Report on an unannounced inspection visit to police custody suites in

West Yorkshire

by HM Inspectorate of Prisons
and HM Inspectorate of Constabulary

8–22 July 2016

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

Glossary of terms

We try to make our reports as clear as possible, but if you find terms that you do not know, please see the glossary in our 'Guide for writing inspection reports' on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

Any enquiries regarding this publication should be sent to HM Inspectorate of Prisons at Victory House, 6th floor, 30–34 Kingsway, London, WC2B 6EX, or hmiprisons.enquiries@hmiprisons.gsi.gov.uk, or HM Inspectorate of Constabulary at 6th Floor, Globe House, 89 Eccleston Square, London SW1V 1PN, or haveyoursay@hmic.gsi.gov.uk

This publication is available for download at: http://www.justiceinspectorates.gov.uk/hmiprisons/ or http://www.hmic.gov.uk

Printed and published by:
Her Majesty's Inspectorate of Prisons
Her Majesty's Inspectorate of Constabulary

Contents

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 West Yorkshire in 2011, when we found a very much improved picture with some areas, in particular strategic management, providing a model for other forces. On this inspection we found that the earlier progress had been sustained, and that there had also been reasonable steps to implement our previous recommendations. We were pleased to find that the estates strategy had led to the improvements in accommodation for detainees that we had previously called for. Some of the remaining weaknesses continued to be linked to areas where the force did not have sole control.

We had two principal areas of concern. The first was the lack of governance for the use of force in the custody suites. Records of when force was used were inadequate, not all staff were correctly trained, and we could not be assured that the use of restraint was always proportionate.

Our second concern was over the way risk assessments were carried out. Weaknesses were particularly evident when detainees were first taken into custody, when the absence of prompt risk assessments, combined with delays in the booking-in process, created unnecessary risks. The approach to carrying out risk assessments needed to be more systematic.

There continued to be strong leadership in the force in relation to custody, and senior officers maintained a keen interest. There was a strong emphasis on safeguarding and diversity. The health care contract was managed efficiently, and there had been discernable progress in the mental health provision. Despite this, too many detainees still did not have their mental health needs properly met, and although there had been a reduction in the number of people held by the force under section 136 of the Mental Health Act as a place of safety, the figure still remained too high.

Following successful collaborative work with the local authorities, the position for children held overnight had also improved. There was increased provision of alternative accommodation, although hard evidence to quantify the level of improvement was not available.

In most cases, staff treated detainees professionally and with respect, and focused on keeping them safe. Since the previous inspection, there had been a welcome increase in the number of individuals dealt with by 'voluntary attendance'.

The custodial estate had been rationalised since the previous inspection. As a result, conditions for detainees in the suites had improved generally and they were all now, at least, reasonably good. Detainees usually received adequate support to make sure they were released safely, although this was not always recorded in the records.

Overall, detainees held by West Yorkshire police were treated decently and in safe conditions, and this was the most positive inspection of police custody we have made for some time. Given the level of commitment shown throughout by staff and managers, we were confident the force would strive to achieve the further improvements necessary.

We noted that of the 23 recommendations made in our previous report after our inspection of 2011, six recommendations had been achieved, 10 had been partially achieved, six had not been achieved, and one was no longer relevant. This report highlights 18 areas for improvement.

Dru Sharpling CBE
HM Inspector of Constabulary

Peter Clarke
HM Chief Inspector of Prisons

September 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 We conducted a documentary analysis of custody records as part of the police custody inspection. This analysis was carried out on a representative sample of the custody records across all the suites in the force area opened in the week before the inspection was announced. The records analysed were chosen at random, and a robust statistical formula provided by a government department statistician was used to calculate the sample size required to ensure that our records analysis reflected the throughput of the force's custody suites during that week.[2] The analysis focused on the legal rights and treatment and conditions of the detainee. A total of 172 records were analysed.

2.4

Custody suites	**Number of cells**
Leeds (Elland Road)	40
Wakefield	35
Bradford	34
Calderdale (Halifax)	21
Kirklees (Huddersfield)	21

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

Leadership, accountability and partnerships

2.5 The force had made progress in implementing the recommendations of our previous inspection in 2011, which had improved outcomes for detainees. There was a clear governance structure, and senior officer leadership and oversight had provided a stronger and better resourced infrastructure to support the delivery of custody services.

2.6 The custody function was managed at district level, although a central team had responsibility for policies, monitoring and performance arrangements and other support. These arrangements gave a clear direction for the service, with a strong focus on identifying and improving areas of concern. However, they were still not yet sufficiently embedded to ensure consistent practice across the force.

2.7 Resources to deliver custody services were not deployed in the most effective way, and there was an overreliance on response sergeants and police constable gaolers to carry out core custody activities. Staffing numbers did not always meet the agreed establishment level, and some suites worked under significant pressure.

2.8 The force gave safeguarding a high priority, led from the top of the organisation. There were weaknesses, which the force recognised, in the local authority schemes to provide appropriate adult (AA) services to children and vulnerable adults (see also paragraph 2.32).

2.9 The force had its own internal inspection regime, which involved interviews with custody staff and an audit of custody records. Themes that were identified were fed back to the senior officer in each district and to the wider custody staff. This was a positive initiative. However, the quality assurance processes were very broad and were not focused on the specific areas of vulnerability and risk, which would have been a more effective way of promoting the safe and respectful treatment of detainees and continuing professional development of staff.

2.10 Governance and oversight of the use of force in custody were inadequate. Officers were not required to complete auditable forms to document use of force. As a result, it was not possible to assess its appropriateness, monitor trends or to identify learning, which was a strategic and operational risk for the force.

2.11 The quality of record keeping was a concern. In key areas, including bail decisions and pre-release risk assessments (PRRAs), it was inconsistent and in several cases was poor, with too little detail to evidence the actions recorded.

2.12 The force complied with its obligations under the equalities laws, and had suitable arrangements to review and monitor work practice in this area. Custody staff showed a good understanding of how to meet the diverse needs of detainees. However, staff were offered little training on diversity, other than on their induction.

2.13 The force had developed a more assertive approach towards local authorities responsible for providing alternative accommodation for children. It had agreed a protocol with the five local authorities in its area and there was now a better supply of alternative accommodation, mainly through foster care arrangements. The force presented an improving picture of the way children in custody were treated, but this was largely anecdotal and there was little formal data to corroborate this.

2.14 The force worked well with several partners to improve outcomes for detainees, and in particular those who were vulnerable and for children. Some good progress had been made with health care partners to avoid the use of custody as a place of safety under section 136

of the Mental Health Act[3] for people needing mental health assessments. However, the number of people detained in custody as a place of safety was still too high (see paragraph 2.34).

2.15 Independent custody visitors (ICVs) advised us that they had a consistently good working relationship with the force. West Yorkshire benefited from these external views and feedback, which were used to improve services.

Pre-custody: first point of contact

2.16 Police officers and staff were generally alert to, identified and made effective assessments of risk and vulnerability for both victims and suspects. There were good police information systems to identify the vulnerabilities of victims and suspects that call handlers and dispatchers could access confidently. Relevant information about warning markers and safety concerns was prioritised and communicated to officers and was used to inform decision making about how to deal with the incident.

2.17 The police had good access to mental health professionals to assist them in making decisions about how to deal effectively with detainees in need of mental health care. This support and partnership working was well regarded by call centre staff and frontline officers.

2.18 Police officers usually took into account the impact that custody might have on a vulnerable person, including children, but their desire to divert a vulnerable individual from custody was sometimes hindered by a lack of access to the necessary support services.

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

2.19 Detainees were, in general, treated with dignity and respect. Custody staff interacted positively with them and demonstrated a generally good understanding of how best to meet their individual and diverse needs. Some of the practical arrangements for meeting diverse needs were limited or inconsistently applied.

2.20 We had concerns about privacy at some of the custody suites. The discrete booking-in desks were not routinely used, and the location of CCTV monitors at the booking-in desks at two of the older suites were visible to anyone in the custody suite, which was not appropriate. We were concerned that detainees had to wait too long to be booked in after their arrival in custody without a prompt risk assessment completed. We observed two-hour waits at weekends, and in at least one case a detainee waited over three hours. We viewed CCTV footage where force was used in holding areas during these waiting times as conflicts escalated.

2.21 Custody staff were caring and clearly focused on keeping vulnerable people safe by identifying and managing risk. However, some practices, such as the removal of detainee clothing and issue of paper suits to offset the risk of self-harm, were unnecessary and

[3] Section 136 of the Mental Health Act 1983 enables a police officer to remove, from a public place, someone who they believe to be suffering from a mental disorder and in need of immediate care and control, and take them to a place of safety - for example, a health or social care facility, or the home of a relative or friend. In exceptional circumstances (for example if the person's behaviour would pose an unmanageably high risk to others), the place of safety may be police custody.

demeaning. Risk assessments were dynamic but the generally poor standard of recording in care plans did not reflect the high standard of care we observed. Shift handovers did not involve all staff coming on to duty.

