Report on an unannounced inspection visit to police custody suites in Kent

by HM Inspectorate of Constabulary and Fire & Rescue Services and HM Inspectorate of Prisons

5–16 July 2021

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Note: Data supplied by the force.

Force

Kent

Chief constable

Alan Pughsley, QPM

Police and crime commissioner

Matthew Scott

Geographical area

South East

Date of last police custody inspection

June 2014

Custody suites

Suite	Number of cells
North Kent	40
Medway	40
Maidstone	19
Tonbridge	19
Folkestone	15
Canterbury	15
Margate	13
Total	**161**

There is a non-designated suite at Bluewater, which has six cells.

Annual custody throughput 2020/21

27,966

Custody staffing

- 4 force custody managers (inspectors)
- 50 custody officers
- 120 designated detention officers
- 1 custody operations supervisor
- 1 bail sergeant
- 1 bail officer

Health service staffing

Kent Police employs:

- 26 forensic healthcare professionals (including 2 paramedics), of whom 23 are full-time equivalent (FTE) and 3 are part time; and
- 2 forensic healthcare managers FTE (who are also nurses).

Executive summary

This report describes our findings following an inspection of Kent Police custody facilities. The inspection was conducted jointly by HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) and HM Inspectorate of Prisons (HMIP) in July 2021. It is part of our programme of inspections covering every police custody suite in England and Wales.

The inspection assessed the effectiveness of custody services and outcomes for detained people throughout the different stages of detention. It examined the force's approach to custody provision in relation to safe detention and the respectful treatment of detainees, with a particular focus on vulnerable people and children.

This inspection of custody facilities took place during the COVID-19 pandemic. To manage risks, we adapted our methodology to carry out some of our activities remotely and minimise our physical presence in the force and its custody suites. To achieve this, we gave the force more notice than normal of the inspection. Our case reviews and analysis, interviews and focus groups were carried out remotely. Our observations were carried out over a two-week period but with no more than two of our inspectors in a suite at one time.

We also recognise that the force's operating policies and procedures continue to reflect the risks due to the pandemic. Measures to minimise the spread of the COVID-19 virus, such as wearing face masks, are in use in the custody suites. The way that some custody services are provided is also affected, for example there are some differences to how detainee risks are managed.

We last inspected custody facilities in Kent Police in 2014. Our 2021 inspection has established that, of the 36 recommendations made during that previous inspection, 29 have been fully or partially achieved. The remaining seven recommendations have been determined in this inspection as areas still requiring attention.

To aid improvement, we have made two recommendations to the force (and the police and crime commissioner) addressing main causes of concern, and have highlighted an additional 22 areas for improvement. These are set out in section 6.

Leadership, accountability and partnerships

Kent Police has a clear governance structure to oversee the safe and respectful provision of custody services and support continuous improvement. Meetings at strategic and operational level consider and discuss important areas of custody. However, oversight of how the force provides detainee health services is relatively under-developed. A clinical governance group has recently been set up to improve this.

Custody officers and staff are committed to providing a good service. However, a lack of direction about who should be carrying out tasks can result in inconsistent practices and outcomes for detainees, including:

- long waits for some detainees to be booked in;
- delays in carrying out cell checks; and
- reviews of detention not always being done on time.

The force has changed its shift patterns and is increasing the number of custody officers to help address these inconsistencies and better meet demand.

The force mostly follows the guidance set out in the Police and Criminal Evidence Act 1984 (PACE) codes of practice (the main exception relates to reviewing detentions). It has adopted Authorised Professional Practice – Detention and Custody (APP guidance) set by the College of Policing and has some additional local policies and practices. But the force isn't consistent in following either APP or its own policies, particularly those relating to managing detainee risk.

There are some good performance management arrangements. The force monitors information on important areas of custody at strategic and operational meetings. However, gaps in the information limit the usefulness of this activity. For example, the force does not know how long detainees wait to see a healthcare practitioner. This means that it cannot assure itself that healthcare provision is timely and appropriate.

Information on the use of force is not always accurate. There is little governance and oversight over when and how force is used, and limited routine quality assurance over incidents. This makes it difficult for Kent Police to show that, when force is used, it is proportionate and justified. However, the cases we examined (including CCTV footage of incidents) were generally managed well.

The quality of entries on custody records varies. Reasons for decisions are usually clear and well recorded. However, important information is sometimes missing, or there is not enough detail to describe what action has been taken.

The force has a good understanding of the Public sector equality duty. There is good oversight to identify and address disproportionality in how detainees are treated, which is supported by an emphasis on knowing detainees' ethnicity.

There is a good focus on diverting vulnerable people and children away from custody, and working with other organisations, such as the St Giles Trust, to prevent (re)offending.

Pre-custody: first point of contact

Frontline officers have a good understanding of vulnerability and clearly consider it when deciding whether to arrest someone. They only take children to custody as a last resort – that is, when all other options have been explored.

However, frontline officers told us they do not have enough advice and support from mental health professionals to deal with people experiencing mental ill-health.

They said this often leaves them with little choice other than to detain them under section 136 of the Mental Health Act 1983 for the person's own and/or other's safety.

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

Custody staff treat detainees respectfully and are calm and patient when talking with them. They respond well to their diverse needs. In general, appropriate support is given to meet the particular needs of women in custody, and there is good provision to meet religious needs. Custody staff use telephone interpreters for detainees who speak little or no English, although this tends to be limited to the booking-in process. Adjustments for detainees with physical disabilities or impaired mobility vary between the suites.

Custody officers and designated detention officers identify detainee risks well but do not always set appropriate observation levels, particularly for detainees under the influence of alcohol and/or drugs (who should be roused at least every 30 minutes). Observation checks are mainly carried out on time, but some are late. We have significant concerns over the way in which some aspects of risk are managed. Working practices do not always follow APP guidance or assure the safety of detainees.

In general, detainees receive their individual rights in custody in an appropriate manner and detention is appropriately authorised. Good explanations (oral and written) are given to detainees about their rights and entitlements while they are in custody.

Some detainees spend a long time in custody, with long waits before they are booked in or interviewed. It isn't always clear what causes the delays. Reviews of detention are usually in person but are not always carried out in the best interests of the detainee – they tend to be done when the inspectors have a block of time, which makes some too early and some too late. Some aspects of the reviews do not always meet the requirements of PACE Code C.

Custody officers give good explanations to detainees released on bail about what this means but do not always explain the consequences of interfering with an investigation to those released under investigation.

In the custody cell, safeguarding and health

Conditions and cleanliness throughout the custody estate are good, and there is some natural light in all cells. There are potential ligature points (which could be used by a detainee to self-harm) in all the suites. This is mainly due to the design of toilets and sinks, and the fit of cell hatches. During the inspection we gave the force a comprehensive illustrative report detailing these points as well as the general condition of the estate.

