personal safety training together. The force held mandatory continuing professional development days twice a year for all staff.

3.10 Custody inspectors dip-sampled a total of only 15 custody records per month from a throughput of around 1,000 detainees (1.5%). Only one of the 15 dip-sampled records was cross-referenced against the CCTV footage. Although feedback on the quality of the sampled records was provided, too few records were sampled to draw representative and meaningful conclusions, which restricted the opportunities for organisational learning.

3.11 The custody manager produced regular updates on custody matters, both in monthly custody meetings and through email communication to all custody staff. The force's operational policy and procedure for custody matters, held on the force intranet, was easily accessible.

Area for improvement

3.12 The dip-sampling of custody records should be increased to allow for a representative and meaningful sample and to facilitate organisational learning.

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 There were good arrangements for privacy when booking in detainees, and staff regularly used the discrete booking-in space. Custody staff had good individual interactions with detainees; they were polite and responded appropriately to detainees during the booking-in process, particularly those who were vulnerable or in an agitated state.

4.2 There was a clear awareness of the diverse needs of detainees, particularly those of children, and the force had made significant changes since the previous inspection. Children were treated as vulnerable by virtue of their age. We saw children being booked in at the discrete booking-in desks. They were also screened by Criminal Justice Liaison and Diversion workers, to identify any additional needs and support that might be required, and they were located in designated cells away from adult detainees. Data supplied by the force highlighted the overall downward trend of children being brought into custody (from 742 in 2014/15 to 585 in 2015/16 – a reduction of 21%).

4.3 Women's needs were mostly well addressed. They were given the opportunity to speak to a female member of staff but were not consistently assigned a female member of staff to look after their welfare while in custody, and were not asked if they required sanitary products. All detainees were asked about their religious and dietary needs. Some religious items and books were available in both suites and were stored respectfully. All detainees were asked if they had dependants.

4.4 There were no specific adaptations to cells to make them suitable for detainees with disabilities, such as wider doorways or lowered cell call bells. An adapted toilet and thick mattresses were available at Bournemouth, and a wheelchair was available at both suites. There was little information in Braille or in an easy-read format. Hearing loop equipment was available only at Bournemouth, and custody staff were not confident about using it.

4.5 Custody staff understood the importance of respecting the requests of transgender detainees, particularly about the gender of the person who searched them.

Safety

4.6 Most of the risk assessments we observed, and those we reviewed from custody records, were of high quality, with a good amount of relevant detail. The risk assessment included useful questions about any additional support that detainees were receiving in the community, to help custody staff to identify those with vulnerabilities. The custody records and our observations highlighted some impressive interactions with detainees when completing these assessments, and probing questions were used to elicit information from detainees to inform their care plan. Custody sergeants paid close attention to detainees' demeanour when it was inconsistent with the answers being given to the questions.

4.7 When detainees refused or were unable, through intoxication, to answer the risk assessment questions, in most cases custody staff made good attempts to formulate a care plan to meet their immediate needs.

4.8 Detainees' corded clothes and shoe laces were removed routinely (with their shoes then left outside the cell), which was disproportionate, particularly when they had been assessed as a low risk.

4.9 Observation levels were generally set appropriately and enhanced observations (basic cell visits combined with intermittent rousing) and rousing were used effectively. We observed close teamwork between DOs, sergeants and HCPs in managing the risk of some detainees. There was appropriate use of CCTV and glass-fronted cells to monitor the more vulnerable detainees. We observed a small number of constant observations; in one case, we saw an officer reading a book and in another we saw one using their mobile phone, both of which were inappropriate.

4.10 Risk assessments were reviewed regularly, particularly when detainees were under the influence of substances, and we were assured that observation levels were adhered to. Overall, the quality of information contained in custody records was of a high standard. The rationale to support reductions or increases in observation levels was generally well recorded and justified.

4.11 Custody staff had a sound awareness of rousing practice, and the outcome of these checks was mostly well recorded; we observed good teamwork between DOs, sergeants and health services staff. However, we were concerned about the use of pain compliance; in one case, this involved the application of pressure to the ear lobe to rouse a child (16 years of age) over a period of two hours. There was no clear justification in the custody record for the use of this technique.

