Inspecting policing in the public interest

Report on an unannounced inspection visit to police custody suites in

Avon and Somerset

by HM Inspectorate of Prisons
and HM Inspectorate of Constabulary

1–12 August 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.

We previously inspected Avon and Somerset Constabulary in 2012, when we described provision in police custody as adequate. In the current inspection, we found that the constabulary was at a critical point where it needed to implement some key changes and engage staff in the process. In particular, we identified work practices that needed to be improved, in order to ensure that detainees consistently received a good level of care.

Since the previous inspection, there had been a lack of continuity in leadership. Managers acknowledged that this had created difficulties, and seemed to recognise that this had hindered them. Although a substantial amount of organisational change had taken place, this was not matched with the necessary cultural change, and a lack of consistency was still evident across the constabulary. The absence of reliable data in a number of important areas was a considerable weakness and meant that lessons were not always learned, and limited the amount of improvement that could be made.

Despite this, custody staff generally dealt with detainees in a respectful, dignified and professional way. In the previous three years, Avon and Somerset had reduced from 22 to five custody suites, with only four of these suites being in day-to-day use. The physical conditions of the custody suites were disappointing. At Yeovil, they were generally poor and the three remaining sites were also in need of remedial decoration.

One of our principal concerns was about use of the incapacitant spray PAVA. Although not widespread, its use was far more frequent than we have previously come across. In many cases, PAVA appeared to be used to enforce the compliance of detainees, which was not appropriate.

As we have often found elsewhere, there was a lack of clarity in relation to the governance and oversight of the use of force in custody. There were not sufficient data available for the constabulary to confirm that the force used had always been appropriate, or to allow it to monitor trends and identify learning. This situation remained unchanged from the previous inspection.

Health care provision for detainees in custody was good. It was encouraging to discover that the constabulary had taken a robust stance in ensuring that detainees with mental health issues were not brought into custody. However, we still found a number of cases involving vulnerable people being held in custody when there were clear concerns in relation to their safety, and mental health problems.

We were pleased to find that there was a strong emphasis on avoiding the detention of children. Custody staff told us that the number of children entering custody was reducing as other options, such as voluntary attendance or community resolution, were being sought, although there was no hard evidence to prove this.

Our observations revealed that pre-release support was better in practice than records indicated.

Overall, it was clear that progress had been made in some areas, although this had been achieved at a slow pace. In the short term, the high use of PAVA spray needed immediate attention and work was required to raise the standard of living conditions for detainees.

We noted that, of the 33 recommendations made in our previous report after our inspection of July 2012, 12 recommendations had been achieved, 15 had been partially achieved, four had not been achieved and two were no longer relevant.

This report provides three recommendations to the constabulary and highlights 26 areas for improvement.

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October 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 (CRA) was carried out on a representative sample of the custody records, across all of the suites in that area, opened in the week prior to the inspection being 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 sample of 142 records were analysed.

Custody suites	**Number of cells**
Bridgwater	36
Keynsham	48
Minehead	7
Patchway	48
Yeovil	12

Leadership, accountability and partnerships

2.4 The constabulary had delivered a number of improvements since the previous inspection. There was strong governance and leadership from the Police and Crime Commissioner (PCC) and chief officer team, which provided a clear focus on professionalising the role of

[1] http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/inspection-criteria/
[2] 95% confidence interval with a sampling error of 7%.

custody staff, and the custody team had been rationalised to provide a stronger and better resourced infrastructure to support the delivery of custody services.

2.5 The pace of organisational change in the constabulary had not been matched by that of cultural change, with differences between the suites as a result of varying challenges in urban and rural areas and the different outlooks developed over time by custody staff dispersed across numerous custody suites. The custody function sat within the wider criminal justice department, and resources were ring fenced, which ensured that only staff fully trained in custody duties carried out this role. However, many shifts were covered by onerous overtime shifts, which presented significant risks to the constabulary.

2.6 The constabulary followed *Authorised Professional Practice* (APP) but had also developed a number of local guidance documents, although some of these contradicted each other.

2.7 There was a lack of clarity in relation to the governance and oversight of use of force in custody. Data provided by the constabulary were inaccurate and local policies were unclear. We were not assured that there were sufficient data available for the constabulary to assess whether all instances of use of force were appropriate, or to allow it to monitor trends and identify learning.

2.8 The constabulary demonstrated that it complied with equality legislation but there was little strategic focus on custody services and no monitoring of custody services by protected characteristics to demonstrate the fair treatment of detainees.

2.9 Independent custody visitors (ICVs) reported consistently good working relationships with the constabulary and felt that they had a constructively critical role.

2.10 The health care contract was managed efficiently, with clear accountability for performance and robust monitoring of data, including timeliness. However, the performance and partnership arrangements for health care provision were complicated, reflecting the regional split of providers and the large number of stakeholders. The arrangements were not sufficiently well integrated to provide assurance that operational practice was in line with policy.

2.11 Partnership working to improve the identification and management of risks to the welfare of vulnerable detainees in custody was becoming more effective. The constabulary had taken a robust stance in ensuring that detainees with mental health issues were not bought into custody under section 136 of the Mental Health Act 1983. Progress was also reported in relation to avoiding custody for children. However, there were limited data to demonstrate this, and a number vulnerable people, including children, were still being detained when alternatives should have been available.

Pre-custody: first point of contact

2.12 From the detainee's first point of contact with the police service, officers and staff were generally alert to, identified and made effective assessments of risk and vulnerability. Frontline officers were reasonably well informed when responding to incidents. Communication centre staff were compassionate in their dealings with people reporting crimes but their restricted access to Niche (an electronic police records management system) inhibited the free flow of important information.

2.13 No partner agencies were based in the communication centre, although there were advanced plans for mental health professionals to be located there.

2.14 Police officers and staff who had contact with children recognised them as vulnerable by virtue of their age, and the impact of custody on vulnerable people, including children, was a serous consideration for police officers. Officers and staff demonstrated a good understanding of the limited diversion schemes in the constabulary and made appropriate referrals to them.

2.15 Police officers' attempts to divert vulnerable individuals from custody were sometimes hindered by a lack of services that could support them to respond more effectively.

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

2.16 In general, custody staff dealt with detainees in a respectful, dignified and professional way. There were some good facilities to meet detainee needs, and custody staff took additional support measures to meet individual needs. However, detainee needs were not always met; for example, women were not routinely offered a female officer to help with their particular needs. Custody staff generally relied on their own experience to meet diverse or individual needs, rather than being developed and supported by training to provide a consistent and appropriate approach.

2.17 Custody sergeants completed risk assessments for all detainees and in most cases asked appropriate supplementary questions. Recording in care plans was often superficial and did not always reflect the risks identified or required levels of care. Shift handover arrangements were reasonably good but not all detention officers (DOs) were always present.

2.18 There was a lack of engagement between some custody staff and vulnerable detainees, and routine checks were sometimes superficial. Governance of the use of anti-rip clothing was poor and we were not assured that its use was always justified.

2.19 Arresting officers were well versed in the need to meet the necessity criteria contained in PACE code G[3] and were able to supply the relevant details to allow custody sergeants to authorise arrest.

2.20 The constabulary had invested in voluntary attendance facilities, which diverted some individuals from the custody suites. In the previous three years, there had been a 55% increase in the number of voluntary attendees.

2.21 Most detainees were booked in promptly on arrival at the custody suites, but some custody sergeants did not always ask arresting officers for their time of arrival. We saw several records in which the booking-in rather than the arrival time was recorded, which indicated that some of the data supplied by the constabulary may not have been reliable.

2.22 Data supplied by the constabulary concerning the average length of detention for immigration detainees were not reliable. Custody staff told us that they were usually held for up to 24 hours following service of an IS91 warrant of detention, before transfer to an immigration removal centre. We saw detainees in these circumstances who had been held for long periods, one for over 56 hours.

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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.

2.23 Pre-charge bail was poorly administered, with inadequate documentation of the rationale for bail. We found little evidence of timely supervision of cases where detainees were released on bail. However, crime enquiries in these cases were mostly appropriate, although they were not always prioritised effectively or conducted expeditiously. Our analysis of case materials indicated that custody sergeants discussed bail cases with investigating officers before granting bail, resulting in properly tailored bail conditions and durations.

2.24 Custody staff were aware of the detainee complaints process but we were not assured that this was always carried out as required.

In the custody cell, safeguarding and health care

2.25 Since the previous inspection, the number of custody suites had been reduced from 22 to five, with only four of these being in day-to-day use. The physical conditions at Yeovil custody suite were generally poor. The three newer suites at Patchway, Keynsham and Bridgwater were also in need of remedial decoration in the cells and holding areas.

2.26 Cleaning across all four main units was inconsistent, with evidence of poor cleaning and hygiene, although graffiti was removed quickly. Physical environment checks were not carried out systematically. During the inspection, the constabulary took immediate action to remedy the ligature points we identified.