Detainees spoke very positively about their care in custody. Detainee care is generally good. There is a range of food to meet most dietary needs, and the provision of outside exercise in the yard is better than in many other forces we have visited. Distraction items are used to keep detainees occupied, especially children or those with neurodiverse needs.

All the officers we spoke with understand their responsibilities to make sure that children and vulnerable people are safeguarded. Custody officers are generally good at recognising when a vulnerable adult requires an appropriate adult. However, some children and vulnerable adults wait a long time before an appropriate adult is available to support them.

Children are well looked after and cared for. Custody officers and designated detention officers clearly explain what happens in custody. Each child is assigned a named staff member who encourages them to talk about what is happening in their life and any concerns they may have. Girls are assigned a female carer.

The force closely monitors all children in custody, aiming to keep their time there as short as possible. However, it isn't unusual for children to spend more than 12 hours in custody. Those charged and refused bail, although few, are rarely moved by the local authority as they should be.

Our observations in suites and review of clinical records showed that the forensic healthcare practitioners working in the suites provide appropriate treatment and support for detainees. However, because the clinical governance processes for health provision are under-developed it is difficult for the force to show that detainees have access to timely healthcare of appropriate quality.

There is good communication between healthcare and custody staff, who share information about risk where appropriate. Detainees receive support for drug and alcohol problems from the Criminal Justice Liaison and Diversion Service (CJLDS) practitioners working in custody.

The CJLDS offers good support, including for detainees with complex mental health needs. Custody is very rarely used as a place of safety for those detained under section 136 of the Mental Health Act 1983. However, some detainees with significant mental ill-health remain in custody for lengthy periods while they wait for a Mental Health Act assessment. In some cases, they are detained under section 136 because their assessment has not been or cannot be completed before they are due to be released.

Release and transfer from custody

Custody officers work well with detainees to make sure they are released safely. Particular attention is given to making sure that children and vulnerable detainees get home safely. Other organisations are involved to provide support when needed.

Designated detention officers complete digital person escort records (dPERs) when detainees are transferred to court or recalled to prison. The records vary in quality and do not always contain enough detail. Custody officers do not supervise or take part in these transfer arrangements, but after we raised this problem with the force it started to change its practice.

Detainees are generally collected for court promptly. Some are seen by the virtual courts running in three of the suites. When virtual courts are used there can be delays leading to detainees spending longer in custody, but these delays are not in the control of Kent Police.

Causes of concern and recommendations

Cause of concern: Managing custody services

There is a lack of direction over how custody services are provided, which means that officers and staff aren't always deployed effectively. In particular:

- designated detention officers carry out some duties they are not authorised to do;
- work is sometimes duplicated when designated detention officers book detainees into custody;
- non-custody staff are sometimes relied on to carry out tasks which are not their responsibility; and
- local policing inspectors carry out reviews of detentions to fit around their other commitments rather than the detainee's needs.

This leads to inconsistent practices, and potentially different and sometimes poor outcomes for detainees.

Recommendation

The force should clarify its expectations of all officers and staff performing or involved in custody duties. It should provide enough oversight in custody suites so that officers and staff are used in the most effective and efficient way to ensure consistent and timely outcomes for detainees in all suites.

Cause of concern: Detainee safety

The force is not managing detainee safety well enough:

- observation levels for detainees under the influence of alcohol or drugs are often set too low;
- the details of interactions with detainees who need to be roused (during checks) from the influence of alcohol or drugs are not always properly documented;
- checks on detainees are often carried out by looking through spyholes, and some are late with no reasons recorded why;
- detainee cell checks are sometimes grouped together and recorded on each individual's custody record, which is poor practice;
- different designated detention officers carry out checks so there is little continuity to assess changes in a detainee's demeanour;
- constant watches of detainees by CCTV or in person are not always carried out or recorded well enough;
- not all custody staff attend handovers; and
- not all custody officers visit the detainees they are responsible for at the start of their shift, and when visits are made there is little interaction with the detainee.

These practices do not follow APP guidance and potentially place detainees at significant risk of harm.

Recommendation

The force should take immediate action to mitigate the risk to detainees by ensuring that its risk management practices follow APP guidance and are carried out and recorded to the required standard.

Introduction

This report is one in a series of inspections of police custody carried out jointly by HM Inspectorate of Prisons (HMIP) and HM Inspectorate of Constabulary & Fire and Rescue Services (HMICFRS). 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). The joint HMICFRS and HMIP national rolling programme of unannounced police custody inspections, which began in 2008, ensures that custody facilities in all 43 forces in England and Wales are inspected regularly.

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. HMIP and HMICFRS are two of several bodies making up the NPM in the UK.

Our inspections assess how well each police force is fulfilling its responsibilities for the safe detention and respectful treatment of those detained in police custody, and the outcomes achieved for detainees.

Our assessments are made against the criteria set out in the *Expectations for Police Custody*. These standards are underpinned by international human rights standards and are developed by the two inspectorates. We consult other expert bodies on them across the sector and they are regularly reviewed to achieve best custodial practice and drive improvement.

The expectations are grouped under five inspection areas:

- leadership, accountability and partnerships;
- pre-custody: first point of contact;
- in the custody suite: booking in, individual needs and legal rights;
- in the custody cell: safeguarding and health care; and
- release and transfer from custody.

The inspections also assess compliance with the Police and Criminal Evidence Act 1984 (PACE) codes of practice and the College of Policing's Authorised Professional Practice – Detention and Custody.

The methodology for carrying out the inspections is based on:

- a review of a force's strategies, policies and procedures;
- an analysis of force data;
- interviews with staff;
- observations in suites, including discussions with detainees; and
- an examination of case records.

We also conduct a documentary analysis of custody records based on a representative sample of the custody records across all the suites in the force area open in the week before the inspection was announced. For Kent Police we analysed a sample of 147 records. The methodology for our inspection is set out in full at Appendix I.

Wendy Williams CBE

HM Inspector of Constabulary

Charlie Taylor

HM Chief Inspector of Prisons

Section 1. 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

Kent Police has a clear governance structure to oversee the safe and respectful provision of custody services and to support continuous improvement. An assistant chief constable has overall responsibility for the provision of custody services, supported by a chief superintendent, a superintendent and a chief inspector.

There are appropriate meetings at strategic and operational levels to consider and discuss important areas of custody. Meetings include:

- the victims' justice board, which oversees custody matters such as children and those with mental ill-health in custody;
- monthly custody operations meetings, which cover a range of activities, including how detainees are cared for and detainee complaints; and
- daily management meetings, which consider operations, including resourcing.

The force seeks to improve its custody services through this framework of meetings. It has made good progress against our previous inspection recommendations, most of which have been achieved or partially achieved.

However, the force's governance of health services (in custody) is not as good. Clinical governance of the provision of health services is being developed, but at the time of inspection could only provide limited assurance that detainees have timely access to healthcare of appropriate quality.