4.12 Custody staff were not issued with personal anti-ligature knives but carried them on cell keys, which were allocated appropriately to DOs assigned to conduct cell visits.

4.13 The handovers we observed were excellent. They included all members of staff, including the mental health team and HCPs. The information shared was concise and relevant to the safety and welfare of detainees, and there was sufficient focus on the progression of the investigation. A handover sheet, which recorded risks and case progression, was an effective means of ensuring that up-to-date information was shared with incoming staff and we observed nominated custody sergeants taking responsibility to update this during their shift. Incoming staff visited and spoke to detainees after each handover.

4.14 The quality of pre-release risk assessments (PRRAs) was variable, from very good to poor. Those we observed being conducted demonstrated that custody sergeants were focused appropriately on securing a safe release for detainees. However, information on some PPRAs we reviewed did not always address the identified risk factors before release. In some, there were few references to any safeguards being put in place to address identified risks, or to the level of support offered, including transportation home. For example, in one case concerning a detainee who had tied a ligature around his neck while in custody, there was no acknowledgement of this, or of the fact that he had made threats to kill himself, at the point of release. We were particularly concerned about the lack of PRRAs for those detained under section 136 of the Mental Health Act (see also section on health care) who were later released; there was no record of any referrals made, support offered or basic information about how the detainee was going to get home. In other PRRA records we reviewed, we noted the comprehensive and full account of issues identified and addressed before release.

Areas for improvement

4.15 Custody staff conducting constant supervision should not engage in other activities, and significant events and interactions should be recorded.

4.16 Pre-release risk planning should reflect risks arising during custody as well as any consequences of release, and detainees should be offered information about relevant support organisations at the point of release.

Good practice

4.17 *Handovers were excellent. The information template recording risks and case progression, delivered to all staff, including health services staff, was commendable.*

Use of force

4.18 Oversight and governance of the use of force had improved and were comprehensive. The use of force in custody was recorded routinely by custody sergeants; staff were held accountable and managers were aware of its use (see also paragraph 3.4). The custody records we reviewed of detainees on whom force had been used identified who had been present, the techniques used and any attempts made to de-escalate the situation. The CCTV footage we reviewed also highlighted that the force used had been proportionate, with good efforts made to de-escalate the situation. However, detainees were not routinely referred to an HCP after an incident.

4.19 When force was used to prevent a detainee from harming themselves, custody staff completed an adverse incident form routinely, and this was then reviewed by an inspector. Those we looked at were well completed, with sufficient detail, and inspectors had highlighted learning points which had then been fed back to relevant staff.

4.20 All staff we spoke to said that they had undertaken officer safety/personal protection training within the previous 12 months and told us that they would only use force as a last resort. Most detainees arrived at the custody suites in handcuffs but these were removed promptly.

4.21 Strip-searches were authorised properly and recorded in the custody records we reviewed. However, data on the number of strip-searches performed were not easily accessible by the force, so there was no means of monitoring the extent to which it was used and whether it was proportionate and necessary. We watched CCTV footage of a detainee having his clothes removed forcibly, to be replaced with anti-rip clothing. Following the removal of the detainee's trousers and underwear, an officer appeared to conduct an intimate search for drugs. We referred the incident to the custody manager to review, as we were concerned that this search had not been authorised.

Area for improvement

4.22 Data on the use of strip-searches in police custody should be collated, easily accessible and monitored to ensure that it is used appropriately.

Physical conditions

4.23 The physical conditions in both operational suites were good. Cleaning regimes were effective and any defects found were resolved. Both custody suites had dedicated staff available daily to clean cells and other areas within the suites. Showers were generally clean and well maintained, and had reasonable privacy.

4.24 We conducted random cell inspections and identified minor ligature points at both suites, which we referred to managers so that remedial action could be taken where appropriate. In each of the custody suites daily cell checks were completed, recorded and reviewed appropriately by supervisors.

4.25 After booking in, detainees were escorted to their cell by a DO or one of the custody sergeants. DOs were allocated cell keys and took full responsibility for accessing and locating detainees in the cell area. Cell equipment, such as the emergency call bell and intercom, were not routinely explained to all detainees. Cell bells were generally answered promptly.