2.27 The collation of data on the use of force in custody was weak. Individual use of force forms were not always completed. We were not assured that all force was proportionate to the risk or threat posed. There was significant use of incapacitant spray in the controlled custody environment. This was sometimes used inappropriately to gain compliance from detainees, and governance of its use was inadequate. There was some poor, and potentially unsafe, practice, including the use of prolonged restraint of a detainee in the prone position. Handcuffs and leg restraints were sometimes used on detainees for too long after they were compliant.

2.28 The constabulary was unable to provide accurate data concerning strip-searches in custody. However, our CRA indicated that strip-searching was relatively rare, and the few we observed were authorised correctly.

2.29 Microwave meals and cereal bars were provided readily. Replacement footwear was not routinely offered to detainees who had their shoes removed. There was little evidence of the outside exercise areas being used. Despite the availability of large stocks of books, magazines and old newspapers, there was no age-appropriate reading material for children or material in foreign languages.

2.30 The Police and Criminal Evidence Act 1984 (PACE) reviews we observed were timely and fully recorded on detention logs. In our CRA, just over a third of first reviews had taken place early, and custody inspectors told us that this was common practice due to their shift patterns. In our CRA, we found that telephone reviews had been conducted with children (see paragraph 6.25).

2.31 There was limited guidance and training for custody staff in relation to safeguarding children and vulnerable adults. Custody staff were aware of potential safeguarding concerns and most had knowledge of the wider safeguarding arrangements in place. However, there was little additional provision for children and vulnerable adults, such as the use of private booking-in rooms or the 'vulnerable' cells.

2.32 Children and vulnerable adults did not consistently receive timely support from an appropriate adult (AA) during their time in custody. Access to AAs during the day was good but outside of normal working hours provision was limited, and AAs generally attended only when the detainee was due to be interviewed. Some detainees spent a long period in custody before receiving advice and support from an AA.

2.33 There was a clear focus on diverting children from custody, and bail was used to minimise the time that they spent in custody and avoid overnight detention. However, some children spent long periods in custody, and children charged and refused bail often remained in custody overnight because of the lack of alternative accommodation.

2.34 Physical health care provision was delivered by Mitie. Leadership of the service was visible and effective. Practitioners were capable and confident, and detainees received timely assessments and treatment. The care provided to detainees overall was good. Medicines management was good and overall governance was sound. Substance misuse services were impressive, with a team based in every suite. There was an appropriate focus on harm minimisation and signposting detainees to community services.

2.35 Mental health care services were provided by two different specialist trusts and there was variability in their provision. The service for the Yeovil and Bridgwater suites was generally good but the Patchway and Keynsham suites received a more fragmented level of input. Recent changes in policy had reduced section 136 detentions but we still found that vulnerable detainees with potential mental health needs were being held in custody.

Release and transfer from custody

2.36 In most cases, we were assured that pre-release risk arrangements generally secured a safe release for detainees, although recording was poor and most custody records gave little indication that risks were always addressed.

2.37 Sergeants were generally properly focused on the circumstances that could put detainees at risk on release, and offered any necessary assistance and support. While we saw some detainees without money or means of transport being given bus tickets or police transport home following release, we also found a small number who were left stranded without sufficient means to get home or to safe accommodation.

2.38 Posters displayed at most suites signalled that, in most cases, detainees would not be provided with transport. This was a potential deterrent for vulnerable people seeking help.

2.39 Some court cut-off times were too early, causing extended stays in police cells, particularly at weekends.

Areas of concern and recommendations

2.40 There was insufficient gathering and monitoring of performance data in key areas to promote the safe and respectful detention of people in custody.

Recommendation: The constabulary should strengthen its approach to performance management and ensure that data (including children in custody, detained people with mental health issues, use of force, adverse incidents and strip-searching) are accurately recorded, and routinely collated and analysed to identify trends, inform organisational learning and improve outcomes for detainees.

2.41 All aspects of the use of force lacked governance and effective oversight, and data on the use of force in custody were not recorded effectively. Individual use of force forms were not always completed following the use of force in custody. We were not assured that all force was proportionate to the risk or threat posed. There was significant use of incapacitant spray in the controlled custody environment, and governance of its use was inadequate. Aftercare for many detainees who had this spray used against them was not good enough. There was some poor, and potentially unsafe, practice – we were particularly concerned by a long restraint in the prone position. Handcuffs and leg restraints were sometimes used on detainees for too long after they were compliant.

Recommendation: The constabulary should maintain effective management oversight of all use of force incidents and trends in custody, including the use of incapacitant spray. Only the minimum force necessary should be used and its application should always be proportionate. All staff involved in incidents should complete individual use of force forms.

2.42 Despite a robust stance in ensuring that detainees with mental health issues were not bought into custody under section 136 of the Mental Health Act, too many vulnerable detainees with mental health problems, but not dealt with under section 136, were held in custody owing to a lack of more appropriate options.

Recommendation: The constabulary should reduce the number of vulnerable people detained in custody. The constabulary should routinely audit its custody records to identify where vulnerable individuals with mental health problems have been detained for minor offences, and use this information to develop with partners a better understanding of the position and take effective action to put more appropriate alternatives in place.

Section 3. Leadership, accountability and partnerships

Expected outcomes:
There is a strategic focus on custody, including arrangements for diverting the most vulnerable from custody. There are arrangements to ensure custody-specific policies and procedures protect the wellbeing of detainees.

Leadership

3.1 There was an efficient governance structure for custody, with clear lines of responsibility at strategic and operational levels. Since the previous inspection, there had been a significant reduction in the size of the custody estate. There had also been a greater commitment to professionalising the custody role, along with an attempt to provide a stronger and better resourced infrastructure to support the delivery of custody services.

3.2 The custody function sat within the wider criminal justice department, and specialist resources were ring fenced for the delivery of custody services, with no requirement for response officers to provide resilience. This ensured that only fully trained staff engaged in custody duties, and they were able to maintain their professional and occupational competence through regular training. However, in order to have sufficient custody staff on duty in each suite, many shifts were covered by overtime, including onerous double shifts, which presented significant risks to the constabulary and was not a sustainable position. We were not assured that were sufficient resources available to deliver safe custody for detainees.

3.3 Custody staff were generally well supported, with ongoing training. Custody sergeants received a comprehensive four-week initial training course and had an additional four training days each year to maintain occupational and operational competence. There had been force-wide training on vulnerability, although not all custody staff had been involved in this, or had received more-specialist training on vulnerability to help them in their roles (see paragraph 5.5).

3.4 In order to make better use of resources, the constabulary had introduced the detainee transport service (DTS), staffed by DOs, which enabled frontline officers to continue to respond to emergency calls while detainees were transported to the custody suite. This appeared to be a positive initiative, although information was not consistently relayed from arresting officers to the DTS, and onwards to custody staff, which could have led to a breach of the Police and Criminal Evidence Act 1984 (PACE) and posed risks in the custody suite.

3.5 The constabulary followed the College of Policing's *Authorised Professional Practice* (APP) – the official source of professional practice on policing – for custody but also supplemented this with a number of local guidance documents, to cover perceived gaps in the national guidance. Policies and standard operating procedures (SOP) were accessible to staff on the local intranet, although we found that some local policies contradicted each other, which was confusing for staff.

3.6 There had been clear and strong leadership by the chief officer team, together with the PCC, to improve partnership working (see below) and the provision of alternatives to custody for vulnerable people. The constabulary reported an improving position in relation to local authority provision for children and those with mental health problems; however, there

were limited data to measure performance in this area, to evidence the impact on positive outcomes for detainees (see area of concern 2.40).

3.7 National safeguarding policies and practices were followed but there was little guidance for custody services. Custody and frontline officers showed an understanding of safeguarding concerns and how to refer these to more specialist help but the approach was not well supported by training or policies addressing issues that might arise in custody.

Accountability

3.8 We recognised the difficulty within the constabulary of establishing and maintaining a consistent strategic approach to developing and delivering services during a period of high staff turnover at chief officer level, affecting continuity of leadership. The pace of organisational change in the delivery of custody services had not been matched by that of cultural change. The culture was not homogeneous across the custody suites, reflecting the differences in the challenges between urban and rural areas, and in the outlook of custody staff.

3.9 The constabulary had regular custody management meetings, chaired by the Chief Inspector, and the minutes showed that custody services were monitored. There were also quarterly meetings within the wider criminal justice department, chaired by the Assistant Chief Constable. However, the performance monitoring of custody was unclear and limited, with little performance information available to show how well different aspects of the service were performing (see area of concern 2.40)

3.10 The constabulary had an effective relationship with its current health care providers and there was clear accountability for performance, with evidence of robust monitoring of data, including timeliness. The contract was managed efficiently and the senior management team regularly charged credits when the contracted targets were not met.