The force provides custody services in seven suites (plus a contingency suite) with a team of:

- 4 custody inspectors;
- 45 custody officers; and
- 120 designated detention officers.

We found that suites often operate with minimum staffing levels (usually one custody officer and two or three designated detention officers). Frontline supervisors are asked to cover custody officer duties when there are shortages. Although trained, these officers aren't always confident in the role. Police constables sometimes act as gaolers but aren't able to carry out all the duties required of a designated detention officer.

Custody officers and staff are committed to providing a good service to detainees. But there isn't always sufficient direction for staffing resources in the suites to clarify who should do be doing particular tasks.

We found inconsistent approaches to running the suites. For example, designated detention officers can book detainees into custody so that custody officers can be available for the duties only they can carry out, such as releasing detainees and discussing cases with investigating officers. But this does not happen consistently. It sometimes leads to duplication when elements of booking in need to be repeated so that the custody officer can authorise detention or agree a risk level. Designated detention officers also have their own tasks to do.

We found that demand is not always managed well, which sometimes results in:

- long waits for some detainees to be booked into custody;
- delays in carrying out cell checks;
- detention reviews not always being carried out in time; and
- officers not having time to take their rest breaks.

We also saw designated detention officers carrying out tasks that are the responsibility of the custody officer, which they are not authorised to do. For example, assessing whether a detainee is fit to be interviewed and completing pre-release risk assessments for detainees going to court or released from virtual court. This is contrary to Authorised Professional Practice – Detention and Custody (APP guidance).

Other examples of staff not being used in the best way include:

- Arresting and investigating officers routinely escort detainees to and from their cells and around the suite. Designated detention officers should do this.
- Detention reviews are sometimes too early or late because they are carried out by local policing inspectors, who are under time pressure from commitments outside custody.
- Custody inspectors do not review detentions, even though they may be in the suite when they become due. This shows that reviews aren't carried out in the best interests of the detainee, but on the availability of reviewing inspectors.

Overall, we found that the staffing arrangements in suites, including how custody and non-custody staff are used, are leading to poor outcomes for some detainees. Some spend longer than necessary in custody. This is a cause of concern.

The force conducted an internal review of custody staffing and as a result:

- the number of custody officers will increase from 45 to 50; and
- shift patterns have changed to overlap to provide additional staff between 12.00pm and 3.00pm, which the force has identified as a busy period, and to allow staff to take rest breaks.

The force is progressing these improvements through its custody change programme but it is too early to assess how well this is working.

Initial custody training is good and is followed by continuous professional development:

- Custody officers complete a two-week initial training course before undertaking their duties. This is followed by mentoring from more experienced colleagues.
- Frontline sergeants who carry out custody duties receive the same training as custody officers. However, some told us that they don't do these duties often enough to feel confident and are over reliant on designated detention officers to guide them.
- Designated detention officers have a three-week initial training course. They are mentored while completing a record of achievement, which is signed off by supervisors.

Custody officers and staff also receive online and face-to-face training sessions. For example, recently they had attended a session on autism.

Police officers acting as police constable gaolers are not trained for the role.

The force has adopted APP guidance set by the College of Policing and also has its own local policies and practices. However, neither of these are followed consistently. This includes managing aspects of risk, as detailed later in this report.

Since our last inspection in June 2014, there have been two deaths in custody. Both were in the Tonbridge suite. The IOPC investigated and made some learning recommendations to the force.

Area for improvement

The force should ensure that all custody staff follow the College of Policing Authorised Professional Practice – Detention and Custody, as well as its own guidance, so that detainees receive an appropriate and consistent level of treatment and care.

Accountability

Performance management arrangements are generally good. Performance is monitored at:

- meetings such as daily management meetings, monthly custody operations meetings, and the victims' justice board;
- the force's main performance meeting with the police and crime commissioner; and
- the Kent criminal justice board, which includes liaison and diversion and mental health service representatives.

However, there are gaps in the force's data that limit its ability to monitor some custody services. For example, there is not enough information about healthcare arrangements to assess how long detainees wait to see a healthcare practitioner or for a mental health assessment. Information on immigration detainees is also limited. The force also told us that it is difficult to extract some data from Athena, its custody system.

The force regularly reviews custody services by theme. For example, children in custody and cases where detention is not authorised. Findings are used to help improve services and communicated to staff as learning in the monthly custody newsletter.

There is good learning from adverse incidents in custody and when staff have successfully intervened, for example, when a detainee was self-harming. Incident reviews are discussed at the monthly operational performance meeting, which is attended by representatives from the force's professional standards department.

The force mostly follows the PACE codes of practice. For example, we saw good attention to meeting the PACE Code G necessity test when authorising detention. However, not all aspects of reviewing detention follow PACE Code C – mainly in relation to reminders following sleeping reviews and making representations about whether detention should continue.

There is little governance and oversight of the use of force and restraint in custody suites. Data on the use of force is not accurate enough. And there is insufficient detail recorded on detention logs to determine what force was used or why it was necessary. Not all staff complete individual use of force forms in line with National Police Chiefs' Council (NPCC) guidance.

There is also little routine quality assurance of the use of force, with few incidents reviewed. This makes it difficult for Kent Police to show that when force is used, it is proportionate and justified. However, in the 20 cases we looked at, which included CCTV footage, overall we found that cases were managed well. We only referred two cases back to the force for learning.

The quality of recording on custody records is inconsistent and detention logs are often confusing to read. We saw some very detailed entries explaining why decisions had been made and the reasons for actions such as strip searches. However, it is very difficult to follow events in order. Important information is sometimes missing, such as

how a rousal check has been carried out or when an appropriate adult was called and when they arrived.

Standard texts within the system (Athena) are used for common tasks such as cell visits. However, the free text that staff add to document their actions often contradicts them. For example, the text saying “cell entered detainee roused” is often followed by the designated detention officer recording that the detainee was not roused.

Multiple cell checks are sometimes recorded without changes to the detail for each detainee, which is poor practice. Routine dip sampling and quality assurance of records is limited and does not identify the concerns we have raised above.

The force has a good understanding of the Public sector equality duty. Staff have received some online training relating to the Equality Act, as well as bespoke training such as the respectful searching of transgender detainees. The force has senior officer champions for each of the protected characteristics. A newly formed equality, diversity and inclusion (EDI) academy is developing cultural audits.

There is good oversight to identify disproportionality. Staff are regularly reminded to ask detainees to self-define their ethnicity to ensure this data is accurate. This is monitored at monthly meetings. The force recently reviewed the ethnicity of children charged and remanded to understand why black and Asian children are over-represented.

The force is open to external scrutiny and makes sure that independent custody visitors (ICVs) can easily visit the custody suites to speak with detainees. Custody staff are receptive to feedback from ICVs and issues raised are dealt with promptly. During the first waves of the COVID-19 pandemic, the force arranged remote visits so that ICVs could speak with detainees on the phone. There are regular meetings with the scheme manager to follow up any themes.