4.26 Each suite had a fire evacuation policy and staff were aware of it. They told us that fire drills were undertaken annually, and records of fire evacuations and drills were held on the custody intranet site.

Detainee care

4.27 Overall detainee care was good. Mattresses, pillows and clean blankets were provided but mattresses were not always cleaned between uses. Sufficient stores of clean blankets, replacement clothing and underwear were available across the suites. Toilet areas in cells covered by CCTV were pixelated to afford some privacy. Toilet paper was available in cells.

4.28 All suites had limited stocks of reading materials but few had any in foreign languages or anything suitable for children. Reading materials were generally provided only on request, which required detainees to have prior knowledge of their availability.

4.29 The provision of meals and drinks was good at both suites, and in our CRA 93 (79%) detainees had been offered a meal. At Bournemouth, there was a reasonable range of food available, including hot food, sandwiches, cereal and basic microwavable products. At Weymouth, the canteen was used to provide meals for detainees during opening hours, and a range of sandwiches, crisps and biscuits were available at other times.

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 Operational officers had a good understanding of PACE code G[3] and were able to provide thorough reasons for the necessity of arrest. Custody sergeants were able to cite only a few examples of when they had refused to authorise detention when the circumstances had not merited it. We saw them asking if alternatives to custody had been considered. Detainees were routinely given a clear and straightforward explanation about the circumstances of their arrest. Officers told us that the purpose of this was to help the detainee understand why they had been taken in to custody and reduce the possibility of any confusion.

5.2 Alternatives to custody were available in the form of voluntary attendance[4] and fixed penalty notices. Voluntary attendance had been used 1,701 times between May 2015 and February 2016. The force had only recently started to record these figures, so there were no comparison data; however, the force told us that the number of arrests was in a steady decline (see also section on strategy).

5.3 Since the previous inspection, the number of immigration detainees taken into custody had reduced substantially. Force records showed that, in 2014/15, 115 immigration detainees had been arrested in Dorset and that, on average, they had spent 18.5 hours in custody, both figures being less than half of those recorded in 2008/09. Custody staff told us that when they required specialist assistance for such detainees, they received prompt and helpful telephone advice from Home Office immigration enforcement officers.

5.4 The AA schemes for vulnerable adults and children worked well at both custody suites. Custody staff told us that there were rarely any serious delays in obtaining support. In our CRA, an AA had attended in all of the cases we examined involving children. The average time for an AA to arrive was just under eight hours. However, in one case, owing to late notification, there had been a delay of 11 hours before the parent of a detainee had attended. It was often difficult to determine precisely how long it had taken for AAs to attend because records were unclear. In most cases, the AA had arrived only in time for the interview, which was poor practice as it meant that they would not have been able to support the child or vulnerable adult throughout their period in custody.

5.5 Force records showed that in 2014/15, 428 children had been detained at Bournemouth and 232 at Weymouth. They also showed that, in the previous 10 months, bail had been denied on 22 occasions, for 13 different children who had been charged and not bailed. Staff gave mixed responses about whether or not they contacted the local authority routinely to request alternative accommodation in these circumstances. Some staff told us that they no

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

[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.

longer did this because they knew that accommodation was not available in Dorset. Others said that, despite knowing that there would be no accommodation available, they contacted the local authority routinely, simply to ask the question. However, examples of the latter practice were rarely recorded, so it was impossible to verify this (see area of concern 2.35). This meant that all children charged and not bailed spent the night in police custody.

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.[5]

5.7 Custody staff were confident about using professional telephone interpreting services and it was clear that these were used regularly when detainees had difficulty communicating in English.

Area for improvement

5.8 Detainees should have access to appropriate adults (AAs) from the point of booking into custody. The force should ensure that AAs are requested to attend as soon as possible, to ensure the welfare and safety of vulnerable adults and children in custody.

Rights relating to PACE

5.9 On admission to the custody suites, detainees were given clear information about their legal position and notified that they were entitled to have someone told about their whereabouts. During the booking-in process, all detainees were advised of their right to consult the PACE codes of practice and were given a leaflet explaining their rights and entitlements. Sergeants were able to locate the relevant guidance in various languages, and we were told that they were able to obtain the services of a British Sign Language signer when a detainee had hearing difficulties. At Bournemouth, there was a version of the rights and entitlements document in Braille but it was not up to date. Full copies of PACE were available to detainees on request, at both of the suites.