3.11 There was a lack of clarity in relation to the governance and oversight of use of force in custody. Local policy set out when officers and staff were required to document the use of force but this was unclear. We were not assured that sufficient data were available for the constabulary to assess whether all instances of use of force had been appropriate, or to allow it to monitor trends and identify learning. While we recognised that there were plans to improve this situation, it remained unchanged from the previous inspection and was a significant weakness (see section on safety: use of force and area of concern 2.41).

3.12 The constabulary had taken a robust stance in ensuring that detainees with mental health issues were not bought into custody as a place of safety under section 136 of the Mental Health Act 1983,[4] and had issued a clear directive to this effect in June 2016. Although the number of detainees entering custody under section 136 had reduced considerably, we came across several cases where vulnerable people with documented mental health problems, and for whom there had been safety concerns, had been held in custody. We were not assured that the constabulary understood why such a large number of detainees with mental health problems were still detained in custody when alternative solutions would have provided better outcomes for them (see also section on mental health and area of concern 2.42).

[4] 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.

3.13 The constabulary had increased its focus on equality and diversity, having designated champions at chief officer level and developed role models at senior officer level. It was able to demonstrate that it met the requirements of the Equality Act 2010 and the public sector equality duty, with an equality strategy in place and clear strategic objectives against which progress was monitored and published. However, there were no equality objectives, and there was no specific focus, in relation to promoting equality and diversity within custody services. In addition, there was little monitoring of services by key protected characteristics to demonstrate fair treatment and any over- or under-representation in the treatment of detainees, and to identify areas for improvement.

3.14 The constabulary encouraged, and was open to, external scrutiny. ICVs reported a consistently good working relationship with the constabulary and felt that they had a constructively critical role. No serious concerns had been raised by detainees to ICVs about treatment and conditions; the most prominent complaints they had received related to housekeeping.

Partnerships

3.15 The two NHS mental health providers were broadly similar in provision but operated differently. There were five separate multi-agency crisis care concordat groups, convened by the Clinical Commissioning Groups (CCGs). While there was strategic governance and oversight to review health care, performance and partnership arrangements, this structure was complex, reflecting the regional split of providers and the large number of stakeholders. These strands were not fully integrated and the current arrangements did not provide sufficient assurance that operational practice was in line with policy. However, a new force-wide crisis care concordat meeting, chaired by the PCC, aimed to address this.

3.16 There was some constructive engagement with health care partners. The constabulary reported that progress had been made in relation to the provision of mental health services. Issues had been raised at local meetings with health care partners, and the constabulary was working effectively with the CCGs to provide street triage, and crisis teams funded by local authorities. The PCC chaired regular meetings to discuss progress against the mental health concordat, holding both the constabulary and the CCGs to account. Issues raised at the meetings had resulted in increased coverage from crisis teams in the south of the constabulary's area, to improve provision. Although issues remained, including long waits in custody for mental health assessments, the constabulary was taking a robust approach concerning its expectations from health care agencies.

3.17 Operationally, there was some good partnership working – for example, with the youth offending service responsible for providing AAs for children and vulnerable adults. There was also some effective collaborative work between the custody suites and partner agencies through the liaison and diversion scheme. However, wider partnership working aimed at diverting vulnerable people away from custody and reducing reoffending was more limited. Work was under way to develop a jointly funded scheme to keep women out of the criminal justice system.

Section 4. Pre-custody: first point of contact

Expected outcomes:
Police officers and staff actively consider alternatives to custody and in particular are alert to, identify and effectively respond to vulnerabilities that may increase the risk of harm. They divert away from custody vulnerable people whose detention may not be appropriate.

Assessment at first point of contact

4.1 From the detainee's first point of contact with the police service, officers and staff were generally alert to, identified and made effective assessments of risk and vulnerability.

4.2 The constabulary had one communication centre (CC), at its headquarters. CC staff were skilled call handlers and dispatchers, and worked collaboratively, under good supervision, to facilitate appropriate responses to emergency calls, routinely applying the 'threat, harm, risk, injury, vulnerability and engagement' ('THRIVE') decision-making response. They had regular training opportunities but had received limited input on vulnerability, safeguarding or mental health. The CC staff we observed were compassionate in their dealings with people reporting crimes.

4.3 Identifying and responding to vulnerable victims of crime was a priority for the constabulary. Police staff, and to a lesser extent CC staff, demonstrated that they had a good understanding of vulnerability and were aware of the importance of vulnerability assessments for the victims and suspects with whom they came into contact, to ensure that their individual needs and risks were assessed and responded to appropriately.

4.4 Frontline officers were reasonably well informed when responding to incidents. The constabulary records management system, Niche, contained information about vulnerability. This included warning markers and information about previous incidents, and these were used to inform decision making about how to deal with the alleged offender. However, CC staff had restricted access to Niche, which inhibited the free flow of important information. This weakness was confirmed by the police officers we spoke to, who did not have access to mobile devices and therefore relied heavily on immediate and relevant information. An intelligence assessment unit, with access to a range of intelligence databases, was based in the CC and provided additional detailed information to police officers and staff involved in ongoing incidents. The police officers we spoke to said that this was helpful.

4.5 CC staff checked on the police national computer (PNC) for further information relevant to the detainee and officer safety. They also had access to the constabulary's command and control system ('STORM'), which identified a range of important information, including whether the victims and/or suspects at any given incident had any physical or mental health concerns.

4.6 Frontline officers used the national decision-making risk assessment framework when responding to incidents. Training for officers was localised, and varied between districts. For example, officers in Bath had received mental health and suicide and self-harm training, whereas officers in other districts had not received any recent training in these areas.

4.7 There were no partner agencies based in the CC, although there were advanced plans for mental health professionals to be located there. Officers in Bristol benefited from the presence of a mental health triage team, which provided advice and guidance on how to deal

with detainees in need of mental health care, but this facility was not available across the rest of the county.

4.8 Police officers and staff who had contact with children recognised them as vulnerable by virtue of their age. The impact of custody on vulnerable people, including children, was a serious consideration for police officers. Frontline and custody staff we spoke to were aware that custody should be avoided where possible, and they explored a range of relevant alternatives. Police officers' attempts to divert vulnerable individuals from custody were sometimes hindered by a lack of services to support them to respond more effectively.

4.9 Staff received annual refresher safety training, in line with national guidelines and the College of Policing's *Authorised Professional Practice* (APP). There were local protocols for the transport of detainees to custody suites and hospitals to prevent harm, although we were given several examples of officers having to transport vulnerable detainees to hospital because an ambulance had not been available.

Area for improvement

4.10 Communication centre staff should have access to Niche, to ensure that they are able to provide relevant information to police officers and staff when requested.

Section 5. In the custody suite: booking in, individual needs and legal rights

Expected outcomes:
Detainees receive respectful treatment in the custody suite and their individual needs are reflected in their care plan and risk assessment. Detainees are informed of their legal rights and can freely exercise these rights while in custody. All risks are identified at the earliest opportunity.

Respect

5.1 In general, custody staff dealt with detainees in a respectful, dignified and professional way. We observed a large number of interactions in which custody staff treated detainees with care and sought to identify and meet their individual needs. However, this was not always the case, and we saw some closed-circuit television (CCTV) footage showing that a detainee had been left naked in a cell for over four hours, with little regard for his dignity.

5.2 There were arrangements to offer privacy for booking in detainees when this was needed. There were separate booking-in rooms in Patchway, Keynsham and Bridgwater. However, these discrete rooms were mainly used for cases that were particularly sensitive, rather than routinely for children (see also section on safeguarding), women or other vulnerable detainees. This meant that most vulnerable detainees were booked into the custody suite in the same way as all other detainees, which could have hindered them from disclosing information about their needs. There was only one booking-in desk at Yeovil.

5.3 There were a number of facilities in the custody suites to meet the diverse needs of detainees. Patchway, Keynsham and Bridgwater were accessible for people with disabilities and each had a fully adapted shower and toilet room. Wheelchairs were available in all suites and thicker mattresses were provided for people with mobility issues. Information in different languages, hearing loops, a range of religious books and items, and food to meet various dietary and religious needs were all available. Custody staff provided additional support to detainees when needed – for example, they allowed detainees with mobility issues to have a chair in their cell; on one occasion they had given additional support to help a blind detainee cope with his stay in detention; and during the inspection they allowed an older detainee to be seated at the booking-in desk.

5.4 However, in some areas insufficient attention was paid to meeting individual and diverse needs. Girls were not routinely allocated a female member of staff (see also section on safeguarding and recommendation 6.38), and women were not routinely asked if they wanted access to a female member of staff to help with their particular needs; this appeared to be because the custody computer system no longer prompted custody sergeants to ask this question. There was no Braille provision for visually impaired detainees; the religious books were not always stored respectfully; and not all custody staff were aware of aids such as hearing loops.

5.5 Custody staff received limited training on diversity. Although the constabulary had delivered force-wide training on vulnerability, and there was mandatory equality and diversity training, few custody staff said that they had received this type of training. For example, not all staff had received training on mental health issues to help them to recognise particular conditions, or on how they should handle and store religious items. Their knowledge and understanding

of diversity relied on their own experience, rather than being developed and supported by a more systematic approach.