Areas for improvement

- The force should strengthen its approach to performance management by collecting and monitoring information for all its main services and to show the outcomes achieved for detainees.
- The force should improve its oversight of the use of force so that it can show that when force is used in custody suites it is proportionate and justified. This should be based on comprehensive and accurate information.
- The force should improve the quality of its custody records by ensuring that all necessary information is fully recorded. Quality assurance should be strengthened to assess the standard of recording.
- The force should ensure that all custody procedures comply with legislation and guidance.

Strategic partnerships to divert people from custody

There is a good focus on diverting vulnerable people and children away from custody. Some effective partnership working supports this, for example:

- the Kent and Medway Women's Forum works to minimise re-offending for women; and
- the St Giles Trust works with children who have entered custody to try and prevent further offending.

However, despite this effective partnership working, children charged and refused bail often remain in custody because local authorities are unable to provide alternative accommodation. This is a poor outcome for these children.

The force has good joint working arrangements with the Kent and Medway NHS and Social Care Partnership Trust and the Criminal Justice Liaison and Diversion Service (CJLDS). The CJLDS provides valuable support in helping detainees in custody who may have mental ill-health. However, other arrangements to meet the needs of people with mental ill-health are not working so well, particularly out-of-hours when custody-based CJLDS staff are not available. Detainees who need them can wait a long time for a Mental Health Act assessment and subsequent mental health bed.

Police officers responding to incidents sometimes detain people under section 136 of the Mental Health Act 1983 to take them to a hospital place of safety, which could potentially be avoided with better support from mental health professionals.

Section 2. 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

Frontline officers have a good understanding of vulnerability. Those we spoke with said they considered age, mental health and physical disabilities, along with things such as alcohol or drug addiction, as factors that make a person vulnerable. All children are treated as vulnerable because of their age.

The force's intranet site contains guidance and information to help officers recognise and understand vulnerability. Training on different aspects of vulnerability is also available and is usually offered with other training provided by the force.

Officers clearly consider vulnerability an important factor when responding to incidents and deciding whether to arrest someone. They usually discuss alternative, potentially more suitable, actions with their supervisor before taking a person to custody.

In general, frontline officers we spoke with felt they had enough information when dealing with incidents to decide the best action to take. They said that call handlers (who take calls from the public) gathered and passed on as much information as they could, although this could be limited depending on how busy they were. Officers have good information about an incident, and any people who might be involved, on their mobile phones using the Mobile First App (although poor phone signals sometimes affect whether they can use it). Supervisors also provide information from background checks that they carry out.

Keeping children out of custody is a priority for the force. It works with other organisations, such as the St Giles Trust, to prevent re-offending. Frontline officers explore alternatives to custody, including:

- taking children to family members who can look after them;
- arranging voluntary interviews; and
- using community resolutions or interventions that Youth Offending Teams offer.

Officers also ask for advice and help from the force's central referral unit (CRU). The CRU can check the involvement of other agencies with a child, any necessary safeguarding measures and ways of dealing with the incident other than arrest.

Officers believe that this support helps them keep children out of custody. They are aware that custody officers will refuse detention if the arrest of a child cannot be fully justified. However, the nature of some offences leaves no choice but to arrest. They said that sometimes custody is the only way to keep a child safe.

Frontline officers do not feel they have enough support when responding to incidents involving people with mental ill-health. When deciding whether to detain a person under section 136 of the Mental Health Act 1983 for the person's own safety or that of others, officers seek advice from mental health professionals.

The arrangements to obtain this advice do not work well. Officers have a 24/7 dedicated number to ring to speak with the crisis team mental health professionals. But they said that it isn't always answered quickly, or sometimes at all, so they cannot always speak to someone. When advice is given, officers often feel that it is insufficient to help them decide what to do to manage the risk to the individual, themselves and the wider public, and that they have little choice other than to detain them under section 136. In their view, this leads to more people being detained than necessary.

When a person is detained under section 136, officers told us they regularly wait a long time with them for ambulances, in ambulances, in police cars and at hospitals. They said that it was not unusual for this to last for a whole shift. This is a poor use of police officers' time and a poor outcome for the person experiencing a mental health crisis.

Frontline officers should only take people detained under section 136 to custody in exceptional circumstances. Those we spoke with could not recall any recent cases. Information provided by the force shows only one person was detained under section 136 and taken to custody in the last year.

When a person has committed offences for which arrest is required but do not need to be detained under section 136, that person is taken to custody. Any mental health needs are assessed there while the investigation progresses. Enquiries only stop if a mental health assessment results in detention under mental health legislation.

Officers told us that mental health assessments don't always happen in the required timeframe for keeping a person in police custody (24 hours). If they suspect that a detainee is having a mental health crisis in custody, they detain them under section 136 so that they will be taken to a hospital for assessment.

Police officers transport detainees to custody in police cars or vans, depending on the risks the detainee poses. They told us that they would discuss and agree the best way of transporting detainees who are wheelchair users with the detainee. Most officers we spoke with hadn't ever needed to do this.

Area for improvement

The force should ensure that frontline officers dealing with incidents involving people with mental ill-health can access timely and good quality information from mental health professionals to support their decision-making.

Section 3. 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

Custody staff treat detainees respectfully and are calm when talking with them. They explain the processes and requirements of being detained with patience and consistency. They often manage people who are very distressed or upset and defuse tension well. They keep their tone level and are willing to spend as much time as the situation requires.

There is a lack of privacy in all suites, especially for important initial conversations when risks and needs are identified. Most conversations take place at the booking-in desks in the main open area of the custody suite, which differ greatly in size and layout. Booking-in areas are often noisy and busy, which can limit effective communication.

The lack of privacy is mitigated by the reasonably consistent offer of a further conversation in private, but generally only after sensitive matters have been covered. For example, we saw a person charged with online sexual offences being spoken with in an open area, albeit with lowered voices.

There is sufficient privacy in most shower rooms, except some showers at North Kent and Maidstone.

With a couple of exceptions, there are plenty of signs in custody suites informing detainees that CCTV is in use in the custody suites, including in the cells and cell corridors at some suites. All detainees are advised of this when they are booked in. The detainee is not always told when the CCTV in a cell has audio recording.

The in-cell CCTV images all show that the toilets are pixelated and not visible on monitors. Detainees are consistently told this. Staff may take additional precautions, such as asking colleagues not to look at the image on screen while a woman was strip-searched in the cell, but these do not consistently preserve privacy and maintain detainee dignity. The glass-fronted cells at Canterbury are almost opposite each other, which prejudices privacy.

Area for improvement

The force should improve its approach to detainee dignity and privacy by:

- having arrangements to allow private or sensitive information to be disclosed in a confidential environment and advising the detainee of this early on in the booking-in process; and
- ensuring that detainees can shower in sufficient privacy at all custody suites.