2.22 The force had invested in 'voluntary attendance suites',[4] which diverted some individuals from the custody suites. In the previous three years, there had been a 51% increase in the number of voluntary attendees that the force had dealt with, which was encouraging.

2.23 In our custody record analysis, 30% of all cases were marked for no further action, which was significantly higher than the current figure for other forces. This meant that a relatively high proportion of detainees were being discharged without further police involvement. This finding was worthy of further investigation.

2.24 Home Office Immigration Enforcement staff had been based full time in the Wakefield custody suite since September 2014, and they and custody staff reported very good working relations. This initiative had been positive and had helped to streamline the way that immigration detainees were dealt with. Use of telephone interpreting services to deal with non-English-speaking detainees was sometimes hindered by the use of speakerphones, which lacked privacy.

2.25 Non-English-speaking detainees were given a full copy of their rights and entitlements in their own language. However, staff routinely offered English-speaking detainees only a summarised 'easy-read' version of the rights and entitlements, which was not comprehensive.

2.26 Pre-charge bail in West Yorkshire was poorly administered, with inadequate documentation of the supporting rationale for seeking, approving and setting bail, bail conditions and bail terms. Where pre-charge bail had been granted, there was little evidence of adequate supervision of criminal investigations and enquiries. However, the pre-charge bail conditions imposed were generally appropriate, with a particular focus on safeguarding the welfare of victims.

2.27 Since our previous inspection, the recording of complaints had improved significantly. We saw several that were noted during our inspection, and this was further evidenced in our custody record analysis.

In the custody cell, safeguarding and health care

2.28 The physical condition of the custody suites was good, and at Wakefield and Leeds (Elland Road) was excellent. Cell checks of the physical environment were mostly completed according to the schedule, and there was a focus on the identification of ligature points, which was positive. The cleaning and maintenance regime was good, and there was no graffiti in the unoccupied cells we inspected. Custody staff had completed a planned fire evacuation across all the suites, and staff understood the process.

2.29 Detainees were not always given the opportunity to take showers or exercise. Replacement clothing was available but some detainees were given paper suits instead, which was inappropriate. Replacement footwear was not issued routinely, and in all the suites we saw detainees walking about in bare feet or socks.

---

[4] Under voluntary attendance, suspects involved in minor offences attend a police station by appointment to be interviewed about these, avoiding the need for arrest and subsequent detention.

2.30 Too many police officers were out of date with their safety refresher training. Details of the use of force in custody records were generally insufficient or absent. We found a variety of concerns in records and the CCTV footage we reviewed. We asked the force to refer two cases of use of force involving children to the local safeguarding children board. Handcuffs and leg restraints sometimes remained too long on compliant detainees. The use of spit guards/hoods and the incapacitant spray 'PAVA' were more common than we normally see, and we were not assured their use was proportionate or subject to sufficient governance.

2.31 The Police and Criminal Evidence Act (PACE) reviews we observed were thorough and fully recorded on detention logs. In our custody record analysis, just under a quarter of first reviews had taken place early, with two-thirds of those conducted when the detainee was asleep. There was no record of detainees being reminded that reviews had taken place while they were asleep.

2.32 Custody and frontline staff recognised the importance of safeguarding children and vulnerable adults, demonstrating a good understanding of safeguarding needs and, where necessary, seeking support from more specialist teams to meet these. Custody staff diverted children and vulnerable adult detainees away from custody where possible, and sought to minimise their detention times. However, children and vulnerable adults did not always have the help of appropriate adults (AAs) to support them through the custody process. Delays in the arrival of AAs meant that some detainees spent longer than necessary in custody, and it was not usually possible to obtain an AA outside of normal working hours. Despite the force's strong focus on avoiding keeping children in custody overnight, too many still were. Alternative accommodation was not consistently provided, as required under PACE, for children charged and refused bail.

2.33 Leeds Community Healthcare Trust had provided primary care services since April 2014. Clinical governance arrangements and patient care were generally good, although some detainees still experienced delays in being seen. West Yorkshire police effectively monitored performance. The clinical environment and medication management had improved and was good. Detainees had appropriate access to symptomatic relief for alcohol withdrawal in custody, but these medications were not sent with detainees to court, which presented risks to their health. No substance misuse input was available at Calderdale (Halifax) but provision at the other suites was satisfactory.

2.34 Mental health provision in the Wakefield and Bradford suites had improved, but overall many detainees did not have their mental health needs met due to insufficient embedded provision and regular delays in access to assessments for and transfers to mental health facilities. Too many detainees were still held in police custody under section 136 of the Mental Health Act.

Release and transfer from custody

2.35 Arrangements to ensure a safe release for detainees were much better in practice than indicated on the custody records. We were assured that all detainees had a pre-release risk assessment that either addressed or mitigated risks identified in custody. Sergeants paid appropriate attention to ensuring detainees had the means to get home. Detainees were given a useful support leaflet before their release.

2.36 Arrangements with local remand courts were generally reasonable but early court cut-off times sometimes meant that detainees were held for too long in police custody. The quality of person escort records was variable.

Areas of concern

2.37 All aspects of the use of force lacked governance and effective oversight. The force did not record data on the use of force in custody effectively, and records of force in custody records were poor or absent. Too many staff were out of date with their annual refresher training. Handcuffs and leg restraints were sometimes used on detainees for too long after they were compliant, and there was particularly poor governance of the use of spit hoods/guards and incapacitant spray, which we were not assured were always a proportionate response.

West Yorkshire Police should maintain effective management oversight of all use of force incidents. This should include the use of spit hoods/guards and incapacitant spray. Only minimum force should be used at the lowest level and it should be proportionate to the threat posed. All staff involved in incidents should account for their actions on individual use of force forms. Staff should be adequately trained in the use of force at least annually.

2.38 The booking in of detainees was not prioritised effectively according to individual risk. Detainees had excessive waiting times to be booked in after arrival in custody, and CCTV footage we viewed showed that force was also used in holding areas during these waits as conflicts escalated.

The force should ensure that the booking in of detainees is effectively prioritised according to individual risk, and that the process is efficient and reduces excessive waiting times.

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 The force had improved custody services, strengthening its approach in several areas. There had been progress in implementing most of the recommendations from our 2011 inspection, which had improved outcomes for detainees. The force recognised that there was more to do and was committed to providing an improved service.

3.2 There was a clear governance structure, and senior officer leadership and oversight had provided a stronger and better resourced infrastructure to deliver custody services. This included force-wide scrutiny from senior officers who regularly visited suites and provided documented feedback.

3.3 The custody function was managed at district level, although a central team had responsibility for policies, monitoring and performance arrangements and other support. This team reported to a superintendent with responsibility for custody and criminal justice. These arrangements were providing a clear direction for the service and a strong focus on identifying and improving areas of concern. However, they were not yet sufficiently embedded to ensure consistent practice across the force.

3.4 The force had clear and accessible policies on custody functions to guide staff. A 'custody online knowledge area' was also used to email custody staff with up-to-date custody practices or changes.

3.5 The force had reviewed its resources and staffing levels for custody services, and had reduced the number of staff and changed shift patterns to provide a more effective and efficient service. However, response sergeants and police constable gaolers were called on regularly to perform custody roles. This was not always the best use of resources as it involved significant costs to ensure that staff covering the custody role were adequately trained, and took frontline staff away from their duties in the district. The use of non-custody staff potentially also affected the consistency of service provided to detainees.

3.6 The force had a strong focus on protecting and diverting vulnerable people and children away from custody, and this was the approach followed by custody staff. Safeguarding was given a high priority. This was a clear message from senior staff and made explicit in the relevant policy. West Yorkshire had been involved in the Ministry of Justice's pilot to use out-of-court disposals to divert people away from the criminal justice system, and was continuing to develop this approach – for example, voluntary attendance and community resolutions were used as alternatives to custody (see paragraph 5.21).

3.7 Children and vulnerable adults, however, did not receive an adequate appropriate adult (AA) service. Although concerns about AAs were discussed at district force meetings and meetings with other agencies, the force had limited monitoring of data such as waiting times and who performed the role, which would have improved understanding of the key

concerns. The force had recognised the weaknesses in the local authority schemes to provide AA services and was exploring how these could be improved (see paragraphs 6.31–6.32).

Accountability

3.8 The monitoring arrangements for custody services were generally sound. A quarterly custody board monitored the health care provision as well as wider performance management. Its recent focus had included tracking throughput, waiting times and staffing levels. Data were also routinely collated and analysed to identify trends, and to inform organisational learning and improve outcomes for detainees.