5.10 PACE reviews completed at night were often conducted by telephone. In the sample of 75 records we examined where reviews were required, 31 were carried out face to face, 28 were carried out while detainees were sleeping, and in five instances a review was not carried out. In cases where the detainee was asleep, records showed that they were not always advised that a review had taken place.

5.11 Solicitors were contacted promptly and the duty solicitor scheme provided a quick response, although detainees who requested a named solicitor sometimes had to wait longer. At both suites, there were adequate facilities for legal interviews to take place in private and detainees could also speak to their legal representatives by telephone.

5.12 Custody sergeants were clear about the importance of ensuring that detainees were fit to be interviewed. Records showed that there were no delays in seeking specialist advice for individuals thought to be under the influence of alcohol or drugs. Care was also taken to ensure that detainees received sufficient breaks between interviews.

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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 and keep him/her there.

5.13 DNA samples were stored correctly in freezers until they were collected for processing. The system for collecting DNA samples was regular and effective.

5.14 The local magistrates' courts accepted detainees until approximately 2pm on weekdays. Although this was slightly later than at the time of the previous inspection, we still regarded it as too early. At Weymouth, we were told that the working relationship between staff at the custody suite and at the magistrates' court was extremely good. Cases were generally prioritised appropriately so that vulnerable detainees were not held in police custody for unnecessarily long periods. Bournemouth Magistrates' Court was busier, so there was less flexibility in the prioritisation of listings, but custody staff at the Bournemouth suite said that they did not encounter serious problems in getting cases heard expeditiously. Custody staff at both suites said that there were sometimes delays in organising transport to court with the escort provider, but that community-based police colleagues usually helped when they needed urgent access to transport.

Areas for improvement

5.15 Up-to-date versions of the PACE codes of practice should be available in suitable formats, at all suites.

5.16 When PACE reviews take place while detainees are asleep, they should always be notified about this when they wake up.

Rights relating to treatment

5.17 Helpful forms giving advice to detainees and their friends and families about how to make a complaint were available at both custody suites. At Weymouth, we were told that if a detainee wished to make a complaint about their arrest or treatment while in custody, they would need to do this after they had been released. By contrast, at Bournemouth, staff told us that detainees could make formal complaints while they were still in custody.

5.18 At Bournemouth, we observed a detainee complaining about his treatment in the custody suite. The officer dealing with him explained that he had the right to complain about this formally, and shortly afterwards the detainee was given the opportunity of speaking to the duty inspector. Following a brief private discussion, the detainee appeared content that his views had been taken into account.

Area for improvement

5.19 Detainees should be able to make a complaint about their care and treatment before they leave custody.

Section 6. Health care

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

Governance

6.1 CRG had taken over primary health care services in September 2015, following joint procurement by Dorset Police and NHS England. Partnership working between the force, CRG, mental health providers, substance misuse providers and NHS England was good. Service provision was underpinned by a recent health needs assessment and an appropriate range of well-attended governance and partnership meetings. Weaknesses in clinical incident reporting had been discussed in partnership meetings and were being addressed.

6.2 The contract required that HCPs attend 80% of requests within 45 minutes. Response times were monitored rigorously and had been achieved in 99% of instances in the five months to January 2016. A nurse was based at each suite 24 hours a day and a forensic medical examiner (FME) was on call for both suites. CRG data indicated that nurses completed 95% of all assessments. We had been concerned at our previous inspection that some FMEs were on call for police custody and the sexual assault referral centre at the same time, but this no longer occurred. However, FMEs were regularly on call continuously for several days and there had been a few occasions in the preceding months when the FME had been the only HCP on duty for a suite, which raised concerns about fitness to practice. Generally, FMEs were required to attend only once or twice in each 12-hour shift, which mitigated this risk, and more FMEs were being recruited to address this issue.