Meeting diverse and individual needs

Custody staff give due attention to meeting the diverse needs of detainees and generally respond well to those with protected characteristics. They have received some face-to-face training in aspects of equality, diversity and inclusion. However, several said that they had not been able to access online training due to a lack of time in their working day.

Staff are confident in asking detainees about their ethnicity, but don't always do it. They can describe appropriate treatment for transgender detainees and understand the correct approach to searching and other personal matters.

In general, women in custody are given appropriate support. In most cases, there are sufficient female designated detention officers to provide a suitable level of care. However, there are often delays in designating a named officer and them making direct contact with the detainee to discuss female care or welfare issues. If there are no female detention staff available, other female police officers (for example, from the local response team) are asked to be named officers. However, they aren't always readily available.

In most cases, women are held in cells away from men. Menstrual care products are generally made freely available, although the stock is not always sufficiently varied to meet all needs. At North Kent, a sign at the desk says they will be given on request.

Foreign national detainees include people arrested at the border or after entry to the country. There is good co-operation between custody staff and the immigration authorities (Immigration Enforcement, Border Force, and UK Visas and Immigration). During the inspection, about 30 foreign nationals were brought into police custody after crossing the English Channel.

Custody staff regularly use telephone interpreting when conducting initial assessments of risks and needs, even when detainees have some basic English. All suites have dual handsets for this purpose, although it is more common for the speakerphone facility to be used. This reduces the privacy of the conversation. It is rare for telephone interpreting to be used at subsequent stages of the detention process, except sometimes in preparation for release or a detention review. This could limit detainee understanding of important processes or prevent staff from effectively communicating risk and welfare issues.

Staff are familiar with procedures for contacting a detainee's embassy or equivalent when necessary.

Printed copies of rights and entitlements are available in a variety of languages. But custody records did not show that they were always given to detainees who would need them. There are hearing loops in the suites. There are no copies of rights and entitlements in Braille but there are plenty in an easy-read format. However, the two leaflets issued to detainees on release (one generic and one from the Criminal Justice Liaison and Diversion Service) are not available in any foreign language.

There are some adjustments for detainees with physical disabilities or those with impaired mobility, but this provision is not consistent throughout all custody suites. Our observations on the level of adjustment include:

- In most suites, thicker mattresses are available to make the bench higher, so they are easier and more comfortable for a detainee to use.
- At Medway, there is a wet room (for showering) with good access, but without other aids such as grab rails.
- North Kent has wheelchair access. There are blue lines painted on the walls of all cells to assist detainees with a visual impairment. An adapted toilet and shower are available. There is a lowered call bell in one cell.
- At Tonbridge, there is a lowered call bell in one cell.
- Some showers at Maidstone and Margate, and a toilet at Canterbury, have grab rails.

Following a risk assessment, detainees can keep mobility aids such as crutches in their cell.

Several staff are aware of the problems faced by neurodivergent people in custody, often because of personal experience. Some cells at Medway and two at Canterbury have doors made largely of glass, which are suitable for those anxious about a confined space. Some staff are confident to explain which items from the distraction activity box (such as stress balls, word searches, sudoku and origami) they had found useful for neurodivergent detainees such as those with autism or ADHD.

All detainees are asked about religious needs on their arrival. All suites (except Bluewater) have respectfully stored religious books and artefacts. In general, the provision is better than in many other forces.

Area for improvement

The force should strengthen its approach to meeting the individual and diverse needs of detainees by ensuring that:

- there is consistently suitable provision for detainees with disabilities, including extra thick mattresses and arrangements for detainees to access an adapted shower and toilet when needed;
- a suitable range of menstrual care products are freely available at all suites;
- the two-way handsets are used for interpretation so that confidential information cannot be overheard;
- interpreting services are used at all points during detention where important information needs to be given or requested;
- all detainees are asked to self-define their ethnicity when being booked into custody; and
- a female member of staff is available to make early contact with any female detainee and can perform the role effectively.

Risk assessments

The approach to identifying risk is generally good. However, there are significant weaknesses in the way risk is managed. Some working practices mean that the force does not consistently ensure the safety of detainees. This is a cause of concern that we expect the force to address immediately.

Some detainees are booked in promptly, but during busy periods some wait for lengthy periods in holding rooms or vehicles before their detention is authorised (see Individual legal rights, below). There is some management of queues to prioritise booking in according to risk or for children or vulnerable detainees.

Custody officers and designated detention officers focus appropriately on identifying risks, vulnerability factors and welfare concerns during booking in.

Custody staff interact well with detainees to complete the risk assessment template. They ask relevant supplementary and probing questions. However, questions specific to COVID-19 are not always asked and are recorded inconsistently. There is routine cross-referencing to the police national computer (PNC) warning markers to help identify additional risk factors, although arresting and escorting officers are not routinely asked if they have any relevant information for the risk assessment.

Initial care plans do not always reflect observations at a level that is commensurate with presenting risks. It is of concern that the observation levels set for detainees who are under the influence of alcohol and/or drugs rarely include rousal checks (APP guidance Level 2), which poses significant risks.

In general, observation levels are reviewed regularly. There is mostly enough information and justification on custody records to show when and why they have been changed, for example when a detainee sobers up.

The frequency of checking on detainees is mostly as required. However, we found some late visits with poor justification recorded. For example, “delayed as busy at booking-in desk”.

We found some examples of poor practice where checks do not follow APP guidance. These include:

- Checks aren’t always carried out by the same member of staff, which means that changes in a detainee’s behaviour or condition might not be readily identified.
- In several of the suites, checks are completed by custody staff looking through the cell spyhole, which does not constitute an acceptable welfare check.
- Where rousal checks are required, staff do not always document how they conduct them or what a detainee’s response was on being roused.
- Some custody records show multiple cell checks being recorded on a detainee’s record rather than an entry that relates to that individual only.

When detainees are assessed as needing closer observation at either Level 3 (constant observation via CCTV) or at Level 4 (physical supervision in close proximity), we expect custody officers to fully brief the officer(s) responsible for the observations. We found that the quality of briefing and issue of documentation to record interactions with detainees is inconsistent. Some observing officers only receive a handover from the observing officers they are replacing, rather than from the custody officer.

Officers performing observation duties frequently remain in post for long periods without any breaks, which does not follow APP guidance. Not all are properly focused on their duties, for example taking phone calls or using handheld devices when they should be observing detainees.

Since our last inspection, handovers between shifts have improved. There is room for further improvement. For example:

- handover content is generally good and has a sufficient focus on risk and welfare, but not all custody staff routinely take part in handovers; and
- after a handover, most custody officers visit the cells of all detainees in their care, but they do not always communicate with detainees during that time.

These practices do not follow APP guidance and are not ensuring detainee safety.