3.9 The force had strengthened its approach to quality assurance. It had introduced an internal inspection regime, including an annual three-day thematic inspection involving interviews with custody staff, and an audit of custody records. Themes identified were fed back to the senior officer in each district and to the wider custody staff through the knowledge network. Although this was a positive initiative, the quality assurance processes were very broad. They needed to focus more on specific areas of vulnerability and risk in order to promote the safe and respectful treatment of detainees and continuing professional development of staff more effectively.

3.10 Governance and oversight of use of force in custody were inadequate. The force did not require individual officers or staff to complete auditable forms to document the use of force and enable it to assess its appropriateness, monitor trends and identify learning. This was a strategic and operational risk. (See area of concern 2.38 and also paragraphs 6.11–6.18.)

3.11 The quality of record keeping overall was a concern. Record keeping in key areas of the custody records, including bail decisions and pre-release risk assessments (PRRAs), was inconsistent. In several cases we found it was poor with not enough detail to evidence the actions taken and any justifications, where needed. Although the practice and the care shown to detainees that we observed were better than that recorded, the force needed to make improvements in this area.

3.12 Detainees had excessive waiting times to be booked in after their arrival in custody. We viewed CCTV footage where we saw force used in the holding areas during these periods. The force needed to prioritise the booking in of detainees effectively according to individual risk, and ensure that excessive waits in holding areas did not lead to an escalation of conflict.

3.13 The force complied with its obligations under the equalities laws by having a diversity and equality strategy and policy, clear equality objectives and an equality action plan. Information on monitoring on the basis of ethnicity, gender and age was published annually. An equality and diversity governance structure at strategic and operational levels oversaw the force's approach, and there had been equality impact assessments of policies, including those for custody. A recent audit by the office of the Police and Crime Commissioner had shown that the force was complying with its equality duties. However, custody staff had received little training on the force's responsibilities under equalities legislation, which represented a risk.

3.14 The force encouraged and was open to external scrutiny. Independent custody visitors reported a consistently good working relationship with the force, and were confident that their feedback was acted on. The force used these external views and feedback to improve services.

Partnerships

3.15 The force worked well with several partners to improve outcomes for detainees, particularly those who were vulnerable and for children. There had been some good progress with health care partners to avoid the use of custody as a place of safety under section 136 of the Mental Health Act.[5] Although some problems remained - including officers waiting in hospitals with detainees, detainees leaving hospitals before being assessed and becoming missing persons, and delays waiting for ambulances - the force was clear about what it expected from partners to improve outcomes for vulnerable people, and the position was improving. However, the number of people detained in custody as a place of safety was still too high, and people brought into custody for committing offences but displaying mental health problems spent too long in custody waiting for a mental health assessment.

3.16 There had also been progress to avoid the overnight detention of children who had been charged but had bail refused. The force had agreed a protocol with the five local authorities in its area and there was now a better supply of alternative accommodation, mainly through foster care arrangements, and some very limited provision for secure accommodation. There were procedures to support the arrangements. However, although improving, alternative accommodation was still not always provided, and the force was unable to provide any performance information to demonstrate how effective these arrangements were in avoiding the detention of children overnight.

3.17 Some agencies that provided support to vulnerable people were available for detainees to be referred to on release. These referrals were normally facilitated through the health care provider and offered support across a range of health needs, as well as some practical advice - for example, on debt or housing. However, the force did not monitor any outcomes of these to demonstrate their impact, and there were no wider partnership arrangements to minimise offending and reduce reoffending, and so keep vulnerable adults and children out of the criminal justice system.

Area for improvement

3.18 The force should monitor the outcomes for detainees referred to partner agencies, and extend partnership working into broader diversion schemes focused on keeping children and vulnerable adults out of the criminal justice system.

---

[5] Section 136 of the Mental Health Act 1983 enables a police officer to remove, from a public place, someone who they believe to be suffering from a mental disorder and in need of immediate care and control, and take them to a place of safety - for example, a health or social care facility, or the home of a relative or friend. In exceptional circumstances (for example if the person's behaviour would pose an unmanageably high risk to others), the place of safety may be police custody.

Section 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 for both victims and suspects.

4.2 West Yorkshire Constabulary had a customer contact centre (CCC) in its headquarters where staff responded to all emergency and non-emergency calls. Call dispatchers in each of the five divisional control hubs were responsible for sending out the most appropriate response. All staff routinely applied the 'threat, harm, risk, injury, vulnerability and engagement' (Thrive) decision-making response to each call effectively, and written justification for the action taken was recorded on each call. CCC staff and dispatchers had received appropriate training on vulnerability, child sexual exploitation and human trafficking.

4.3 CCC staff and dispatchers associated vulnerability with both victims of crime and detainees, which was good. The force records management system (Niche) contained information about vulnerability. Some of the markers on Niche helpfully identified whether children were known to be at the address, if anyone was subject to public protection arrangements, and if there were any physical or mental health concerns. Vulnerability markers were also highlighted and accessed on the force's command and control system (Storm). Staff checked on the police national computer (PNC) for further information relevant to the detainee and officer safety.

4.4 Frontline officers used the national decision-making risk assessment framework when responding to incidents. Ongoing training of frontline officers was predominantly via-e-learning, which was perceived poorly by staff. The CCC generally provided prompt and relevant information, and officers also had access to further information on mobile devices. This included any warning markers, and information about vulnerability and previous incidents, and was used to inform decision making on how to deal with the alleged offender.

4.5 There were mental health professionals in four of the five divisional control hubs, located alongside call dispatchers. The combination of mental health expertise alongside the IT systems provided frontline officers with vital information that helped them to make informed decisions about how best to respond to detainees in need of mental health care. This support and partnership working was well regarded by call centre staff and frontline officers (see paragraph 6.61).

4.6 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. Frontline and custody staff we spoke to recognised that custody should be avoided where possible, and they actively explored a range of relevant alternatives. Police officers' desire to divert vulnerable individuals from custody was sometimes hindered by a lack of services that could support them to respond more effectively (see also paragraphs 6.31–6.34 and 6.63).

4.7 As a result of a change to the format of custody training within the force, not all staff had received their annual officer refresher safety training, in line with national guidelines and Authorised Professional Practice. There were local protocols for the transport of detainees to custody suites and hospitals to prevent harm. Handcuffs were applied on a risk assessment basis and not routinely (see also paragraph 6.17).

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 Custody staff generally treated detainees courteously. The interactions that we observed, particularly during booking in, were mostly positive and respectful, despite often challenging behaviour by some individuals. Staff were sensitive in their approach towards diversity; for example, they recognised the importance of being aware of the distinctive characteristics of transgender detainees and those with learning difficulties. It was also positive that custody staff invited detainees to self-define their ethnicity, rather than make assumptions about this. This message was reinforced by prominently displayed posters promoting this approach in all the custody suites.

5.2 Women and children coming into custody were usually allocated a gender-suitable 'specific point of contact' staff member for the duration of their time in custody, which was also positive. This gave detainees continuity of care and access to a particular member of staff if required. Custody staff could also use a template to update the detainee's record to show particular actions taken to meet individual requirements, such as offering female detainees hygiene products. This showed a strong intention to meet diverse needs, although our observations and examination of case records indicated that the template was not consistently used or updated, limiting its effectiveness.

5.3 Formal arrangements for identifying and meeting diverse needs were inconsistent. Detainees entering custody were regularly asked information such as their dietary needs or caring responsibilities, which allowed individual needs to be identified appropriately. However, not all the suites provided sufficient privacy at booking-in areas to gather this information. While the newer suites at Leeds (Elland Road) and Wakefield offered considerable privacy, the layout at the other suites meant that detainees were booked in within close proximity to one another, which could hinder their disclosure of sensitive information about their personal circumstances or needs. Although each custody suite had a separate and private booking-in desk for more sensitive cases, our observations and staff feedback indicated that these were not used routinely or consistently to book in women and children. The lack of privacy to make disclosures could potentially affect women's and children's experience in the custody suite and their welfare.

5.4 We identified some further concerns about privacy. CCTV monitors at the booking-in desks at Kirklees (Huddersfield) and Calderdale (Halifax) custody suites were visible to anyone in the custody suite. Although the monitors did not record images inside cells, detainees could potentially observe other detainees who were being dealt with in the processing room, in exercise yards, being brought in through the van dock or moving around the custody corridors. This was not appropriate.

5.5 Hearing loops were only available at Leeds and Kirklees. There was also no material available in Braille (including detainees' rights and entitlements), although the force was attempting to

rectify this. Comprehensive religious materials (including texts and prayer aids) were not routinely available in all the suites, and were not always stored respectfully or handled appropriately. There was also little reading material that was age-appropriate for children or in foreign languages (see paragraph 6.25).