Areas for improvement

5.6 All custody staff should receive adequate training in diversity.

5.7 When vulnerable detainees are being interviewed, full use should always be made of the private booking in rooms.

Risk assessments

5.8 Detainees were generally dealt with quickly on arrival at the custody suites. We saw some vulnerable people being identified early and prioritised through the booking-in process. However, there were no formal triage procedures to prioritise such detainees, and there was little evidence to show that ongoing risk assessments took place when there were delays in booking in.

5.9 During the booking-in process, detainees were asked if they understood what had happened to them before their detention and if they had any immediate needs. Custody sergeants completed formatted risk assessments well, and most asked supplementary questions and paid particular attention to detainees' mental and physical health needs. They usually identified initial risks effectively, including those people in custody for the first time. However, they did not routinely cross-reference the PNC for warning markers and historic information held on the Niche system, to help to further inform risk assessments.

5.10 In general, custody staff dealt patiently and sensitively with detainees who were intoxicated and/or vulnerable. Responses to demanding behaviour were not over-reactive or heavy handed and we saw officers dealing patiently with difficult situations in a calm and measured way. However, the recording in care plans was often superficial, and did not always reflect all identified risks or the required levels of care.

5.11 Levels of observations were mostly set appropriately and were commensurate with the risk posed, although we came across a few cases where set levels of observations had not been adhered to. In most cases individual care for vulnerable people was good and based on ongoing assessments of the risks they presented. However, in a minority of cases we saw a general lack of engagement between some custody staff and vulnerable detainees, and routine checks were sometimes superficial. In addition, DOs often checked detainees through observation panels, without opening doors to engage with them. We saw some practices that were unnecessary – for example, the routine removal of detainees' corded clothing and footwear was disproportionate, particularly for those assessed as low risk.

5.12 Staff were aware of how to rouse sleeping/intoxicated detainees when the level of observation required it, and this was done well. Monitoring through CCTV was used in addition to physical checks. The Patchway, Bridgwater and Keynsham custody suites had dedicated staff who monitored CCTV cameras and responded to cell call bells and telephone calls.

5.13 Although we rarely saw it being used, we were told that the use of anti-rip clothing (known by custody staff as 'suicide suits') to mitigate the risk of self-harm occurred reasonably often. The descriptions we were given of cases involving its use indicated that higher levels of observation may have been a more appropriate option. Governance of the use of this

clothing was poor, with inconsistent recording, and we were not assured that its use was always justified.

5.14 Not all custody staff carried personal anti-ligature knives. In most custody suites, knives were attached to the cell keys or left at booking-in desks. Some staff visited cells without carrying keys or anti-ligature knives, which compromised detainee safety and was poor practice.

5.15 Shift handover arrangements were reasonably good but DOs from the on-duty shift did not attend, which potentially compromised the quality and accuracy of the information shared. The handovers we observed were well conducted in private and focused on risk, detainee welfare and case progression.

Areas for improvement

5.16 There should be an ongoing risk assessment of all detainees for whom the booking-in process is delayed.

5.17 Detainees' clothing and footwear should only be removed on the basis of an individual risk assessment.

5.18 Anti-rip clothing should only be used to mitigate the risk of self-harm in exceptional circumstances and as a last resort, and there should be protocols to govern its use.

5.19 All custody staff should carry anti-ligature knives at all times.

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

Individual legal rights

5.21 Custody sergeants were responsible for booking detainees into custody. Arresting officers provided a full explanation of the circumstances of, and the reasons for, arrest before detention was authorised. 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. We saw some officers providing thorough reasons to justify their necessity to arrest detainees. We were told that officers regularly contacted custody sergeants for advice in advance of making arrests, and we saw this taking place on a number of occasions.

5.22 The constabulary operated a detainee transport service (DTS) at peak times (see paragraph 3.4). DOs handed over a completed escort form to custody sergeants, providing details of the circumstances of the arrest, offence details and grounds for arrest. However, at Patchway we saw DTS staff bring two detainees into custody without this form being fully completed because officers had not shared this information with them, which delayed the booking-in process.

5.23 Alternatives to custody were available through community resolution,[5] street bail[6] and voluntary attendance[7]. Data confirmed that the number of voluntary attendees had increased

[5] Community resolution applies to the resolution of a less serious offence or antisocial behaviour incident involving an identified offender (both youth and adult), through informal agreement between the parties rather than progression through the criminal justice process.

by 55% across the constabulary. Such interviews took place in external voluntary attendance suites, which supported the ethos of the process to divert individuals from police custody.

5.24 Most detainees were booked in promptly on arrival at the custody suites but some custody sergeants did not always ask arresting officers for their time of arrival. In several cases we observed, and in others we reviewed on CCTV, detainees waited for up to 21 minutes, and the booking-in rather than the arrival time had been recorded. This gap in the timeline had implications for the accuracy of custody records and for ensuring the timely issue of rights and entitlements. Data supplied by the constabulary showed the average waiting times from arrival in custody to authorisation of detention to be six minutes, but these were not accurate in the light of the anomalies we discovered.

5.25 Custody sergeants were aware of the need to keep detention to a minimum and to progress cases quickly. We were told that there were sometimes delays because of factors such as the non-availability of AAs (see section on safeguarding) and low staffing levels in the detainee investigation teams. Constabulary data showed that the average length of detention before charge had been nine hours 35 minutes for the year ending July 2016, which was similar to the average of 10 hours 31 minutes found in our CRA.

5.26 Custody staff reported a good relationship with Home Office Immigration Enforcement officers, several of whom were based in local police stations. Constabulary data showed that 158 immigration detainees had been held in the year to 31 July 2016, an increase from the 60 held in the year to 31 July 2015. Custody staff told us that most immigration detainees were moved on within 24 hours to an immigration removal centre. However, they were unable to provide any reliable data on the average time in custody for immigration detainees following the issue of an IS91 warrant of detention,[8] and during the inspection we saw two immigration detainees who had been held for 28 hours 20 minutes and 56 hours 19 minutes, respectively, following the issue of their IS91 warrant, which was poor.

5.27 During booking in, custody sergeants told detainees of their three main rights,[9] although the Police and Criminal Evidence Act 1984 (PACE) codes of practice were not always explained by custody staff. Sufficient copies of the up-to-date PACE code C were available but we did not see these routinely offered to detainees to read. In most cases, custody sergeants routinely offered detainees a written notice setting out their rights and entitlements, although these were rarely accepted. Custody staff were able to access these notices in foreign languages for non-English-speaking detainees but few staff were aware that an easy-read pictorial version of this document was also available for detainees needing help with understanding or reading. The rights and entitlements notice was not available in Braille.

5.28 If detainees declined the offer of free legal representation, they were told that they could change their mind at any time. Those wishing to speak to legal advisers could do so over the telephone through an intercom or via a mobile telephone handset, in the privacy of their cell, although some legal advisers said that the quality of the intercoms was poor. There were sufficient consultation and interview rooms in all the suites, and legal advisers were given a printout of their client's custody record on request.

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6 Street bail under Section 4 of the Criminal Justice Act 2003 enables a person to be arrested for an offence to be released on bail by a police constable on condition that they attend a police station at a later date. One of the benefits of street bail is that an officer can plan post-arrest investigative action and be ready to interview a suspect when bail is answered.

7 Voluntary attendance is usually used for lesser offences, and involves suspects attending by appointment at a police station to be interviewed about these, avoiding the need for arrest and subsequent detention.

8 An IS91 warrant of detention is served on an immigration detainee when there is no reasonable alternative action, for example, if there is a likelihood that they may abscond or that their removal from the UK is imminent.

9 The right to have someone informed of their arrest, the right to consult a solicitor and access free independent legal advice, and the right to consult the PACE codes of practice.

Area for improvement

5.29 Custody sergeants should always determine the detainee's time of arrival in the custody suite accurately.

Communication

5.30 A professional telephone interpreting service was available to assist the booking-in of non-English speakers. Most staff used double-handset telephones to access this, which afforded privacy. Staff told us that a face-to-face interpreting service was available for interviews but that there were sometimes delays, depending on the language requested, which resulted in some detainees remaining in custody longer than necessary or having to be bailed, where practicable.

5.31 Custody staff had ready access to other documents – such as authorisation of detention and charge details – in a range of languages through the custody intranet.[10] Posters informing detainees of their right to free legal advice were available in a range of languages in all the suites but these were incorrectly displayed as single posters rather than as a complete two-part set.

5.32 All custody staff were able to identify the location of portable hearing loops but there was no signage to advertise this facility.

Access to swift justice

5.33 Pre-charge bail was poorly administered, with inadequate documentation of the supporting rationale for seeking, approving and setting bail; bail conditions; and bail terms. We found little evidence of bail rationales being documented, either in custody records or within the body text of crime investigations recorded on Niche. We also found inconsistent recording of interviews on custody records, which were often not fully completed. By failing accurately to update detainee records, the constabulary was not able to demonstrate that it was dealing with detainee bail in a legitimate, necessary and proportionate manner.