Although custody staff were given advice in a recent newsletter, we saw that cell hatches are not always fully closed. This also does not follow APP guidance, is potentially unsafe and presents a potential ligature point.

More positively, we saw that most custody officers do not routinely remove clothing with cords or other items, such as jewellery, unless an individual risk assessment deems it necessary. They generally record this correctly. However, others routinely remove these items from detainees, regardless of their risk levels and without recording why it is necessary. Detainees are rarely allowed to keep their footwear in their cells, but the reasons for this are unclear.

It is good that all staff carry anti-ligature knives. Cell call bells are audible and can be answered via an intercom system, although the intercom isn't used in some suites due to poor sound quality. Cell call bells are responded to promptly in most instances.

The management of cell keys is sometimes poor. Custody staff should know where the cell keys are at any given time. There is insufficient oversight of when they are given to non-custody staff, which diminishes the control that custody staff should maintain in the suite. Non-custody staff do not always have access to anti-ligature knives, which could compromise detainee safety.

Areas for improvement

The approach to risk should be improved by ensuring that:

- cell hatches are always fully closed;
- custody officers only remove detainees' corded clothing or other items after an individual risk assessment, with the reason for removal fully recorded; and
- custody staff maintain control and oversight of custody keys.

Individual legal rights

In general, detainees receive their individual rights in custody in an appropriate manner.

Some detainees are taken straight to the custody desk with little or no wait; some wait a lot longer. Information provided by the force showed that in the year to June 2021, detainees waited an average of 35 minutes. However, our observations and review of custody records showed that on some occasions detainees waited up to two hours or more. The reasons for delays are not always clearly recorded.

Detention is appropriately authorised. Arresting officers provide good circumstances of arrest and of the necessity to detain (PACE Code G). This allows custody officers to make informed decisions on whether to authorise detention. We observed some good discussions where refusing detention was considered.

When designated detention officers book detainees into custody, they are supervised by custody officers. However, this sometimes leads to duplication if arresting officers must repeat the circumstances and necessity for arrest in the presence of a custody officer to authorise detention.

The force avoids taking people into custody where possible. Alternatives to custody include:

- restorative justice, which is the collective resolution between victim and offender as to how to deal with the consequences of an offence;
- conditional cautions, where the offender admits the offence and accepts the conditions being imposed, and can be prosecuted if they fail to comply; and
- voluntary attendance, where suspects involved in minor offences attend a police station by appointment to be interviewed, avoiding the need for arrest and subsequent detention.

Information provided by the force shows there has been a year-on-year increase of people attending voluntarily for interview. In 2020/21, 3,851 people attended voluntarily (up from 2,619 from the year before). However, voluntary interviews take place in the custody suite because there are no interview facilities available outside. This unnecessarily exposes these people to the custody environment and detracts from its purpose as a diversion from custody.

The number of immigration detainees has also increased year-on-year. In the year to 30 June 2021, 340 people entered custody, compared with 235 people in year ending 30 June 2019. They spent an average of 25 hours and 33 minutes in custody, from arrival to departure. However, the force does not have information to show how long detainees remain in police custody after an IS91 form (immigration service authority to detain) is served, after which they should be collected by immigration services and leave police custody as soon as possible.

Detainees should be kept in custody for the minimum time necessary. However, we found some detainees waited for long periods before being interviewed despite investigators having been assigned quickly after their detention. There was little recorded information to indicate why.

We found little evidence, either in custody records or during our observations, of custody officers contacting investigators to clarify and expedite the progress of cases. For example, we saw a detainee who was released with no further action after spending more than 18 hours in custody. Although some delays could be attributed to waits for appropriate adults (for vulnerable adults or children), it is not clear why other cases weren't dealt with more quickly.

We observed custody officers giving good explanations to detainees about their three main rights and entitlements, which are to:

1. have someone informed of their arrest;
2. consult a solicitor and access free independent legal advice; and
3. consult the PACE codes of practice.

The force has a booklet that explains these rights and contains other useful information. It is usually given to detainees during the booking-in process.

Detainees are offered the PACE codes of practice to read. All custody suites have the latest version (August 2019).

In most suites, posters advising detainees of their right to free legal advice in different languages are displayed in booking-in areas. We saw staff putting posters up during our inspection to fill the gaps where they were missing.

There are sufficient interview and consultation rooms for detainees to consult their legal representatives in private. However, detainees wishing to speak to their legal representatives on the telephone do not always have access to a separate area of the custody suite, which means that some of these private conversations are conducted in the presence and hearing of custody staff.

Not all the custody officers we spoke with were aware of the requirements of PACE Code C Annex M or how to obtain translated detention documents and records for non-English-speaking detainees or those who have difficulty understanding English.

There are copies of the easy-read versions of rights and entitlements in every suite. We saw this given when needed, for example to children and vulnerable adults.

DNA samples obtained from detainees are kept in unlocked boxes. Designated detention officers regularly open them to check that the paperwork accompanying each one is correct. This compromises the integrity of the samples, which should be held securely. Force policy is for samples to be stored at room temperature, but we point the force to guidance from the Faculty of Forensic and Legal Medicine (circa January 2021) that recommends buccal (mouth) swabs are stored frozen.

Area for improvement

The force should ensure that detainees have their cases dealt with promptly and effectively so that they do not spend longer than necessary in custody.

Reviews of detention

Reviews of detention are not always carried out in the best interests of the detainee and do not always meet the requirements of PACE Code C.

Inspectors from the local policing team carry out most reviews of detention. This can lead to some reviews being carried out too early and others too late because they have operational commitments elsewhere. We saw instances of local policing team inspectors undertaking reviews despite custody inspectors (custody managers) being in the suite when the reviews were taking place.

Reviews of detention are usually done in person. Detainees are treated courteously and reminded of their rights and entitlements. In some cases, their welfare is discussed. The reviews we observed, along with our examination of custody records, showed that some were comprehensive and conducted well. Others were not sufficiently thorough. For example, some detainees were not informed that their continued detention was authorised or had had their detention authorised without being given the opportunity to make any representations. This does not meet the requirements of PACE Code C paragraph 15.3.

When reviews occurred while the detainees were asleep, detainees were not consistently reminded at the earliest opportunity that a review had taken place. This does not meet the requirements of PACE Code C paragraph 15.7. When they were reminded, it was not always recorded that their continued detention had been authorised by the reviewing officer.

The standard of recording for reviews is inconsistent and sometimes poor, often lacking any welfare details. Custody officers and staff use pre-populated template text too often. It requires users to delete non-applicable information, which did not always happen in the cases we saw. This makes it difficult to assess whether reviews have

been conducted properly and in the best interests of the detainee. It also creates confusion about what happened.

Area for improvement

Reviews of detention should be carried out to a consistent standard and in the interests of the detainee.