5.6 Staff showed a good awareness of how to help people with mobility issues or disabilities, and made more regular visits to such detainees to ensure their needs were met. Wheelchairs were available and used in all the suites. However, there were low benches in the cells in all the custody suites which, although they complied with Home Office design rules, can be difficult for people with mobility issues; not all suites always offset this through the provision of thicker or additional mattresses. The problems for detainees with mobility issues were compounded by the absence of low-level call bells at all the suites, apart from Leeds and Wakefield.

5.7 There was limited staff training to support them in dealing with people with diverse needs. Although the induction training for all new sergeants and detention officers covered a wide range of topics, including mental health and searching of detainees, this was not supported by the subsequent refresher training for staff, which offered no specific classroom training on any equality and diversity issues. Some e-learning training modules did include these subjects, but were described by staff as of limited value. The force had good advice and guidance on a range of subjects available to staff through its intranet system, but custody staff told us that they tended to rely on their own experiences of working in custody to develop their knowledge of the range of detainee individual needs. This approach risked inconsistency in dealing with detainee needs.

Risk assessments

5.8 Detainees were not made to wait outside police stations in vehicles, and some were booked in quickly, but we observed lengthy waits of two hours at weekends – and over three hours in at least one case. There was little to show that vulnerable detainees were identified quickly to be prioritised through the booking-in process.

5.9 On arrival, detainees were asked if they understood what had happened to them before their detention and if they had any immediate needs. Custody sergeants and detention officers (DOs) under supervision booked detainees into custody. Custody staff interacted very well with detainees to complete risk assessments. They also asked appropriate supplementary questions and paid particular attention to mental and physical health needs. We saw many examples where custody staff dealt patiently and sensitively with detainees, particularly those who were intoxicated and/or vulnerable.

5.10 Custody staff identified initial risks to detainees effectively, including those in custody for the first time. There was routine cross-referencing to police national computer warning markers and historic information held on the Niche records system to inform risk assessments further. However, the subsequent recording in care plans was sometimes cursory, did not indicate all identified risks and was often not representative of the high level of care we observed.

5.11 Our observations indicated that all custody staff were clearly focused on keeping detainees safe. We saw high levels of individual care for vulnerable people based on ongoing assessments of the risks they presented, but we also saw some practices that were unnecessary. For example, the routine removal of detainees' clothing with cords and footwear was disproportionate, particularly for detainees assessed as low risk.

5.12 Some custody staff routinely replaced detainees' clothes with paper suits to offset the risk of self-harm. In some cases, paper suits were used when higher levels of observation would have been more appropriate, and given the detainee greater dignity and better care. Records of the use of paper suits was inconsistent, and we could not be assured that their use was always justified.

5.13 Staff were aware of how to rouse sleeping/intoxicated detainees when the level of observation required it, and did this well, engaging in graduated degrees of contact and communication. Monitoring through CCTV was used in addition to, not instead of, physical checks. The three large suites in Bradford, Leeds and Wakefield had dedicated staff who monitored CCTV cameras, responded to cell call bells and telephone calls, and managed access by appropriate people to the custody suite. These staff were unclear what level of attention they should be giving to the monitors, and acknowledged that they were too busy to monitor anyone except on an ad hoc basis; this needed to be clarified.

5.14 Most detention officers and custody sergeants did not carry anti-ligature knives, but in some custody suites these knives were attached to the cell keys or left at booking-in desks. We sometimes saw staff visiting cells who were not carrying anti-ligature knives, which compromised detainee safety and was poor practice.

5.15 Staff shift handovers did not include all staff, and we saw sergeants and detention officers handing over separately to incoming detention officers, rather than as one team. This potentially compromised the quality and accuracy of the information shared between individual staff, particularly when some shifts were staggered and there were several individual handovers throughout the day. The handovers we observed, particularly between sergeants, were well conducted in private and appropriately focused on risk, detainee welfare and case progression.

Areas for improvement

5.16 Detainees' clothing and footwear should only be removed on the basis of an individual risk assessment, and paper suits should only be used to offset the risk of self-harm in exceptional circumstances and as a last resort.

5.17 All custody staff should carry anti-ligature knives in the custody suites at all times.

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

5.19 The monitoring of detainees through CCTV monitors should be clarified, and the task should be adequately resourced so that it is carried out effectively.

Individual legal rights

5.20 Custody sergeants asked arresting officers to provide a full explanation of the circumstances of, and the reasons for, arrest before authorising detention. Sergeants told us that they were confident in refusing detention when the circumstances did not merit it, and they provided us with details of such cases.

5.21 Alternatives to custody were available through community resolutions and voluntary attendance.[6] Data confirmed that the number of voluntary attendees had significantly increased across the force from 9,009 in 2013/14 to 13,636 in 2015/16 – a rise of 51%. Such interviews took place in external voluntary attendance suites, which was appropriate. However, we saw and staff at Calderdale confirmed that when these facilities were busy, officers reverted to using the custody suite interview rooms, located next to the booking-in desk. This was inappropriate and contrary to the intended ethos of the process, which was to divert individuals from police custody.

5.22 Custody sergeants were aware of the need to keep the length of time in detention to a minimum and to progress cases quickly. In addition to initial delays for detainees waiting to be booked-in (see paragraph 5.8), we were told that there were sometimes also delays due to further factors, such as the non-availability of appropriate adults (see paragraphs 6.31–6.34). Force data showed that the average length of detention before charge was 11 hours seven minutes for the year ending June 2016 (which was slightly longer than the average of nine hours four minutes found in our custody record analysis).

5.23 Our analysis of 172 custody records identified that in 51 cases (30%), no further action was taken against the detainees, which was significantly higher than the comparator of 16% for all police forces since March 2016. We advised the force that this was worthy of further investigation, as it was a significant proportion of the custody output and could highlight a staff training need.

5.24 Since September 2014, eight Home Office Immigration Enforcement staff had been based full time at Wakefield custody suite, which had streamlined the handling of immigration detainees across the West Yorkshire police area. Both custody staff and immigration enforcement staff reported very good working relations, and saw the creation of the unit as a positive initiative. Force data showed that 868 immigration detainees had been held in the year to 30 June 2016 - a 29% increase from the 673 held in the year to 30 June 2014. The force was unable to provide the average time in custody for immigration detainees following service of an IS91 warrant of detention.[7] However, the average length of detention for all immigration detainees was 19 hours four minutes, which was an improvement since our previous inspection.

5.25 During booking in, custody sergeants and detention officers advised detainees of their three main rights[8] and non-English speaking detainees were routinely offered a written notice setting out their full rights and entitlements. However, English-speaking detainees were only offered an abbreviated version of their rights and entitlements, which was a written and pictorial notice referred to by staff as an 'easy-read' leaflet; this did not contain all of the information necessary. None of the custody staff we spoke to were aware that a full copy of the rights and entitlements in English was also available on the force custody services webpage. At Calderdale, a detainee who said that he could not read or write was handed the abbreviated version of the rights and entitlements material and told that it contained pictures; there was no effort to read its contents to him, which was an inadequate response.

---

[6] 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. 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.

[7] 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.

[8] 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.

5.26 At Kirklees, we saw an appropriate adult (AA) attend on behalf of a vulnerable male adult. In the detainee's presence, the DO told the AA of his earlier responses on being advised of his three main rights, and the AA was simply asked if she agreed with these. She was not offered a copy of the rights and entitlements or the PACE codes of practice, and the detainee was not re-read his rights and entitlements in her presence. We also saw a similar approach involving an AA acting on behalf of a 16-year-old girl at Calderdale. These practices failed to recognise the correct role of an AA in supporting individuals (see paragraph 6.30).

5.27 We observed detainees being told they could inform someone of their arrest, which staff sometimes facilitated while the detainee was present.

5.28 Detainees were told during the booking-in process that they could read the PACE codes of practice, but these were not always explained by custody staff. Sufficient copies of the up-to-date PACE C code were available in the custody suites, but we did not see these routinely offered or given to detainees to read.

5.29 All detainees were offered free legal representation and were told that if they declined, they could change their mind at any time and accept this offer. Those wishing to speak to legal advisers could do so over the telephone through the intercom in the privacy of their cell or in private telephone booths – except at Kirklees and Bradford where these calls had to be made at the booking-in desks, which lacked privacy. 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.

5.30 There was an effective system for collecting DNA samples taken in custody, and custody staff were able to relate the circumstances when these would be disposed of.

Area for improvement

5.31 Detainees should be re-read their rights and entitlements in the presence of their appropriate adult.

Communication

5.32 A professional telephone interpreting service was available to assist the booking in of non-English speakers. The majority of staff used loudspeaker telephones to access this, which lacked privacy and were noisy when the suites were busy. Other custody staff passed the telephone handset to the detainee and back, which was not efficient (and similar to what we found at our previous inspection). Staff told us that a face-to-face interpreter service was available for interviews, but there were sometimes delays depending on the language requested, resulting in some detainees remaining in custody longer than necessary.