5.34 A lack of supervision by higher-ranking officers in the investigation of cases led to crime enquiries not being planned or prioritised effectively, and sometimes resulted in detainees having their bail extended or having to be re-bailed. However, crime enquiries in bail cases were generally extensive, appropriate and well documented, although not always timely and targeted.

5.35 Our analysis of case materials indicated that constructive conversations took place between custody officers and investigating officers seeking bail for the detainees they were investigating, resulting in properly tailored bail conditions and durations.

Complaints

5.36 No information on the complaints process was displayed in any of the custody suites but was contained in the rights and entitlements notices offered to all detainees. Custody staff and custody inspectors told us that if a detainee wished to make a complaint while in custody, this would be facilitated, provided that they were in a fit state to participate in the process

[10] PACE code C annex M details the documents considered essential for the creation and provision of written translations.

(for example, not under the influence of alcohol). However, in our CRA we found one case where a detainee who wished to make a complaint had been advised to telephone 101 (the number for non-emergency calls) on his release, which was inappropriate.

Section 6. In the custody cell, safeguarding and health care

Expected outcomes:
Detainees are held in a safe and clean environment in which their safety is protected at all points during custody. Officers understand the obligations and duties arising from safeguarding (protection of children and adults at risk). Detainees have access to competent health care practitioners who meet their physical health, mental health and substance use needs in a timely way.

Physical environment is safe

6.1 Since the previous inspection, the number of custody suites had been reduced from 22 to five, with only four of these being in day-to-day use. The Yeovil suite was in poor physical condition and in need of redecoration. The three newer suites at Patchway, Keynsham and Bridgwater were around two years old but were already showing some need for remedial decoration in the cells and holding areas.

6.2 Cleaning across the four main facilities was inconsistent, with evidence of poor cleaning and hygiene, although graffiti was removed quickly. In the holding cells at Bridgwater and Yeovil, we found blood stains on the walls, even after these areas had been cleaned. Across all suites, surfaces were grubby throughout, and the in-cell toilets at Bridgwater and Keynsham were dirty.

6.3 Daily checks of physical conditions were not always carried out consistently, particularly at Patchway and Keynsham. When checks were completed, they were comprehensive. We identified ligature points in the exercise yards of all four main custody suites; when we pointed these out, the constabulary immediately began work to remove them.

6.4 All custody suites had fire evacuation plans, of which staff were aware. However, fire evacuation drills were not completed in all suites, which contravened legal requirements.

6.5 Defibrillators were located in each of the main suites. These were checked daily for function, by a contracted health care professional, at each custody suite. Custody staff received training in the use of defibrillators at scheduled sessions throughout the year.

Areas for improvement

6.6 The constabulary should ensure that all custody suites are clean and that daily checks of physical conditions are carried out consistently.

6.7 The constabulary should establish and enforce a corporate policy to ensure compliance with statutory fire regulations.

Safety: use of force

6.8 The governance and oversight of the use of force in custody were inadequate. Good attention was paid to ensuring that operational custody staff were up to date with their officer safety/personal protection training. However, the collation of data on incidents in

which force had been used was weak, and we found numerous inaccuracies in the data provided. The standard operating procedures (SOP) for custody stated that use of force forms should be submitted in a range of situations in which force had been used. The system was not yet sufficiently well embedded, and the section in the SOP where 'any other significant use of force' was referred to was open to discretion/interpretation. We requested these forms for 14 incidents but only four were provided, and each of these contained limited information. In most of the custody records we examined, there were clear narrative entries about the use of force in custody. However, when we cross-referenced these with CCTV footage, we found that a few entries did not reflect what we had seen. We also observed a small number of incidents in which the force used had not been documented at all in the custody record (see area of concern 2.41).

6.9 We saw some staff using good skills to de-escalate challenging situations with detainees without resorting to the use of force. However, CCTV footage was retained for only 30 days, so we were unable to review cases that dated back further than this. We carried out an in-depth examination of 15 cases in which force had been used against detainees in custody. Although some staff told us that they would use blankets to cover the heads of detainees who attempted to bite or spit, the CCTV footage showed staff controlling such situations using only approved techniques. Seven of the cases reflected that the level of force had been proportionate to the risk or threat posed and that the situations had been handled well. However, eight cases raised various concerns, and we referred seven of these back to the constabulary. We were not assured that the force used in these cases had always been proportionate to the risk/threat posed. There was often poor deployment of techniques, including a prolonged prone restraint, which is potentially unsafe. We also found that leg restraints and handcuffs were sometimes used for too long on compliant detainees (see area of concern 2.41).

6.10 Our most serious concern arose from the use of the incapacitant spray PAVA in custody, the governance of which was inadequate. An officer safety trainer confirmed that, although training for the use of incapacitant spray included the risks associated with its use in close proximity, there was no specific training for staff on its use in the controlled environment of the custody suite. We come across the use of PAVA in custody suites elsewhere infrequently. We found that its use was relatively commonplace, and high in comparison, in the custody facilities in Avon and Somerset; according to the figures provided by the constabulary, it had been used 107 times in the previous six months. We found that this spray was sometimes used to enforce the compliance of detainees, which was inappropriate. For example, in two incidents in which detainees had put their hands through the cell hatch, incapacitant spray had been used to force them to put them back inside the cell. Aftercare for detainees who had had incapacitant spray used against them was also poor in many cases (see area of concern 2.41).

6.11 Oversight of the use of Taser in custody was much better and we were confident that it was deployed rarely and only as a last resort, and that uses were authorised properly. We were told that Taser had not been used in custody for at least 12 months.

6.12 Detainees did not arrive in custody wearing handcuffs routinely. However, we saw a few compliant detainees remaining in handcuffs for too long after their arrival, which was disproportionate to the threat posed in the controlled custody environment.

6.13 The constabulary was unable to provide data on the number of strip-searches that had taken place in custody during the previous 12 months (see area of concern 2.40). However, we saw few such searches authorised during the inspection, and our CRA indicated that strip-searching was relatively rare, and always for appropriate reasons.

Detainee care and PACE reviews

6.14 All detainees were asked during booking-in if they had any special dietary requirements. Microwave meals and cereal bars were available, and food and drink were provided at mealtimes and on request. Food preparation areas were clean but several microwave ovens were dirty. Not all the suites had an up-to-date guide to identify the suitability of the microwave meals for special diets (such as gluten-free, nut-free and kosher). In our CRA, 111 out of 142 detainees (78%) had been offered a meal, including all 12 detainees held for over 24 hours.

6.15 Mattresses and pillows were provided, and staff wiped these down with disinfectant wipes between uses. There were good stocks of clean blankets, which were routinely offered to detainees at night and on request during the day. A small amount of toilet paper was routinely available in the cells, and the view of the toilet area was obscured on CCTV images of the cells. At Yeovil, the cells had no hand-washing facilities but these were available on cell corridors and could be used on request, and subject to the availability of staff.

6.16 All suites had clean showers but in Patchway, Keynsham and Bridgwater these were not sufficiently private. Custody staff said that they were not always able to offer showers but would do so if a detainee requested it, provided that there were sufficient staff available. In our CRA, 20 detainees (14%) had been offered a shower, eight of whom had been held for over 24 hours. Cotton towels were generally not available and detainees had to use paper towels. Stocks of toiletries were available in all of the suites.

6.17 T-shirts and jogging bottoms were readily available as replacement clothing for detainees whose clothing was seized for evidential purposes or otherwise soiled. Other than at Yeovil, replacement underwear was available.

6.18 All shoes were routinely removed from detainees before they entered their cells. Plastic flip-flops, and in some cases foam slippers, were available in the suites as replacement footwear but these were not routinely offered to detainees. We saw several detainees in the suites walking about in socks or in their bare feet. The replacement footwear and clothing available were not appropriate for detainees to wear on being transferred to, and subsequently released from, court. Custody staff indicated that they would accept replacement clothing for detainees from family and friends if this was made available.

6.19 Nicotine replacement products were readily available in all of the custody suites, which was positive. Detainees were told that they should not use the product if they had experienced various health conditions; they were also warned about possible side effects before being asked to sign a disclaimer, and we saw this taking place before the product was issued.

6.20 All the custody suites had at least one outside exercise area, which allowed detainees access to some fresh air, but we found little evidence of these being used. In our CRA, seven detainees (5%) had been offered outside exercise, only one (8%) of whom had been held for over 24 hours. At some suites, staff told us that, to facilitate exercise, they would lock detainees in the exercise area and monitor them from the booking-in areas via CCTV.

6.21 The custody suites had stocks of books, magazines and old newspapers, generally provided by staff. There were no age-appropriate reading materials for children or any in languages other than English. We saw several detainees being offered reading materials during their detention. However, in our CRA only 12 detainees had been offered access to reading materials, two of whom had been held for over 24 hours.