6.3 Staffing levels were reasonable and nurse shortages were usually covered by regular agency staff. All of the current nurses had transferred from the previous provider without current appraisals, clinical supervision or sufficient professional development, such as level 3 safeguarding training. A training needs analysis was being completed and an enhanced training plan was being introduced from April 2016. All nurses were in date with life support and relevant medication management training, but clinical supervision was still not available and no clinical audits or staff appraisals had been conducted by CRG.

6.4 A lead FME, appointed in January 2016, provided around one day a week of clinical leadership, including circulating guidance by email and investigating clinical incidents. CRG circulated a monthly clinical governance newsletter which highlighted key issues, including new guidance and medical alerts. Registration status was monitored. HCPs had easy access to relevant current policies and procedures.

6.5 Detainees could complain about health services through a dedicated system. We were told that no health-related complaints had been received since the start of the contract. Professional telephone interpreting was used for detainees with limited English, but this took place in the main custody suite, so we were not assured that it was always conducted in private.

6.6 HCPs said that they risk assessed whether detainees could be seen in clinical rooms with the door closed. A detainee's right to request an HCP of the same gender was displayed clearly. The clinical room at Bournemouth complied fully with infection prevention and control standards, but the room at Weymouth contained non-compliant sinks, flooring and wall tiles. Cleaning standards were good and clinical rooms were deep-cleaned by cleaning contractors

before forensic sampling, which was good practice. Appropriate, well-checked clinical stock and equipment were held in both clinical rooms.

6.7 Custody staff had annual first-aid and automated external defibrillator (AED) training and had easy access to regularly checked AEDs. HCPs held additional emergency equipment, including oxygen and emergency drugs, which was checked regularly. Ambulance response times for emergencies were reported to be good.

Areas for improvement

6.8 Detainees should be treated by appropriately trained health services staff, who receive clinical and managerial supervision, staff appraisals and clinical leadership. A clinical lead should complete regular audits and provide consistent and visible clinical leadership.

6.9 The clinical environment at Weymouth should meet the required infection prevention and control standards.

Good practice

6.10 *Clinical rooms were deep-cleaned before forensic testing, minimising the risk of contamination.*

Patient care

6.11 All detainees were offered the opportunity to see an HCP, and custody sergeants also referred them for assessment if there was an identified risk or clinical need. The most common reasons for referral were fitness to detain or interview and detainee request. In our CRA, 50 (42%) detainees had required assessment by an HCP.

6.12 We saw good interactions between HCPs and detainees, and the quality of care provided was good. SystmOne (the electronic clinical record system used in prisons) was available in each suite but was not being used at the time of the inspection because of internet security concerns; although this issue was currently being addressed, it seriously limited the opportunities for data collection and analysis. Paper records were used and most we examined were completed to a reasonable standard, although they focused primarily on physical health problems. Clinical records were stored securely and a care plan was shared with custody staff. Custody staff and HCPs worked collaboratively, including joint handovers, and custody staff we spoke to were positive about the health care provided.

6.13 CRG drug cupboard keys were accessible only by HCPs. Standardised stock medication was well organised, checked regularly and stored securely. HCPs completed stock checks of medication to treat opiate and alcohol withdrawal twice daily and balances were correct during the inspection. Both suites contained out-of-date pharmaceutical reference books, although all HCPs had access to online reference material.

6.14 Custody staff tried to retrieve medications from detainees' homes, where appropriate, and this was checked by health services staff before administration. All medication was administered by HCPs. Custody staff stored detainees' own medication securely.

6.15 Symptomatic relief for drug and alcohol withdrawal was easily available, although this was not sent with the detainee to court, which could lead to serious health consequences for those withdrawing from alcohol. Some HCPs we spoke to, and the CRG policy, indicated that only

pregnant women on community methadone prescriptions for opiate addiction could continue this medication in custody, which was too limited. However, some HCPs we spoke to interpreted the policy more broadly and records we examined showed that FMEs had continued opiate substitution treatment in some instances.

6.16 Nicotine replacement therapy was not available, which could exacerbate the distress of prolonged detention for those who smoked.

Areas for improvement

6.17 Medication that is due to be taken while a detainee is at court should be sent with them, with clear administration instructions.