5.33 Posters in several languages informing detainees of their right to free legal advice were available in all the custody suites but these only ranged from A to P (Arabic to Polish), with no languages from the latter part of the alphabet. Custody staff were not aware of the requirement to have other documents – such as authorisation of detention, charge details, etc - available in a range of languages.[9]

---

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

Access to swift justice

5.34 West Yorkshire police rarely recorded on the crime investigation log the rationale for the decision to request that a suspect be bailed. Similarly, while the custody system automatically generated an entry on to the custody log when bail was granted, these rarely contained sufficient information to clarify the rationale for this decision.

5.35 In our examination of the administration of bail in West Yorkshire, we found poor record keeping in both the crime investigations and the custody record logs. In a high proportion of the cases we reviewed, there was no active supervision of ongoing investigations where a suspect was on pre-charge bail, and no way of determining if enquiries had taken place swiftly. When enquiries were not completed before a suspect answered bail and a further period on bail was sought, there was often no explanation for why enquiries had not yet been completed.

5.36 Although guidance for staff was available on the appropriate length of bail, it was not always adhered to and we found a general uniformity of two months in the bail periods granted (with a few exceptions). This lack of variation indicated a blanket attitude to bail durations, with little consideration to the actual requirements of the investigation or the needs of the detainee.

Complaints

5.37 No information on the complaints process was displayed in any of the custody suites. However, it was contained in the full and abbreviated versions of the rights and entitlements notices offered to all detainees, as well as in a support leaflet offered to detainees on release. Custody staff told us that if a detainee wished to make a complaint while in custody this would be facilitated, provided they were in a fit state to participate in the process (for example, not under the influence of alcohol). We saw staff noting complaints from detainees at both Leeds and Kirklees, and found additional evidence of this in our custody record analysis, which was a significant improvement since our previous inspection.

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 The custody estate in West Yorkshire had reduced significantly since the 2011 inspection from 12 suites to five. Our previous three recommendations about the physical conditions had been achieved, which was positive.

6.2 Leeds (Elland Road) and Wakefield were impressive new private finance initiative (PFI) buildings. Leeds custody suite was largely in good repair and condition, although the effect of a throughput of nearly 14,000 people in 2015/16 was showing in the condition of some cells. At both Leeds and Wakefield, all cells had CCTV fitted, and there was a good amount of natural light in the booking-in areas and cells. We identified no apparent ligature points in cells. Exercise yards were in good condition and had natural lighting.

6.3 Calderdale (Halifax) custody suite had been refurbished in 2011 and given an additional four cells, raising the capacity to 21. The suite had been given new windows and low benches, as well as new cell door hatches, which were safer to use. There had been considerable efforts to reduce the risk of ligature points by re-filling gaps. Four of the cells were covered by CCTV.

6.4 Kirklees (Huddersfield) custody suite provided a similar standard of accommodation as Calderdale. It had a standard capacity of 16 during the day, with an additional five court cells - converted to Home Office standards - available out of hours. All the court cells had CCTV coverage, but they did not have natural light or toilets; we were told that as these cells were some distance from the custody desk, they were only used for detainees assessed as presenting a low risk. This suite had also recently had a major refurbishment, with adjustments to reduce the risks of ligature points, improve the heating and extend the CCTV coverage. However, we did identify some cell hatches that were loose with a possible gap that could potentially be used as a ligature point in the cell. Although this risk was low, it needed to be effectively managed and we reported it to the force.

6.5 Bradford custody suite had also recently benefited from a refurbishment, and improvements to the cell intercom system. Eight of the cells had CCTV coverage. Two of the cells were larger than normal; we were told that these were used for individuals who had come into custody for the first time or for children or female detainees.

6.6 All five suites used the same forms to conduct the daily, weekly and monthly checks of the physical environment. There was a focus on the identification of ligature points as part of the checking process, which was positive. Most of the forms we reviewed were completed daily with few gaps, but we were unable to find any recent weekly checks completed at Kirklees. The daily checks were carried out by the detention officers (DOs) and the weekly checks by the custody sergeant. We were told, and found evidence, that where problems with cleanliness and hygiene or broken equipment were identified, prompt action was taken to

resolve this. The cleaning and maintenance regime was good overall, and there was no graffiti in the unoccupied cells we inspected, which was impressive. The custody inspector completed a monthly review of the forms and a further review of the condition of the suites. This system worked well and (aside from the ligature points we identified), the suites were in good order.

6.7 The use of cell equipment, such as the emergency call bell and intercom, was generally explained to detainees and they were mostly answered promptly. The location of the cell call intercom at the booking-in desks at Calderdale and Kirklees did not allow for privacy, and the interaction between the DOs and the detainees in their cells over the intercom could be heard loudly and clearly in the booking-in area, which was not appropriate.

6.8 Defibrillators were available in all the custody suites and staff were aware of their location. Custody staff had received annual refresher training in their use. There was a system to ensure that the equipment was checked and certified to be in good working order. There were first aid boxes in all the suites, but their contents were not standardised, and there was no contents list to identify the quantity of stock in each box or that items had been removed and needed to be replaced.

6.9 Each suite had a fire evacuation policy and procedures prominently displayed. The force's health and safety reports confirmed that each suite had conducted a practice fire evacuation between January and June 2016. Each suite was given feedback and learning points, such as ensuring fire evacuation boxes were routinely checked and replenished and that all staff were aware of the fire evacuation procedures. The custody staff we spoke to were confident about how to act in the event of a fire, and each could give a detailed description about the arrangements to be followed.

Good practice

6.10 *West Yorkshire police had conducted a series of planned fire evacuation across the five suites. Routine fire evacuation drills demonstrated the force's ability to evacuate all people safely from their premises in an emergency, and provided ongoing learning to custody staff.*

Safety: use of force

6.11 The governance and oversight of the use of force in custody were inadequate. The collation of data on the use of force was weak, and our custody record analysis, case audits and observations found numerous inaccuracies in the data provided. We were not assured that all uses of force in custody were accurately recorded in custody records. We observed a few incidents where force was used in holding cells and was not subsequently recorded on custody records. Some custody records contained reasonable accounts of force used, but most of those we examined contained little or no detail to justify the force used (see recommendation 2.38).

6.12 Data provided by the force showed that over 40% of custody staff were out of date in some part of their safety/personal protection training, which was unacceptable. It was also unacceptable that staff who had used force against detainees were not required to complete a use of force form to justify their actions (see recommendation 2.38). However, throughout the inspection we saw some staff using good skills to de-escalate challenging situations with detainees without resorting to the use of force, which was positive.

6.13 Through our custody record analysis, case audits and observations we identified 17 incidents where force had been used, and we cross-referenced these against CCTV footage where

possible. Some incidents took place in cells where there was no CCTV coverage. CCTV footage was kept routinely for 90 days, and so we were unable to view footage dating back further than this. There were learning points in all of the incidents we reviewed. We were not assured that managers reviewed CCTV footage to confirm to themselves that force was proportionate to the risks posed or to identify any learning points.

6.14 Two of the incidents we reviewed involved the use of force against children. One involved a self-harming young person who was restrained to remove his clothing, and who was subsequently left naked for a period of time. The second involved a girl with identified mental health issues who was heavily restrained on two occasions in a short period. We requested that the force make safeguarding referrals for both these cases.

6.15 We were not assured that the use of force was always necessary or proportionate to the risks or threats posed. Other concerns from the CCTV footage included: poor use of techniques, some of which were potentially injurious to the detainee; large numbers of officers sometimes involved in the restraint, which appeared unnecessary; and leg restraints and handcuffs remaining in place for too long on compliant detainees. We observed low-level force used twice on children to remove cords from clothing, which we considered disproportionate in the absence of an individual risk assessment (see paragraphs 5.12 and 5.16). We were further concerned that this action seemed to heighten frustration and aggression by some detainees, and potentially led to force being used against them unnecessarily.

6.16 We rarely come across the use of Taser, irritant/incapacitant spray and spit guards/hoods in police custody suites. It was positive that Taser had not been used in custody in West Yorkshire in at least the previous 12 months. However, we were concerned by the relatively common use of spit guards/hoods, which staff told us was frequent, and we saw one applied during the inspection. While custody sergeants authorised their use, we were not assured that there was sufficient governance or that they were applied for the shortest possible time. Their use was not always recorded or justified on custody records. Unusually, we saw several custody sergeants carrying the irritant/incapacitant spray 'PAVA', and were told that its use was increasing in custody. In the records and CCTV that we were able to review, we were not assured that the deployment of PAVA was always proportionate to the risk posed or that it was used safely and in line with guidance. In one case, we were concerned about the poor aftercare of a detainee who had PAVA used against him in a cell while three staff were restraining him. He was left in the cell where the spray had been used, did not have his clothes changed until several hours afterwards, and was not seen by health care staff for at least four hours (and this was not specifically about the use of the irritant spray against him). The use of PAVA was also not explicitly referred to in his custody record (see recommendation 2.38).