6.22 With the exception of Yeovil, the custody suites had designated visits facilities. Staff told us that they would only allow visits in exceptional circumstances and when staffing levels permitted.

6.23 Police and Criminal Evidence Act 1984 (PACE) reviews were undertaken by custody inspectors or, in their absence during the night, by divisional duty inspectors. We found that there were often only two custody inspectors on duty to cover the four custody suites, which meant that a large proportion of reviews were conducted remotely, by telephone. The face-to-face reviews that we observed were timely, appropriate and fully recorded on detention logs. However, in our CRA it was often unclear how reviews were conducted – for example, if the detainee was spoken to, especially when these were performed remotely. It was encouraging to learn that a project had been commissioned to install video conference equipment in the three new suites. This initiative was designed to enhance the quality of PACE reviews carried out remotely.

6.24 In our CRA of 96 records in which an initial PACE review had been required, 37 (35%) had been carried out early. Custody inspectors told us that they often conducted reviews early, provided that they were confident that there would be no change in the detainee's circumstances, because of their shift patterns. We saw no detainees being told that reviews had taken place while they were asleep, and custody sergeants confirmed that the information that such a review had been conducted was not exchanged during staff shift handovers or flagged on Niche, and therefore could be overlooked.

6.25 In our CRA, four out of nine initial reviews and two out of four secondary reviews with children had been conducted over the telephone, rather than in person. Custody inspectors confirmed that it was common practice to carry out reviews by telephone, except at the suite where the inspector was based.

Areas for improvement

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

6.27 All custody suites should facilitate exercise periods for detainees.

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

6.29 Reviews of detention should be conducted in accordance with the Police and Criminal Evidence Act 1984, code C.

Safeguarding

6.30 The constabulary relied on national and *Authorised Professional Practice* (APP) guidance to govern its approach to safeguarding, supplemented by some local guidance for child protection. There was no specific guidance to cover safeguarding issues arising from detaining vulnerable adults or children in custody, although it was policy that all children under 17 should be referred to a health care professional. There had been no specific training for staff on safeguarding and their responsibilities in relation to this.

6.31 Custody staff were alert to potential safeguarding concerns and were able to give examples of actions they had taken in response. One case they described concerned a girl detained for committing an offence but, as a result of care and support from custody staff, she had been

able to disclose child sexual exploitation offences committed against her, which were subsequently investigated. Most custody staff were also aware of the wider constabulary and partnership safeguarding arrangements to address concerns but considered that the responsibility for making referrals resided with arresting and investigating officers or the health care professionals.

6.32 There was limited provision to meet the needs of children. Custody staff recognised the adverse effects of custody on children and offered a good level of care to support them, offering regular meals and drinks. However, custody sergeants did not routinely use the discrete booking-in rooms, the 'vulnerable' cells with glass doors or a separate wing for child detainees, to keep them away from adults (see area for improvement 5.7). Children were not routinely assigned a designated member of staff – including girls, for whom it is a legal requirement for them to be allocated a female member of staff. Although our case audits of children and our observations in the custody suite indicated that children were normally placed on 30-minute observations (or constant observations if particular concerns were identified), this was not done routinely and not governed by guidance. Some of our case audits included children who had been placed on hourly observations, which was inadequate.

6.33 The AA service did not consistently provide timely support to children and vulnerable adults. Family or friends were contacted to act as an AA in the first instance. When this was not possible, an AA was sought through arrangements with either the youth offending team or social services, or through the emergency duty team out of hours. Custody sergeants said that the AA arrangements generally worked well during the day. There was some provision during the evening but little or none during the night. AAs were requested to attend at the time of the detainee's interview but this, along with the limited provision outside normal working hours, meant that some vulnerable detainees and children spent long periods, including overnight, without support, waiting for an AA to arrive. It also meant that some detainees did not have access to advice and help early on in their detention, in line with good practice. Our CRA of 17 cases showed an average wait of about eight hours from the detainee arriving in custody to an AA arriving, and in one case no AA had been provided.

6.34 Custody staff and the AA services reported good working relationships, and meetings were held to identify and resolve any issues arising from the service. Guidance was given to AAs who were not familiar with the role, and they were able to talk to detainees in private. However, the constabulary did not monitor provision of the AA services, to enable it to assess how well the service was performing and meeting detainee needs. Our case audits showed that not all the information about the AA was recorded on the custody record – for example, whether they were family members or had been sent by the independent service provider, making it difficult to monitor the service accurately and identify where improvements were needed.

6.35 There was a clear focus on avoiding the detention of children. Frontline officers explored alternatives to custody, such as voluntary attendance or community resolution (see also paragraph 5.23), to avoid detaining children, and custody staff said that the number of children entering custody was reducing. When children were brought into custody, custody sergeants sought robust justification before authorising detention and refused it when necessary. Bail was used to minimise the time that children spent in custody and avoid overnight detention where possible.

6.36 Despite this positive and proactive approach, some children spent long periods in custody. Our CRA of 12 children showed that children spent an average of just over 12 hours in custody, with the longest time being just under 30 hours. Five of these children had been held overnight. A similar picture was revealed in our case audits of 10 children. Although performance information was monitored for children charged with an offence and refused bail (see below), it was not for those who were detained pending investigation. The latter

children made up the majority of those detained overnight, and we were not assured that the constabulary fully appreciated this position or the reasons for it.

6.37 Despite reports of improved partnership working, joint working arrangements with local authority partners with a statutory duty to arrange alternative accommodation for children who were charged and refused bail still did not work well, resulting in children remaining in custody overnight. Custody sergeants requested accommodation and escalated cases where necessary but this did not always result in the provision of either secure or non-secure accommodation, and they told us about the difficulties in trying to obtain alternative accommodation. Information provided by the constabulary showed that in July 2016, 14 children had been charged and had bail refused, of whom 13 had been detained overnight. Although cases involving such children were reviewed, to ensure that all efforts had been made to obtain alternative accommodation, there was no information to show whether accommodation had been requested in all of these cases, or the reasons why the requests had not been met.

Areas for improvement

6.38 The constabulary should improve its approach to safeguarding in custody by providing specific guidance and training to custody staff so that concerns are consistently recognised and addressed. In particular, it should ensure that all girls aged under 18 who are detained are allocated a designated female member of staff.

6.39 The constabulary should ensure that the appropriate adult service provides timely support to children and vulnerable adults, and that the lack of provision outside of normal working hours does not lengthen a detainee's time in custody.

6.40 The constabulary should reduce the number of children detained in custody overnight, and ensure that they are not detained unnecessarily in cases where alternative accommodation should be provided by the local authority.

Governance of health care

6.41 The physical health care service was provided by Mitie but this was due to transfer to G4S from September 2016. Leadership of the physical health care service was effective and health care professionals (HCPs) were present in all four suites. Oversight and governance were robust, with induction, training and supervision arrangements fully embedded and valued by practitioners. There was a full range of policies, which staff were familiar with, including those related to safeguarding. There was comprehensive information available for detainees, including clear reference to the separate health complaints process. Partnership arrangements with the police were effective and performance monitoring arrangements appropriate. Although there were good local relationships with other health providers, there were no formal joint forums between all the agencies.

Area for improvement

6.42 All health providers should meet periodically with police staff in the custody localities to improve collaborative working and enhance outcomes for detainees by promoting better communication and creating a vehicle to address local concerns.

Patient care

6.43 Detainees requesting or needing to see a health care professional were generally seen within an hour of arrival but urgent referrals were seen more promptly, and we found that longer delays had been clinically justified. Custody staff we spoke to valued the contribution made by HCPs. The clinical interactions we observed were delivered sensitively by skilled, experienced individuals, who provided clinically appropriate care. Medical input was readily accessible through the on-call arrangements, which primarily delivered enhanced support and supervision for complex care issues. There were separate facilities for forensic sampling in all suites, except at Yeovil, where this process was carried out in the treatment room, which was cramped and inadequate for this purpose.

6.44 Handwritten clinical records were legible and the samples we assessed were of good quality. HCPs shared appropriate information with the police through their entries in the custody record. Medication management arrangements were good, and routine stock checks robust. Emergency equipment was appropriate, and checked and maintained regularly. All HCPs were trained in intermediate life support and were competent to respond to medical emergencies.

6.45 There were a number of patient group directions which supported HCPs to administer an appropriate range of prescription-only medicines.

6.46 Detainees could continue to receive validated prescribed medications while in custody. Symptomatic relief was provided, when clinically indicated, for those withdrawing from drugs or alcohol, and detainees could continue to receive prescribed opiate substitution therapy.