6.18 Detainees on confirmed opiate substitution treatment for opiate addiction should be able to continue their prescribing in custody, if clinically appropriate.

Substance misuse

6.19 Support for the high number of detainees presenting with substance misuse issues had improved and was good. A drug worker attended each suite daily and saw all adult detainees with documented substance use issues, to discuss any need for support with drug or alcohol issues, although this visit, and the outcome, was not recorded consistently on the custody record. All detainees who required support were referred promptly to an appropriate service. Custody, mental health and CRG staff could also refer detainees to the drug service for follow-up after release. All children were screened by the mental health liaison and diversion practitioners and were referred for community substance misuse support, if required.

Mental health

6.20 Mental health provision in the custody suites had improved considerably and was excellent. Dorset HealthCare University NHS Foundation Trust (DHUFT) provided a mental health liaison and diversion practitioner in each suite daily between 7am and 7pm. This practitioner identified if detainees of concern were known to mental health services by checking the Trust electronic clinical records system (RiO). They then offered a mental health assessment to those who needed it and referred them to relevant services, including 'support, time and referral' workers within their team, who could provide support in the community after release. Custody, CRG and community mental health staff told us that the mental health provision was responsive and that there was good partnership working. We saw some effective and collaborative joint working between the mental health practitioners, custody staff and community services.

6.21 All detainees aged under 18 years were referred to the mental health practitioner, who checked if the child was known to mental health services. A young person screening tool informed ongoing care; those with immediate needs were assessed by the practitioner while in police custody, and those with lower levels of need were followed up by a specialist youth practitioner in the community.

6.22 Custody and health services staff told us, and our case audits indicated, that Mental Health Act assessments generally occurred promptly, although we found a record of one exceptional instance where a detainee had waited over 20 hours for the assessment to be completed, before being transferred to a mental health bed a few hours later. The mental

health practitioners liaised with the relevant services when they were on site; when they were not present, custody sergeants could refer directly to the service, which ensured prompt access.

6.23 DHUFT provided telephone advice and triage from 7pm to 3am daily, to support street police officers in managing those presenting with mental health needs. Only nine people had been detained in police custody under section 136 of the Mental Health Act[6] in the 10 months to January 2016 as a result of this service, which represented a marked decrease, and a revised multiagency section 136 policy had been implemented in July 2015.

6.24 Strategic joint working between the police and mental health services was underpinned effectively by regular strategic mental health legislation multi-agency group meetings and a local Crisis Care Concordat action plan. Custody staff we spoke to demonstrated satisfactory understanding of mental health issues and received formal mental health awareness training from mental health staff.

Good practice

6.25 *Detainees of all ages had excellent access to prompt mental health support, and children and young people had access to a specialist youth practitioner in the community.*

[6] Section 136 of the Mental Health Act 1983 enables a police officer to remove, from a public place, someone they believe to be suffering from a mental disorder and in need of immediate care and control, and take them to a place of safety – for example, a health and social care facility, or the home of a relative of friend. In exceptional circumstances (for example, if the person's behaviour would pose an unmanageably high risk to others) the place of safety may be police custody. Section 136 also states that the purpose of detention is to enable the person to be assessed by a doctor and an approved mental health professional (for example a specialist social worker or nurse), and for the making of any necessary arrangements for treatment or care.

Section 7. Summary of areas of concern, recommendations and areas for improvement

Areas of concern and recommendations

7.1 **Area of concern:** When bail for children was denied post-charge, it was unclear if alternative accommodation was sought through the local authority, as required statutorily. Records indicated that this was rarely the case. Additionally, and while discussions were taking place, the force had not yet secured a protocol with the local authority to provide accommodation. This meant that such children were being detained unnecessarily in police cells.