6.17 It was positive that detainees did not arrive routinely in custody wearing handcuffs. However, we saw see a few cases where compliant detainees remained in handcuffs for too long after their arrival. This was disproportionate to the threat posed in the controlled custody environment.

6.18 In the previous 12 months, 1,997 detainees (4%) were subject to a strip search in custody, which was relatively low. We saw very few strip searches authorised during the inspection, and all of these were for proper reasons.

Detainee care and PACE reviews

6.19 Microwave meals were available, and food and drink were provided both at mealtimes and on request. All detainees were asked during booking in if they had any special dietary

requirements. Food preparation areas were clean and well equipped, but not all the suites had a guide to identify the suitability of microwave meals for special diets (such as gluten-free, nut-free, kosher, etc). In our custody record analysis, 142 of the 172 detainees (83%) were offered a meal, including all 10 detainees held for over 24 hours.

6.20 Mattresses and pillows were provided, but at some suites these were not always cleaned between uses. Stocks of blankets were clean and were routinely offered to detainees at night and on request during the day. The majority of cells had toilets but detainees had to request toilet paper as it was not routinely available. The view of the toilet area was obscured on CCTV images of the cells. Some cells had no handwashing facilities but these were available on cell corridors and could be used on request, and subject to the availability of staff.

6.21 All suites had clean showers which were private. Custody staff said they were not always able to offer showers but would do so if a detainee requested it and there were sufficient staff. We saw detainees facilitated to have showers in some of the custody suites. However, in our custody record analysis only five detainees were offered a shower, two of whom had been held for over 24 hours. Cotton towels were available at all suites as well as hygiene products, including razors, shaving cream and combs. There was a choice of female hygiene products in all the custody suites.

6.22 Sweatshirts, T-shirts and jogging bottoms were readily available as replacement clothing for detainees whose clothing had been seized for evidential purposes or otherwise soiled. Replacement underwear was also available. We saw a female detainee at Wakefield who was interviewed wearing her pyjamas and in her bare feet. She was given a sweatshirt, jogging bottoms and foam slippers, but only after her interview had been completed. We saw replacement clothing issued appropriately to detainees who had cords in their trousers, as these were routinely removed to mitigate risks, but we also saw paper suits issued to detainees in similar circumstances, which was poor practice (see paragraphs 5.11 and 5.16).

6.23 Shoes were routinely removed from detainees, sometimes even when these did not have shoelaces. Plimsolls and foam slippers were available in all the suites but not always routinely offered to detainees. We saw many detainees in all the suites walking about in socks or in their bare feet.

6.24 All the custody suites had at least one outside exercise area which allowed detainees access to some fresh air. These were not often used. At Calderdale we heard two detainees requesting to be allowed into the exercise yard but this was deferred as the staff were too busy. In our custody record analysis, only nine detainees, were offered outside exercise, three of whom had been held for over 24 hours. At some suites we were told that to facilitate exercise, detainees would be locked in the exercise area and monitored via CCTV from the booking-in areas. This practice had an element of risk as some exercise areas had potential ligature points (drains in the floor), and was contrary to the force policy that all detainees should be personally supervised while using the areas.

6.25 The custody suites had large stocks of books, generally provided by staff, but very few magazines or newspapers, age-appropriate reading material for children or material in foreign languages. We saw several detainees offered reading materials during their detention. In our custody record analysis, 17 detainees (10%) were offered access to reading materials, three of whom had been held for over 24 hours.

6.26 Not all suites had designated visits facilities but where they did, staff told us they would only allow visits in exceptional circumstances and when staffing levels permitted.

6.27 Reviews of detainees were undertaken by custody inspectors or, in their absence, by the response (duty) inspectors. We observed some very good face-to-face PACE reviews with detainees that were timely, appropriate and fully recorded on detention logs. Inspectors told

us that they were likely to conduct a review early if it meant it could be achieved face-to-face, rather than while the detainee was asleep. In our custody record analysis, of 108 records where a PACE review was required, 26 were carried out early (24%) but 17 of these took place while the detainee was asleep. The earliest of these reviews took place just two hours 10 minutes after the detainee's detention was authorised. 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 the Niche custody computer system and therefore could be overlooked.

Areas for improvement

6.28 All detainees held overnight, or who request one, should be offered a shower. Replacement footwear should be provided for all detainees if their own footwear is removed, and all custody suites should facilitate exercise periods for detainees.

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

Safeguarding

6.30 Safeguarding was a priority for the Force, and there were appropriate safeguarding policies in place. Custody and frontline staff clearly recognised the importance of ensuring that children and vulnerable adults were appropriately safeguarded. Staff understood the support available, how to make referrals to the force's own safeguarding teams or those in partner agencies, and the role of the multiagency forums that considered cases involving children and vulnerable adults. However, there had been no specific training for custody staff on safeguarding and their responsibilities, which could lead to inconsistencies in approach.

6.31 Children and vulnerable adults did not consistently receive the support they were entitled to through a timely appropriate adult (AA) service. In the first instance, the force tried to obtain a family member to act as an AA or, in the case of a child in care, an adult from the children's home. Where this was not possible, an AA was requested through arrangements with the Youth Offending Service (YOS) for children, and through the local authority social care departments for vulnerable adults. Outside of normal working hours, the service relied on the emergency duty team in the local authorities.

6.32 Access to the daytime AA service for children was generally regarded as good by the custody sergeants, and some custody suites had local arrangements to extend the AA service for children into the late evening through YOS volunteer schemes. However, custody sergeants reported difficulties in securing AAs for vulnerable adults, and at night it was highly unlikely that an AA would be available for either children or vulnerable adults.

6.33 Custody sergeants used bail where possible to avoid overnight detention when an AA was not available, especially for children. However, the lack of access to AAs meant that some detainees remained in custody for longer than needed or overnight. We observed this on at least one occasion, and it was evident in some of the case records we looked at. Also, AAs who were not parents or guardians were not normally available to attend the custody suite until the interview with the detainee was scheduled. This meant that children and vulnerable adults did not always receive support during the early stages of their detention, which was not good practice. There was written guidance for AAs in the custody suites, and custody sergeants said that they issued this along with any verbal guidance, which was particularly important to ensure that family members or guardians were clear about the role.

6.34 Custody staff demonstrated a good understanding of children's safeguarding needs. There was a clear focus on diverting children away from custody and minimising any time spent in custody. We observed some examples of this in practice and in our examination of case records. However, some children still remained in custody for long periods. Our custody record analysis of 15 children showed that they spent an average of nine hours and 45 minutes in custody, ranging from 25 minutes to 20 hours. The force did not collate specific data on the length of time children spent in custody to inform how it could improve the detention of children (see paragraph 3.16).

6.35 Custody staff provided good care to children while they were in custody. Where possible, children were detained in cells away from adult detainees and were placed on 30-minute observations as a minimum, which ensured regular contact. There were arrangements to designate a member of the custody staff as a single point of contact for children to look after their needs, with a female member of staff for girls (see paragraph 5.2). We observed staff using age-appropriate language, and case records showed that children were offered food and drink, and in some cases reading material.

6.36 Although case records and our observations showed a clear focus on dealing with children as quickly as possible to minimise their time in custody, there were no arrangements to treat them differently or as a priority in the holding room. As with adult detainees, children could sometimes wait a significant time before they were seen by the custody sergeant and booked into the custody suite. We were also very concerned that there were cases where force was used when dealing with children, which in our view was not proportionate (see paragraph 6.14). These areas raised safeguarding concerns that the force needed to address.

6.37 Despite the force's focus on diverting children away from custody, children were still detained in custody overnight. The numbers were monitored centrally, and custody sergeants were aware that their decisions were scrutinised. However, as part of our custody record analysis we looked at the records for 15 children, of whom seven were held in custody overnight, indicating a significant proportion of children brought into custody

6.38 In cases where children were charged and refused bail, it was the responsibility of the local authority to provide alternative accommodation to prevent the child being detained in custody overnight. The force audited cases where alternative accommodation was not provided to ensure that custody staff had made the requests, and raised these further when needed so that it could hold the local authority to account when failing to provide alternative accommodation. Although there had been some good partnership working and protocols developed on the provision of alternative accommodation (see paragraph 3.16), in practice these were not yet embedded or working effectively, resulting in some children being unnecessarily detained overnight in custody.