Access to swift justice

The force's current arrangements to provide swift justice are not working well enough, despite oversight of those who are bailed or released under investigation through the victims' justice board.

Management of those released on bail or under investigation rests initially with frontline supervisors. There are arrangements to review investigations within agreed timescales:

- sergeants are expected to review crimes every 28 days;
- inspectors are expected to review crimes every three months; and
- chief inspectors are expected to review crimes every six months.

However, many cases remain as released under investigation for a long time. Our analysis of custody records showed that 49 percent of cases were concluded during the detainee's first period in custody. This means that more than half of those arrested by the force are bailed or released under investigation pending further enquiries.

The force collects and monitors the use of bail and released under investigation. Information provided by the force shows that, as at 12 July 2021, there were a total of 672 people on bail and 5,268 people released under investigation. Bail cases are generally managed well in line with the Policing and Crime Act 2017 legislation on the use of pre-charge bail. However, there are delays for detainees who have been released under investigation. Just over one third of cases are over six months old, nearly 10 percent of which have been waiting more than two years for their investigations to be finalised.

Custody officers clearly explain the consequences of breaching bail, and any conditions, to detainees. When a suspect is released under investigation, custody officers also clearly explain the possible outcome of the investigation. Outcomes can include no further action, court summons or a voluntary interview.

Suspects released under investigation are given a notice outlining the offences they may commit if they interfere with victims or witnesses during the investigation. However, unlike for bail, the consequences are not always explained in person on their release.

Complaints

Information on how to make a complaint can be found in the custody information booklet that is given to detainees. This contains details of their continuing rights and entitlements. In addition, there are leaflets available in custody that tell detainees how they can comment on the service they have received.

Posters advising detainees on how to complain are in the custody suites but include outdated information. This was corrected during our inspection.

Custody officers know to take complaints while a detainee is in custody. However, we found examples where a complaint was either not taken or not recorded in the custody record.

Section 4. 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

The custody estate in Kent has seven full-time designated suites and one part-time non-designated suite (used as a contingency suite).

There are potential ligature points in all eight, mainly due to the design of toilets, sinks and fit of cell hatches. During the inspection, we gave the force a comprehensive illustrative report detailing the ligature points as well as general conditions.

Overall, conditions and cleanliness throughout the custody estate are good. There is some natural light in all cells and no evident graffiti. The custody suites are well maintained and benefit from an annual two-week closure programme, which provides an opportunity for redecoration and any additional works.

Most cells have benches that are higher than expected in standard cells, making it easier for detainees who are older or have mobility issues. Most cells have toilets, appropriately obscured from view on CCTV. Some also have in-cell handwashing basins or wash outlets, although there are no signs to indicate if the water is suitable for drinking.

Cell call bells function correctly and are generally responded to within appropriate timeframes.

There is no formal, daily safety maintenance check of the physical environment (which includes cells and communal areas) as detailed in the APP guidance. A weekly check should be conducted, but records suggest these are not always completed. We were told that repairs are completed quickly.

CCTV covers most of the suite and all the cells (except at Bluewater).
Notices advising detainees that CCTV is in operation are prominently displayed in all the suites and cells (except at North Kent and the ground floor cells at Medway).

Custody staff are aware of emergency evacuation procedures, and how and where to evacuate detainees in an emergency. However, while all staff told us they had been involved in regular fire scenario exercises, very few had taken part in an evacuation drill to ensure the procedures work in practice in line with fire regulations (the legal requirement is to carry out an annual evacuation drill).

Force data shows that there have only been four drills covering three suites in the previous six months. The drills did not always identify learning points or document any action taken when they did. However, there are sufficient sets of handcuffs in the custody suites to evacuate the cells safely if required.

Areas for improvement

- The force should address the safety issues involving potential ligature points. Where resources do not allow them to be dealt with immediately, the risks should be managed to ensure that custody is provided safely.
- Signs in cells should advise detainees whether the water is suitable for drinking.
- There should be thorough daily and weekly maintenance checks. These should be conducted and recorded consistently.
- The force should adhere to legal requirements for fire regulations, particularly for emergency evacuations.

Safety: use of force

Kent Police has information about when force is used in custody. Most of the custody records we looked at explained why force had been used, although the level of supporting detail varied. Some other information was either inaccurate or incomplete.

In the cases we reviewed, not all officers and designated detention officers who had been involved in an incident submitted use of force forms as required. We expected to see 97 use of force forms from the incidents we reviewed on CCTV, but only received 37. Without looking at CCTV coverage, the force may not know what happened or the type of force used.

Some of the information provided about restraint equipment was inaccurate. It showed emergency restraint belts (ERBs) and leg restraints were used often. The force does not use ERBs anymore, but when fast straps are used it is recorded on the computer system as ERBs. This is confusing and makes it difficult to show that restraint equipment is being used appropriately or proportionately.

There is no routine dip sampling of the use of force in custody, although there have been three assessments in the last year. These include a detailed review of:

- custody records;
- the use of force forms;
- custody CCTV; and
- body-worn video, where available.

The reports confirm our findings that not enough use of force forms were submitted.

Kent Police relies on use of force being noted on the custody record or on a use of force form: there is no other way for it to determine if force has been used.

We expect the force to address the concerns on documenting use of force accurately as part of the area for improvement in the accountability section of this report. This says that the force should improve governance and oversight of the use of force based on comprehensive and accurate information.

More positively, the cases we looked at on CCTV were nearly all managed well. We reviewed 20 cases (some involving multiple incidents) and saw officers and designated detention officers show patience and offer reassurance. There were good examples of staff de-escalating difficult situations with detainees to avoid or minimise the use of force. We saw similar approaches when we were in the suites. However, the use of force to remove clothing occurs regularly, for example where cords are present. This could potentially be avoided by setting higher levels of observation, commensurate with the perceived risk. We referred two cases back to the force to review and learn from. However, overall we found that when force is used it is reasonable, necessary and proportionate.

Police officers and designated detention officers are up to date with their personal safety training. An extension was given during the early stages of the pandemic. Those unable to do the training because of medical reasons are booked in when their circumstances change. We were told that designated detention officer training does not cover de-escalation techniques, which is a missed opportunity.

Most compliant detainees have handcuffs removed quickly on arrival in custody. We saw some arrive with no handcuffs on at all. Frontline officers told us that their use of handcuffs was based on a risk assessment and that they could remove handcuffs when they felt it was appropriate. However, the time that handcuffs are removed is not recorded. This would show whether detainees are in handcuffs for longer than necessary.

We found three cases where detainees remained handcuffed in their cells during close proximity constant watches, including while the detainee was sleeping. We expect the continued use of force to be regularly risk assessed and any restraint removed as soon as possible. There was no evidence that this happened.

All the strip searches we reviewed were appropriate, with good justification recorded on the custody record. They were managed well with good consideration of each detainee’s dignity. Although not an ideal method, CCTV screens are covered with a post-it note or piece of paper to prevent others working in the suite seeing the strip search.