Recommendation: Dorset 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. (2.35)

Areas for improvement

Strategy

7.2 The dip-sampling of custody records should be increased to allow for a representative and meaningful sample and to facilitate organisational learning. (3.12)

Treatment and conditions

7.3 Custody staff conducting constant supervision should not engage in other activities, and significant events and interactions should be recorded. (4.15)

7.4 Pre-release risk planning should reflect risks arising during custody as well as any consequences of release, and detainees should be offered information about relevant support organisations at the point of release. (4.16)

7.5 Data on the use of strip-searches in police custody should be collated, easily accessible and monitored to ensure that it is used appropriately. (4.22)

Individual rights

7.6 Detainees should have access to appropriate adults (AAs) from the point of booking into custody. The force should ensure that AAs are requested to attend as soon as possible, to ensure the welfare and safety of vulnerable adults and children in custody. (5.8)

7.7 Up-to-date versions of the PACE codes of practice should be available in suitable formats, at all suites. (5.15)

7.8 When PACE reviews take place while detainees are asleep, they should always be notified about this when they wake up. (5.16)

7.9 Detainees should be able to make a complaint about their care and treatment before they leave custody. (5.19)

Health care

7.10 Detainees should be treated by appropriately trained health services staff, who receive clinical and managerial supervision, staff appraisals and clinical leadership. A clinical lead should complete regular audits and provide consistent and visible clinical leadership. (6.8)

7.11 The clinical environment at Weymouth should meet the required infection prevention and control standards. (6.9)

7.12 Medication that is due to be taken while a detainee is at court should be sent with them, with clear administration instructions. (6.17)

7.13 Detainees on confirmed opiate substitution treatment for opiate addiction should be able to continue their prescribing in custody, if clinically appropriate. (6.18)

Good practice

Treatment and conditions

7.14 Handovers were excellent. The information template recording risks and case progression, delivered to all staff, including health services staff, was commendable. (4.17)

Health care

7.15 Clinical rooms were deep-cleaned before forensic testing, minimising the risk of contamination. (6.10)

7.16 Detainees of all ages had excellent access to prompt mental health support, and children and young people had access to a specialist youth practitioner in the community. (6.25)

Section 8. Appendices

Appendix I: Inspection team

Maneer Afsar	HMI Prisons team leader
Ian Macfadyen	HMI Prisons inspector
Vinnett Pearcy	HMI Prisons inspector
Denise Hotham	HMIC lead staff officer
Clive Burgess	HMIC staff officer
Majella Pearce	HMI Prisons health services inspector
Sue Simmons	Care Quality Commission Mental Health Act Reviewer
Helen Ranns	HMI Prisons researcher
Joe Simmonds	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.

Main recommendations

All staff working in the custody environment should attend a nationally accredited custody training course. (2.24)
Achieved

The levels of staffing in the agreed model should be adhered to in order to ensure the safety of detainees. (2.25)
Achieved

Recommendations

Shift patterns should be reviewed to ensure that handovers are factored into all shifts. (3.20)
Achieved

A custody users' forum should be introduced to facilitate partnership working at a practitioner level. (3.21)
Achieved

The force meetings structure should be reviewed to streamline processes to ensure that staff are clear about the business model in use and its operation. (3.22)
Achieved

Senior managers in the force should continue efforts to engage effectively with the UK Border Agency to improve working relationships at the strategic level. (3.23)
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

All cells and detainee areas should be fit for purpose and free of ligature points, which custody staff should be trained to identify. (2.26)
Achieved

Urgent remedial action to improve safety at the Bournemouth suite should be undertaken. (2.27)
Achieved

Recommendations

Detainees should be transported in vehicles which are appropriate to the specific needs of the individual concerned. (4.45)
No longer relevant

There should be clear policies to meet the needs of female detainees and those with disabilities or mobility issues while they are in custody or being transported. (4.46)
Partially achieved

Detainees' ability to read and write should be ascertained when being booked into custody. (4.47)
Achieved

Booking-in desks should be of an appropriate height to facilitate effective and private communication between staff and detainees. (4.48)
Achieved

All custody staff should undertake child protection awareness training. (4.49)
Achieved

Juveniles should be located in accommodation which is easy to supervise closely and whenever practicable in a separate area from adult detainees. (4.50)
Achieved

At Poole, the glass panels should be removed from the juvenile detention rooms, so that juveniles can be located in these cells. (4.51)
No longer relevant

There should be an explicit question in the risk assessment to ascertain a detainee's alcohol or drug dependency. (4.52)
Achieved

Spectacles should only be taken from detainees if the risk assessment indicates the need to do so. (4.53)
Not achieved