Areas for improvement

6.39 Access to appropriate adults should be improved so that children and vulnerable adults can have support at the early stages of detention and do not spend longer than necessary in custody because of the lack of provision.

6.40 The force should assure itself that alternatives to avoid detaining children in custody overnight are actively explored so that detention is the last resort.

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

Governance

6.42 West Yorkshire police had commissioned Leeds Community Healthcare NHS Trust (LCH) to provide custody health services since April 2014. Effective partnership working between the force, LCH and NHS England drove service improvement. The health needs assessment was out of date (2012), which meant the force could not be assured that services met detainees' health needs. Performance was discussed at regular well-attended local and regional partnership meetings, and emerging issues were addressed promptly through additional ad hoc contact. Learning from clinical audits, adverse incidents and complaints was shared in the health team and informed service improvement. The force and LCH had an information sharing protocol.

6.43 The service contract required that health care professionals (HCPs) see detainees within 60 minutes of being requested 95% of the time, and that agreed minimum HCP staffing levels were maintained. LCH had regularly failed to achieve performance targets in the first 18 months of the contract, mainly due to staffing problems. Since December 2015, performance was consistently above 95%. In our analysis of 172 custody records, 66 detainees (38%) had required a HCP while detained and the average response time was 20 minutes, although the longest wait was over six hours.

6.44 A HCP was based in each suite over 24 hours. One forensic medical examiner (FME) was on call for all five suites, which sometimes caused delays. However, the number of FME calls was low (around 6% of all HCPs called and reducing as HCPs were trained to expand their roles to include those previously completed by FMEs). Detainees regularly waited longer at the two busiest suites (Leeds and Bradford), despite support from quieter stations when feasible.

6.45 LCH had recruited more HCPs than its agreed staffing level to improve performance and back up. New HCPs had a comprehensive induction. Training opportunities, including supervision, had improved, although they could be difficult to access in work time. Professional registration status was monitored. HCPs had easy access to relevant current policies and procedures.

6.46 Detainees could complain about health services by using a formal procedure. The responses to the four complaints received since April 2014 were appropriate. Professional telephone interpreting was used for detainees with limited English, although not all clinical rooms had dual handset or equivalent facilities. Clinical consultations took place in private with the door closed, following an individual risk assessment, which was appropriate. Detainees' right to request a HCP of the same gender was not clearly displayed, but staff told us this was facilitated when required.

6.47 Several clinical rooms had been refurbished since our last inspection. The facilities at Kirklees and Calderdale were adequate, but were excellent in the other suites. A specialist completed annual infection control audits, and identified areas of non-compliance (including cleaning standards at some suites) were being addressed. Rooms contained satisfactory stock and equipment. HCPs had easy access to regularly checked emergency equipment and drugs.

Area for improvement

6.48 Health provision in the suites should be based on a current health needs assessment.

Patient care

6.49 Detainees were referred to a HCP if there was an identified risk, clinical need or the detainee requested to be seen. Custody staff and HCPs worked together collaboratively and custody staff we spoke to were positive about the health care provided.

6.50 We observed excellent interactions between HCPs and detainees, and the care provided was good. HCPs used SystmOne (the electronic clinical record system also used in prisons), which allowed them easy access to previous records and supported effective data analysis to monitor clinical outcomes. Clinical records were generally good, stored securely and regular documentation audits were completed. Care plans were shared with custody staff, although some were on paper and some were on the Niche computer (which HCPs were being trained to use). HCPs also gave verbal handovers to sergeants and recorded pertinent information on the suite whiteboard. Communication was good but we observed that duplication of the handover (written, verbal and whiteboard) sometimes led to delays in HCPs seeing detainees.

6.51 Drug cupboard keys were only accessible to HCPs. Standardised stock medication was well organised, checked regularly and stored securely. Systems to manage discarded medication were appropriate. A pharmacy technician made frequent site visits and completed audits, which supported effective governance. Twice daily counts of all medication had been implemented following a spike in reported drug recording errors. However, this was very time consuming and was being reviewed.

6.52 Medications were retrieved from detainees' homes where appropriate, checked by health staff before administration and stored securely with their property. HCPs administered most medication, although detention officers were authorised to administer patients' own medication when HCPs were very busy.

6.53 Symptomatic relief for drug and alcohol withdrawal was easily available, although this was not sent with the detainee to court, which could be particularly serious for those withdrawing from alcohol. Detainees could continue opiate substitution treatment in custody if certain requirements were met.

6.54 Nicotine replacement therapy was available on detainee request, which was positive, although its availability was not well advertised.

Area for improvement

6.55 All medication that is due while a detainee is at court should be sent with them with clear administration instructions.

Good practice

6.56 *A pharmacy technician made regular visits to the custody suites, which supported the effective governance of medicines management.*

Substance misuse

6.57 Substance misuse workers did not visit the Calderdale suite, which was a missed opportunity to identify and support detainees, including alcohol users. However, the support available in the other suites was satisfactory. Substance misuse workers were based in Kirklees and

Bradford suites most days and routinely saw all detainees to support them into services. A drug worker attended Leeds (Elland Road) Monday to Friday, but prioritised detainees who had been detained on domestic violence-related offences as part of a multiagency safeguarding initiative, and saw other detainees only if they had time. Liaison and diversion workers at Wakefield offered a signposting service to all detainees.

6.58 Health and custody staff offered information and referral to substance misuse services when appropriate. All five suites offered drug testing on arrest, which gave detainees who tested positive the opportunity to engage in services. At Wakefield, detainees were drug tested based on intelligence, and if they tested positive to certain substances were offered the option of a brief mandated intervention with substance misuse services within a couple of days. The other suites provided a similar service based on trigger offences.

Area for improvement

6.59 Detainees should have easy access to substance misuse services at all suites.

Mental health

6.60 Mental health provision in Bradford and Wakefield had improved significantly since the last inspection, but there was insufficient access to embedded provision overall, and regular delays in access to assessments for and transfers to mental health facilities meant many detainees did not have their mental health needs met. Too many detainees were still held in police custody under section 136 of the Mental Health Act.[10]

6.61 The force area had a complex commissioning and delivery structure, covering multiple mental health trusts, clinical commissioning groups and local authorities. Effective multiagency partnership working through the mental health crisis care concordat,[11] regular local and regional meetings and other improvement initiatives had reduced the use of section 136, including those detained in police custody. However, the number remained too high at 91 in the six months to February 2016. Most were detained in police custody because they were intoxicated or had a violent history, although the number detained in police custody in Leeds had significantly reduced because the local crisis unit (Becklin Centre) had expanded its criteria to support this group based on clear policies and individual risk assessment. Mental health support services in four of the five divisional control hubs, plus the Leeds mental health crisis triage provision, helped response officers to support people in crisis more effectively, including diverting those from being detained under section 136.

6.62 In Wakefield, mental health liaison and diversion services provided by the local council to the NHS England specification engaged detainees of all ages and all identified vulnerabilities every day, including support for up to 12 weeks after discharge to prevent further crisis. Two mental health nurses employed by Bradford District Care Foundation Trust provided an all-age service in the Bradford suite on weekdays, including support to the courts and probation. Both services had improved outcomes for detainees, partnership working was

---

[10] 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.

[11] A national agreement between services and agencies involved in the care and support of people in crisis setting out how they will work together to ensure that people having a mental health crisis get the help they need.

good and custody staff were very positive about the support offered. The other suites had no separate mental health provision.

6.63 Custody and health staff reported, and our case audits indicated, that detainees with severe mental health issues, including children, regularly experienced long waits for assessment and/or transfer to mental health facilities, extending their time in custody. Protracted delays in ambulances attending custody suites extended detention in police custody for up to six hours in the cases we examined. Health staff said that some services would only accept an FME referral, even when the HCP was a mental health nurse, which created further delays.

6.64 Custody staff we spoke to demonstrated satisfactory understanding of mental health issues and received e-learning mental health awareness training.

Areas for improvement

6.65 People detained under section 136 of the Mental Health Act should only be held in police custody as a place of safety in exceptional circumstances.

6.66 Detainees with mental health issues should receive prompt assessments and support in all suites.

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 Our custody record analysis, case audits and observations assured us that all detainees had a pre-release risk assessment. However, records of this were mostly poor with little information, and we could not be assured that all identified risks had been addressed or mitigated before release. We were often unable to determine how detainees, particularly the most vulnerable, got home.

7.2 The practice we observed was much better than the records indicated. All the pre-release risk assessments we observed showed good attention to securing a safe release for the detainees. Initial risk assessments and care plans were always checked to ensure all identified risks had been addressed or managed to provide a safe release. Some suites did not have ready access to public transport but sergeants ensured that detainees had the means of getting home safely. Travel warrants to pay for detainees' rail fares were used if detainees had no money. Police officers were sometimes relied on to arrange transport home, particularly for more vulnerable detainees who had no other means of getting home safely.