Substance misuse

6.47 The 'arrest, intervention and referral service' (AIRS) was provided by Swanswell, which offered a proactive and timely service for detainees with drug or alcohol problems. A team was based in every suite and operated from 7am to 10pm on Monday to Friday, and 7am to 3pm at weekends. The team operated an arrest referral service, with a focus on harm minimisation and reducing reoffending. Every detainee was screened and approached to offer support and information. In addition, practitioners responded to need identified by custody staff or other health professionals. The team appropriately signposted detainees to a range of services and, if necessary, accompanied them to their initial appointments. Swanswell led an innovative drug education programme that diverted people found in possession to a drug awareness course. Governance of the service was good, with the PCC's office having oversight of it. The staff we met were motivated and committed to their roles, with good access to training and supervision. The service was relevant and effective, with good links to housing agencies and other bodies. Young people were also seen by the service and were signposted or directly referred into age-appropriate services. Intravenous drug users were offered clean needles and syringes on release, which was good practice.

Mental health

6.48 Mental health care services were provided by two different specialist trusts: Somerset Partnership NHS Foundation Trust for Yeovil and Bridgwater suites, and Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) for Patchway and Keynsham suites. Both services aimed to provide a mental health assessment and diversion service to people in custody on referral from custody staff or other HCPs, or directly from detainees. Both services covered custody suites, magistrates' courts and crown courts, working from 8am to 8pm, seven days a week. The teams had access to electronic clinical records, and essential

non-clinical information recorded in the police Niche records. Before seeing a new referral, they checked the NHS electronic record to gauge if the detainee was already known to services and, after assessment, liaised with other agencies to support the detainee's mental health needs.

6.49 We received contrasting reports of the effectiveness of the two services from custody staff, and this was reinforced by our observations. Somerset Partnership NHS Foundation Trust delivered a generally good service, and the team was readily accessible in the custody suites. They routinely screened all detainees, gave timely assessments and provided appropriate support. AWP provision was more fragmented, with frequent delays in assessment, which could have led to needs not being met and risk not being addressed. Staffing shortages and their lack of coverage of the wider catchment area (which included Wiltshire) meant that AWP liaison and diversion staff were not always on site, resulting in a less responsive service than that provided by the Somerset team.

6.50 We found some delays in carrying out assessments for detention under the Mental Health Act, which could have led to detainees remaining in custody for too long, particularly when the initial assessment by the AWP team had been delayed. Children were seen across all suites by specialists from AWP but vacancies in this latter team, coupled with the general AWP staffing issues, had led to some potential gaps in the service, although we were reassured by practitioners that support for children would be prioritised.

6.51 The AWP team reported significant problems with connectivity to their Trust's electronic records in the custody suites, so tended to base themselves upstairs, above the custody suite, where internet reception was better. This meant that they were not as visible to the custody team, and resulted in a less proactive service.

6.52 There were also some differences in the working relationships between custody staff and the two mental health teams. We heard about many positive working relationships but this was less evident in the suites covered by AWP, where there appeared to be tension between the two groups of staff and a lack of understanding about each other's role.

6.53 There was effective joint working between the police force, clinical commissioning groups and other key stakeholders to improve mental health support for people in crisis. However, there were limited opportunities, particularly in Avon, for joint learning or dialogue between frontline mental health practitioners and custody staff. In addition, there was limited access to formal mental health awareness training for custody staff, and few opportunities for them to provide qualitative feedback on service provision.

6.54 Since June 2016, there had been a change of policy so that people detained under section 136 of the Mental Health Act 1983 would only be taken into police custody if there was a significant risk of violence (see also paragraph 3.12). In June, there had been no detentions under section 136, and in July only two, representing a drop from 40 in July 2015 and 20 in May 2016, which was impressive. In Avon, the health-based places of safety were sometimes full or not available for other reasons. We were told that the escalation plan was for a detainee to be taken to the local emergency department in these circumstances, which was not appropriate. However, this option was not indicated in the section 136 policy we were given. In addition, we found evidence that, despite the efforts by police to tackle inappropriate detention under section 136, people with mental health vulnerabilities were still being brought into custody (for example, arrested for breach of the peace) in response to self-harm or suicidal intent (see also paragraph 3.12). In one case, an individual considered by the mental health crisis team to be a suicide risk had been referred directly to the police for intervention. Although the desire to prevent harm was commendable, these decisions were often made in response to gaps in community health services. We were made aware of street triage developments, particularly in the Bristol region, but the diversionary impact had yet to be evaluated.

Areas for improvement

6.55 There should be a review of the capacity and approach used by the Avon and Wiltshire mental health team to ensure that it meets the needs of detainees.

6.56 Joint training and dialogue between frontline police custody staff and the liaison and diversion teams should be periodically facilitated, to develop greater understanding and awareness of each other's responsibilities and to foster constructive working relationships.

6.57 There should be a resolution of the connectivity problems for the teams at Patchway and Keynsham, so that the staff can operate at full capacity within the custody suites as part of the team.

6.58 Governance arrangements should ensure that frontline police contribute to the evaluation of mental health provision, particularly providing qualitative assessment of services.

6.59 The time taken to undertake mental health assessments should be routinely monitored and action taken to reduce delays for detainees waiting for assessment and transfer under the Mental Health Act.

6.60 The provision of section 136 suites and contingency arrangements when suites are full should ensure that people with identified mental health needs are not inappropriately detained in police custody.

Section 7. Release and transfer from custody

Expected outcomes:
Pre-release risk assessments reflect all risks identified during the detainee's stay in custody. Detainees are offered and provided with advice, information and onward referral to other agencies as necessary to support their safety and wellbeing on release. Detainees appear promptly at court in person or by video.

Pre-release risk assessment

7.1 Most of the pre-release assessments we observed paid sufficient attention to securing the safe release of detainees. In most cases, sergeants were aware of circumstances that could put detainees at risk on release, and they offered any necessary assistance and support. One pre-release assessment we observed was notably poor: the woman's initial risk assessment was not reviewed and she was not asked any of the standard pre-release risk assessment questions. Although she was told that she could use the telephone at the front desk, she left custody with no money and wearing only a T-shirt, even though it was raining. We spoke to her, and she said that the sergeant had told her that he had 'no statutory duty' to get her home. This was unsatisfactory but it was not clear how often this type of scenario arose.

7.2 We saw some detainees without money or means of transport being given bus tickets or police transport home following release. However, posters displayed at all but one custody suite stated police force policy that detainees would not be provided with transport in most cases. We were not assured that this was appropriate when the police had displaced the detainees into mostly remote locations, with poor transport networks. Moreover, this was a potential deterrent for vulnerable people to seek help, and supported staff to do little to help those without means to get home or to a place of safety.

7.3 A support leaflet with useful telephone numbers was available but not always given to detainees on their release, and there were some leaflets about additional support to women and the homeless.

Area for improvement

7.4 Pre-release risk assessments for detainees should take account of all identified risks, and manage and offset these to ensure a safe release.

Courts

7.5 Custody staff at all suites told us that the local remand courts would normally accept detainees until approximately 2pm on weekdays but only to 11am on Saturdays, which was too early. We were also told that there was generally some flexibility each day, depending on how busy the courts were.

7.6 Sergeants and inspectors said that detainees arriving on Friday evenings would get to court on Saturday morning but that those arriving on Saturdays would always have to wait until the courts opened on Monday morning.

7.7 Most of the person escort records we examined were reasonably good and contained adequate detail about the detainee, including when information about self-harm or previous suicide attempts, violence or drugs was cited.

Section 8. Summary of areas of concern, recommendations and areas for improvement

Areas of concern and recommendations

8.1 **Area of concern:** There was insufficient gathering and monitoring of performance data in key areas to promote the safe and respectful detention of people in custody.

Recommendation: The constabulary should strengthen its approach to performance management and ensure that data (including children in custody, detained people with mental health issues, use of force, adverse incidents and strip-searching) are accurately recorded, and routinely collated and analysed to identify trends, inform organisational learning and improve outcomes for detainees. (2.40)

8.2 **Area of concern:** All aspects of the use of force lacked governance and effective oversight, and data on the use of force in custody were not recorded effectively. Individual use of force forms were not always completed following the use of force in custody. We were not assured that all force was proportionate to the risk or threat posed. There was significant use of incapacitant spray in the controlled custody environment, and governance of its use was inadequate. Aftercare for many detainees who had this spray used against them was not good enough. There was some poor, and potentially unsafe, practice – we were particularly concerned by a long restraint in the prone position. Handcuffs and leg restraints were sometimes used on detainees for too long after they were compliant.

Recommendation: The constabulary should maintain effective management oversight of all use of force incidents and trends in custody, including the use of incapacitant spray. Only the minimum force necessary should be used and its application should always be proportionate. All staff involved in incidents should complete individual use of force forms. (2.41)

8.3 **Area of concern:** Despite a robust stance in ensuring that detainees with mental health issues were not bought into custody under section 136 of the Mental Health Act, too many vulnerable detainees with mental health problems, but not dealt with under section 136, were held in custody owing to a lack of more appropriate options.