Night-time observations should not be predictable. (4.54)
Achieved

Strip-searching of immigration detainees should be based on a risk assessment, rather than routine. (4.55)
Achieved

The regular health and safety, maintenance and cleanliness checks should be reviewed and formalised across the custody estate. These checks should be fully recorded and monitored to ensure that identified issues are addressed. (4.56)
Achieved

Repairs should be completed in a timely manner and general maintenance should be managed and carried out expeditiously. (4.57)
Achieved

In those cells at Weymouth with closed-circuit television, the toilet area should be pixelated or blocked out to facilitate privacy. (4.58)
Achieved

Subject to individual needs assessment, nicotine replacement aids should be available to detainees. (4.59)
Not achieved

Staff working in the custody suite should all be familiar with the fire safety arrangements; evacuations should be recorded and the fire safety book routinely used. (4.60)
Achieved

The purpose of cell call bells should be explained to all detainees. (4.61)
Partially achieved

Detainees should be issued with clean mattresses and pillows. (4.62)
Achieved

Female detainees should routinely be offered female hygiene items. (4.63)
Not achieved

Replacement underwear should be available at all sites for detainees who need it. (4.64)
Achieved

Detainees remaining in custody for more than 24 hours should be allowed visits. (4.65)
Not achieved

Procedures for recording and reporting use of force should be consistently applied when force is used in custody. (4.66)
Achieved

Individual rights

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

Main recommendations

The UK Border Agency should engage with Dorset Police to improve working relationships at the strategic and operational level to reduce the time that detainees spend in police custody. (2.29)
Achieved

Recommendations

Interpreting services should be used during the inspector's PACE reviews for detainees for whom English is not their first language. (5.23)
Achieved

Detainees aged 17 and under should be provided with an appropriate adult. (5.24)
Achieved

Detainees should have pre-court disposals, such as cautions, explained to them in full before being asked to make a decision. (5.25)
Achieved

All detainees who are vulnerable on release should be provided with a range of support to meet their needs, including a list of agencies in the community which might assist them. (5.26)
Partially achieved

Appropriate adults should be readily available 24 hours a day to support juveniles and vulnerable adults in custody. (5.27)
Partially achieved

The force should review how it takes, stores, tracks and submits all DNA and forensic samples taken from detainees. The review should identify gaps in policies, training, storage facilities and audit trails. The review should have a senior officer responsible for delivery of an action plan which addresses the issues. (5.28)
Achieved

When there is a risk of overnight detention and the courts refuse to deal with vulnerable detainees, the case should immediately be passed to a senior police officer to raise with the court. (5.29)
Achieved

The force should instigate discussions with the court service to extend court cut-off times. (5.30)
Partially achieved

Detainees should be told how to make a complaint. (5.31)
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

There should be a review of the provision of substance use arrest referral workers to ensure that a comprehensive service is provided to detainees of all ages across the county. The review should include an analysis of referral data. (2.28)
Achieved

Recommendations

Sufficient medical staff should be provided to ensure separation of duties between the requirements of detainees in custody and the victims of sexual assault. (6.35)
Achieved

There should be a telephone in each clinical room, so that healthcare professionals can make calls about patients and conduct consultations requiring a telephone interpreting service in private. (6.36)
Achieved

The contract should be monitored by the commissioners, rather than relying solely on information from the provider. (6.37)
Achieved

All staff should be able to access clinical supervision. (6.38)
Not achieved

All clinical rooms should be fit for purpose and ready for use at all times. (6.39)
Achieved

Resuscitation equipment should include suction and oxygen. (6.40)
Achieved

All parties involved should seek legal advice to ensure that the pilot policy for the administration of controlled drugs by nurses meets current legislation. (6.41)
No longer relevant

All clinical records should be stored in accordance with Caldicott guidelines and the Data Protection Act. (6.42)
Achieved

Detainees should be able to sign to state that they give consent to clinical information being shared; verbal consent should only be used if a risk assessment has identified a concern about the detainee using a pen. (6.43)
Achieved

There should be a policy to define how, with the introduction of the electronic clinical information system, staff will maintain records of interventions by healthcare staff in detainees' custody records. (6.44)
No longer relevant