7.3 A support leaflet with useful telephone numbers was given to all detainees on their release. Some sergeants spent extra time explaining relevant support agencies that might benefit the detainee. Sergeants were aware of the specific offences and circumstances that made detainees more at risk on release. The safeguarding team carried out a comprehensive pre-release risk assessment for detainees alleged to have committed or been charged with a sex offence, and this was reinforced by custody sergeants before release.

Courts

7.4 Custody staff at all the suites told us that the local remand courts would normally accept detainees until approximately 2pm on weekdays and 10am on Saturdays, which was too early. We were told that there was generally some flexibility each day, depending on how busy the courts were. However, we found some evidence that early court cut-off times resulted in a few detainees being held in custody for longer than necessary. At Calderdale (Halifax), we saw staff attempt to book a detainee into court at 9.30am, but he was refused due to a busy listing day and ended up being detained overnight.

7.5 The quality of the person escort records (PERs) we examined varied. Most were just adequate, a few contained scant information and only a minority were completed to a good standard. There was commonly a lack of specific dates and details when self-harm or previous suicide attempts, violence or drugs were cited.

Areas for improvement

7.6 Senior police managers should work with HM Courts and Tribunals Service and Prison Escort and Custody Services to ensure that early closure times at local remand courts do not result in needlessly long detentions in police custody.

7.7 Person escort records should contain all known information concerning risks posed to or by the detainee.

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

Areas of concern

8.1 West Yorkshire Police should maintain effective management oversight of all use of force incidents. This should include the use of spit hoods/guards and incapacitant spray. Only minimum force should be used at the lowest level and it should be proportionate to the threat posed. All staff involved in incidents should account for their actions on individual use of force forms. Staff should be adequately trained in the use of force at least annually. (2.37)

8.2 The force should ensure that the booking in of detainees is effectively prioritised according to individual risk, and that the process is efficient and reduces excessive waiting times. (2.38)

Areas for improvement

Leadership, accountability and partnerships

8.3 The force should monitor the outcomes for detainees referred to partner agencies, and extend partnership working into broader diversion schemes focused on keeping children and vulnerable adults out of the criminal justice system. (3.18)

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

8.4 Detainees' clothing and footwear should only be removed on the basis of an individual risk assessment, and paper suits should only be used to offset the risk of self-harm in exceptional circumstances and as a last resort. (5.16)

8.5 All custody staff should carry anti-ligature knives in the custody suites at all times. (5.17)

8.6 All custody staff should be involved collectively in the relevant shift handover. (5.18)

8.7 The monitoring of detainees through CCTV monitors should be clarified, and the task should be adequately resourced so that it is carried out effectively. (5.19)

8.8 Detainees should be re-read their rights and entitlements in the presence of their appropriate adult. (5.31)

In the custody cell, safeguarding and health care

8.9 All detainees held overnight, or who request one, should be offered a shower. Replacement footwear should be provided for all detainees if their own footwear is removed, and all custody suites should facilitate exercise periods for detainees. (6.28)

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

8.11 Access to appropriate adults should be improved so that children and vulnerable adults can have support at the early stages of detention and do not spend longer than necessary in custody because of the lack of provision. (6.39)

8.12 The force should assure itself that alternatives to avoid detaining children in custody overnight are actively explored so that detention is the last resort. (6.40)

8.13 The force should reduce the number of children detained in custody overnight, and ensure that children are not detained unnecessarily in cases where alternative accommodation should be provided by the local authority. (6.41)

8.14 Health provision in the suites should be based on a current health needs assessment. (6.48)

8.15 All medication that is due while a detainee is at court should be sent with them with clear administration instructions. (6.55)

8.16 Detainees should have easy access to substance misuse services at all suites. (6.59)

8.17 People detained under section 136 of the Mental Health Act should only be held in police custody as a place of safety in exceptional circumstances. (6.65)

8.18 Detainees with mental health issues should receive prompt assessments and support in all suites. (6.66)

Release and transfer from custody

8.19 Senior police managers should work with HM Courts and Tribunals Service and Prison Escort and Custody Services to ensure that early closure times at local remand courts do not result in inappropriately long detentions in police custody. (7.6)

8.20 Person escort records should contain all known information concerning risks posed to or by the detainee. (7.7)

Examples of good practice

8.21 West Yorkshire police had conducted a series of planned fire evacuation across the five suites. Routine fire evacuation drills demonstrated the force's ability to evacuate all people safely from their premises in an emergency, and provided ongoing learning to custody staff. (6.10)

8.22 A pharmacy technician made regular visits to the custody suites, which supported the effective governance of medicines management. (6.56)

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
Huw Morrisey	HMI Constabulary inspection officer
Patricia Nixon	HMI Constabulary inspection officer
Majella Pearce	HMI Prisons health services inspector
Daniel Carrick	Care Quality Commission inspector
Joe Simmonds	HMI Prisons researcher
Tim McSweeney	HMI Prisons researcher

Appendix II: Progress on recommendations from the last report

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

Strategy

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

Main recommendations

West Yorkshire Police should ensure that ultimate responsibility for court detainees held by G4S and the condition of the cells shared between the force and G4S in the Leeds Bridewell is completely clean and detainees for whom the force has responsibility are not put at risk by weaknesses in the G4S arrangements. (2.22)
No longer relevant

Recommendations

West Yorkshire police should collate the use of force in accordance with the Association of Chief Police Officers policy and National Policing Improvement Agency guidance. (3.17)
Not achieved

Treatment and conditions

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

Main recommendations

There should be clear policies and procedures to meet the specific needs of female and juvenile detainees and those with disabilities or religious needs, and custody staff should be trained to recognise these differing needs. (2.23)
Achieved

Risk assessments should be thorough and provide the opportunity for detainees to raise any relevant issues, and resulting care plans should reflect all the relevant information and be revised when circumstances change. (2.24)
Partially achieved

Recommendations

Booking-in areas should provide sufficient privacy to facilitate effective communication between staff and detainees. (4.8)
Partially achieved

Handovers should be comprehensive, and attended by detention officers and police custody staff, with the area in which the handover takes place cleared of other personnel. (4.16)
Not achieved

Detainees should be handcuffed only when a risk assessment indicates that it is necessary for the safety of staff, the public or the detainee. (4.20)
Not achieved

West Yorkshire police should address the safety issues around ligature points and, where resources do not allow them to be dealt with immediately, the risks should be managed. (4.26)
Partially achieved

Health and safety walk-through arrangements should be thorough and applied consistently at all custody suites. Records of these checks should be maintained. (4.27)
Achieved

Cells should be clean, free of graffiti and properly heated and ventilated, and the particular issues with cells at Leeds CCO being used by the court should be addressed. (4.28)
Achieved

All detainees held overnight, or who require one, should be offered a shower, which they should be able to take in private. (4.35)
Partially achieved

Food offered to detainees should be of sufficient quality and calorific content to sustain them for the duration of their stay. (4.44)
Achieved

Individual rights

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

Main recommendations

West Yorkshire Police should engage with the local authority to ensure the provision of secure beds for juveniles who have been charged but cannot be bailed to appear in court. (5.6)
Partially achieved

Two-handset telephones should be installed, so that interpreting by telephone can be conducted efficiently and privately. (5.7)
Not achieved

PRRAs should be meaningful, with enquiries made about the detainee's risk to self and to others. When concerns are highlighted, full information should be given about sources of help. (5.8)
Partially achieved

West Yorkshire Police should work with relevant partner agencies to ensure appropriate adults are available 24 hours a day to support vulnerable adults and juveniles in custody. (5.16)
Not achieved

West Yorkshire Police should work with senior court managers to minimise delays in holding detainees who are to be produced at court. (5.17)
Not achieved

Detainees should routinely be told how to make a complaint, in line with the Independent Police Complaints Commission statutory guidance, and, unless there is a clear reason not to do so, complaints should be taken while they are still in police custody. (5.20)
Achieved

Health care

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

Main recommendations

Police custody should only be used as a place of safety for Section 136 assessments in exceptional cases, and mental health diversion support should be more readily available. (2.25)
Partially achieved

Recommendations

There should be information-sharing protocols with all appropriate agencies, to ensure that relevant health and social care information is shared efficiently. (6.10)
Partially achieved

Serco and the police should establish responsibility for the ownership of clinical rooms and ensure that rooms are clean, refurbished where necessary, properly equipped and maintained, and meet infection control guidelines. Unnecessary items should be removed from all clinical rooms. (6.11)
Partially achieved

Defibrillators should be conveniently located and checked daily. These checks should be recorded. (6.12)
Achieved

Mental health awareness training should be part of all custody staff annual training, to ensure they are appropriately equipped to support detainees with mental health needs. (6.25)
Partially achieved