Recommendation: The constabulary should reduce the number of vulnerable people detained in custody. The constabulary should routinely audit its custody records to identify where vulnerable individuals with mental health problems have been detained for minor offences, and use this information to develop with partners a better understanding of the position and take effective action to put more appropriate alternatives in place. (2.42)

Areas for improvement

Pre-custody: first point of contact

8.4 Communication centre staff should have access to Niche, to ensure that they are able to provide relevant information to police officers and staff when requested. (4.10)

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

8.5 All custody staff should receive adequate training in diversity. (5.6)

8.6 When vulnerable detainees are being interviewed, full use should always be made of the private booking in rooms. (5.7)

8.7 There should be an ongoing risk assessment of all detainees for whom the booking-in process is delayed. (5.16)

8.8 Detainees' clothing and footwear should only be removed on the basis of an individual risk assessment. (5.17)

8.9 Anti-rip clothing should only be used to mitigate the risk of self-harm in exceptional circumstances and as a last resort, and there should be protocols to govern its use. (5.18)

8.10 All custody staff should carry anti-ligature knives at all times. (5.19)

8.11 All custody staff should be involved collectively in the relevant shift handover. (5.20)

8.12 Custody sergeants should always determine the detainee's time of arrival in the custody suite accurately. (5.29)

In the custody cell, safeguarding and health care

8.13 The constabulary should ensure that all custody suites are clean and that daily checks of physical conditions are carried out consistently. (6.6)

8.14 The constabulary should establish and enforce a corporate policy to ensure compliance with statutory fire regulations. (6.7)

8.15 Replacement footwear should be provided for all detainees if their own footwear is removed or stored outside their cell. (6.26)

8.16 All custody suites should facilitate exercise periods for detainees. (6.27)

8.17 All suites should have a stock of reading material in a range of languages and in easy-read format, and books that are suitable for children. (6.28)

8.18 Reviews of detention should be conducted in accordance with the Police and Criminal Evidence Act 1984, code C. (6.29)

8.19 The constabulary should improve its approach to safeguarding in custody by providing specific guidance and training to custody staff so that concerns are consistently recognised and addressed. In particular, it should ensure that all girls aged under 18 who are detained are allocated a designated female member of staff. (6.38)

8.20 The constabulary should ensure that the appropriate adult service provides timely support to children and vulnerable adults, and that the lack of provision outside of normal working hours does not lengthen a detainee's time in custody. (6.39)

8.21 The constabulary should reduce the number of children detained in custody overnight, and ensure that they are not detained unnecessarily in cases where alternative accommodation should be provided by the local authority. (6.40)

8.22 All health providers should meet periodically with police staff in the custody localities to improve collaborative working and enhance outcomes for detainees by promoting better communication and creating a vehicle to address local concerns. (6.42)

8.23 There should be a review of the capacity and approach used by the Avon and Wiltshire mental health team to ensure that it meets the needs of detainees. (6.55)

8.24 Joint training and dialogue between frontline police custody staff and the liaison and diversion teams should be periodically facilitated, to develop greater understanding and awareness of each other's responsibilities and to foster constructive working relationships. (6.56)

8.25 There should be a resolution of the connectivity problems for the teams at Patchway and Keynsham, so that the staff can operate at full capacity within the custody suites as part of the team. (6.57)

8.26 Governance arrangements should ensure that frontline police contribute to the evaluation of mental health provision, particularly providing qualitative assessment of services. (6.58)

8.27 The time taken to undertake mental health assessments should be routinely monitored and action taken to reduce delays for detainees waiting for assessment and transfer under the Mental Health Act. (6.59)

8.28 The provision of section 136 suites and contingency arrangements when suites are full should ensure that people with identified mental health needs are not inappropriately detained in police custody. (6.60)

Release and transfer from custody

8.29 Pre-release risk assessments for detainees should take account of all identified risks, and manage and offset these to ensure a safe release. (7.4)

Section 9. Appendices

Appendix I: Inspection team

Ian MacFadyen	HMI Prisons team leader
Vinnett Pearcy	HMI Prisons inspector
Kellie Reeve	HMI Prisons inspector
Gordon Riach	HMI Prisons inspector
Fiona Shearlaw	HMI Prisons inspector
Norma Collicott	HMI Constabulary inspection lead
Anthony Davies	HMI Constabulary inspection officer
Anthony Joslin	HMI Constabulary inspection officer
Patricia Nixon	HMI Constabulary inspection officer
Steve Eley	HMI Prisons health services inspector
Sue Simmons	Care Quality Commission inspector
Joe Simmonds	HMI Prisons researcher
Alissa Redmond	HMI Prisons researcher
Laura Green	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 recommendation

The force should implement its decision to reorganise management structures to ensure the corporate and consistent care and welfare of detainees. (2.23)
Partially achieved

Recommendations

Avon and Somerset Police should review its continued use of its eight non-designated police custody facilities to ensure they provide a consistently safe and decent environment for detainees. (3.9)
Achieved

The force should include cross-referencing of custody record dip-sampling, person escort record checking and monitoring of handovers as part of its quality assurance regime. (3.10)
Not achieved

The force should implement its plans to provide structured custody training for DDOs before their deployment in custody. (3.17)
Achieved

The force should implement its plans to introduce regular custody refresher training. (3.18)
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 recommendation

The risk assessment, care planning and observation level process should be monitored to ensure its consistency. (2.24)
Partially achieved

Recommendations

The force should work with partner agencies to ensure that cellular vehicles are clean and have sufficient space for detainees' property, with women and men kept separate. (4.8)
No longer relevant

The closed-circuit television system should effectively obscure the toilet area in cells in Trinity Road. (4.9)
No longer relevant

Staff should be trained to recognise and provide for the individual needs of detainees, particularly those who are vulnerable, juveniles and women. (4.10)
Partially achieved

There should be appropriate cells that meet the needs of older detainees and those with mobility difficulties. (4.11)
Achieved

Closed-circuit television should provide sufficiently clear images at all custody suites. (4.22)
Achieved

Shift handovers should involve all staff on duty and, wherever possible, should be recorded. (4.23)
Partially achieved

Pre-release risk assessments should be of consistent quality and should be subject to dip sampling. (4.24)
Partially achieved

Avon and Somerset Constabulary should collate use of force data in accordance with the Association of Chief Police Officers policy and National Policing Improvement Agency guidance. (4.28)
Not achieved

A programme of regular deep cleaning should be established, and broken, inappropriate or insanitary equipment should be replaced. (4.35)
Partially achieved

Cell call bells should not be permanently muted and should be responded to promptly. (4.36)
Partially achieved

Visits to cells should be undertaken only by custody staff, or if necessary accompanied by them, and custody staff should be aware of who is in the custody suite. (4.37)
Not achieved

Blankets and pillows should be routinely provided to all detainees. (4.47)
Achieved

All detainees held overnight, or who require one, should be offered a shower. (4.48)
Partially achieved

Detainees held for long periods should be offered outside exercise and the exercise yards should be fit for purpose. (4.49)
Partially achieved

Visits should be facilitated for detainees held for long periods, particularly if they are vulnerable. (4.50)
Partially achieved

Individual rights

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

Recommendations

Information about detainees' rights and entitlements should always be available in a range of formats that meet specific needs. (5.10)
Partially achieved

There should be two-handset telephones in all suites to facilitate telephone interpreting. (5.11)
Achieved

Avon and Somerset Constabulary should work with the local authority to ensure the provision of beds for juveniles who have been charged but refused bail to appear in court. (5.12)
Partially achieved

Avon and Somerset Constabulary should work with HM Court and Tribunal Service to ensure that early court cut-off times do not result in unnecessarily long detentions in custody. (5.19)
Not achieved

Detainees should be able to make a complaint about their care and treatment, and be able to do this before they leave custody; data about complaints should be monitored to identify and act upon any trends. (5.21)
Partially achieved

Health care

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

Recommendations

Appropriate clinical supervision arrangements should be made for all health care staff to ensure that practitioners working in isolation reflect on and enhance their clinical practice. (6.11)
Achieved

There should be a clearly agreed protocol and related audits for the checking and restocking of resuscitation kits, with clear timescales and responsibilities identified. (6.12)
Achieved

Response times by forensic practitioners should be reviewed to ensure that detainees receive suitably prompt treatment and do not spend unnecessary time in police custody. (6.23)
Achieved

All health care professionals should record accurately and legibly in the clinical records and on the national strategy for police information systems (NSPIS) in compliance with General Medical Council and Nursing and Midwifery Council standards and codes of conduct. (6.24)
Achieved

There should be a clearly agreed pathway and process for health referrals and assessment, starting with arrival in police custody, identifying the roles and responsibilities of custody staff and health care staff. (6.38)
Achieved

Delays in mental health assessments should be reviewed in both Avon and Somerset and action taken to reduce the long delays for detainees waiting for assessment and decisions. (6.39)
Partially achieved

Current provision of section 136 suites and criteria for admission should be reviewed to reflect the new guidance agreed between the Association of Chief Police Officers and the Department of Health, population density and geography, to prevent people with mental health problems being detained inappropriately in police custody. (6.40)
Partially achieved