Our analysis of custody records showed that the force has a much lower percentage of detainees who are strip searched than many other police forces we have inspected since March 2016. The force is planning its own detailed analysis of strip search information and intends to examine any disproportionality concerns.

Detainee care

Detainee care is generally good. Detainees spoke very positively about the care given to them in custody. They told us that staff had treated them kindly – one woman said they had been "wonderful". Some said that the staff's attitude had helped them to cope with their time in custody.

The range of available food is good and meets most dietary needs, although there is a lack of choice for vegans and vegetarians in some suites. The provision includes microwave meals, porridge pots, fruit pots, breakfast bars and flapjacks. At North Kent, freshly cooked food from the canteen is available at breakfast and lunchtime. The recording of the offer and/or provision of food is inconsistent on custody records. Our observations indicate that the practice of offering food is much better than the documentation of food being offered. However, detainees going to court are not always given breakfast before leaving.

All suites have a selection of new or laundered clothing items. Most cater for a range of sizes. Unless there is a reason not to, detainees normally wear their own clothing. Footwear is generally not permitted in the cells, which means that detainees are left in socks or bare feet.

We saw from the suites and in the custody records that the provision of outside exercise is provided more often than we find in many other forces. The yards, though not large, are clean and in fair condition. Staff are aware of the potential for detainees to de-stress there. Using the exercise yard is subject to a risk assessment, which allows some detainees unsupervised access and reduces demand on staff.

An excellent feature, introduced this year to all suites, is a distraction box. It is not unusual to have distraction materials such as puzzles and colouring materials in custody. However, these boxes also include sensory objects, stress balls and footballs, which are frequently used by detainees in the exercise yards. Many of them appreciate this. Detainees are routinely asked if they would like something from the box in some suites, but are not always asked in others.

Mattresses and pillows are available in all cells. Blankets are available and usually provided.

APP guidance says that detainees should be routinely provided with a supply of toilet paper unless there is a good reason not to. Although practice varies, toilet paper is generally only issued on request. (In some suites, a small amount of tissue is placed in cells before occupancy.) Staff say this is because of the risk of misuse. In many cell corridors, toilet paper is not stored or handled hygienically.

The offer and provision of showers is better than we have seen in many forces' custody suites. Showers are generally offered to those who are going to court. During busier times of day, they are generally not offered. They are only provided on request and subject to staff availability, including for detainees held overnight. During the inspection, all immigration detainees brought in after long, arduous journeys were provided with showers.

In all but a few cells in Tonbridge and Margate, detainees can wash their hands in the cell.

In most suites, reading matter consists of boxes of popular novels donated by staff or others. This meets most needs, although there is little provision for non-English speakers or younger age groups. Some suites have old magazines or newspapers to hand out. Although the offer of reading materials is not routine, it is evident in our review of custody records and observations.

Areas for improvement

The force should improve its care for detainees by:

- increasing the range of reading material available in all suites, especially for children and those whose first language is not English, and offering it routinely;
- ensuring that those going to court in the morning have been offered breakfast; and
- improving hygiene through ready availability of toilet paper and handwashing facilities, and through active offers of showers, especially when detainees are held for extended periods.

Safeguarding

All the officers we spoke with understood their responsibilities to make sure children and vulnerable people are safeguarded. They have been trained to protect children and vulnerable adults, and how to spot concerns.

Arresting and/or investigating officers are usually responsible for making safeguarding referrals to the force's specialist teams. They are expected to tell custody officers information they might need to be able to look after and release detainees safely. If custody officers identify concerns while a detainee is in custody, they can make a referral or ask the investigating officer to do this.

Custody officers can look at safeguarding information on the force's computer system, but we found few entries on custody records to show that this information was considered or used during a person's detention. It wasn't clear from the records we looked at whether custody officers had oversight of safeguarding arrangements.

Local Criminal Justice Liaison and Diversion Service (CJLDS) workers visit all detainees, but prioritise children and vulnerable adults. They address any safeguarding concerns, making their own referrals as necessary. However, although we found good entries in some cases, it wasn't always clear from the custody record whether CJLDS workers had communicated with the detainees or if any referrals had been made. We saw CJLDS workers speak with custody officers following their visits but, given the busy environments, we are not assured that this always happens.

The force has recognised these shortcomings and a working group, including members of other agencies such as social services, is considering how to improve safeguarding arrangements.

The arrangements for appropriate adults to support children and vulnerable adults in detained in custody are not good enough. Delays in arranging appropriate adults increase the time these detainees spend in custody.

Custody officers are expected to secure appropriate adults as soon possible. Those we spoke with know this. However, it is not happening quickly enough in many cases. Arresting or investigating officers organise appropriate adults for the detainees they are dealing with. Sometimes this works well – for example, when arresting officers identify a person at the time of the incident who can act as an appropriate adult and ask them to attend custody as soon as possible. In other cases, requests for appropriate adults are not made soon enough. Often, appropriate adults are only asked to attend when the time of interview is known.

Custody officers have little involvement in requesting or chasing up appropriate adults, despite being responsible for securing them. This means that some children and vulnerable adults do not have their rights and entitlements explained to them with the help of an appropriate adult early in their detention. We observed and found cases where there were long delays before an appropriate adult arrived. In one case, we saw a vulnerable female detainee remain in custody for nearly 24 hours before an appropriate adult arrived. In other cases, detainees had to be bailed or released under investigation because an appropriate adult could not be arranged or arrive in time.

Family members are always considered first to act as an appropriate adult. We saw good efforts to contact them quickly and ask them to attend as soon as they could. However, where family could not be contacted or attend, it was usually some time before the appropriate adult scheme was contacted. Similarly, there were delays in contacting the scheme where it was inappropriate for the family member to act as the appropriate adult. For example, when they had been involved in the incident.

Custody records don't always record the time appropriate adults are requested or when they arrive in the custody suite. In the cases we examined it was sometimes difficult to see what steps had been taken. Sometimes the first mention of an appropriate adult was when they arrived.

Kent County Council commissions appropriate adult provision for detainees through The Young Lives Foundation. The appropriate adults on the scheme are volunteers. Custody and other officers spoke highly of them and of their willingness to help. The force relies on information provided by the foundation to show how many requests for appropriate adults are met, and the length of time between the request and arrival. However, without gathering its own information, it is difficult for the force to judge how well detainee needs are being met other than on a case-by-case basis. Our observations and review of cases lead us to conclude that detainees' needs are not met well enough.

Custody officers are confident in deciding whether an adult detainee is vulnerable and needs the support of an appropriate adult. During our observations and review of cases, we saw vulnerability assessments being used to inform such decisions. In our view, most of these decisions are made correctly so that vulnerable adults, although subject to the delays described above, receive the support they are entitled to.

Custody officers can download the National Appropriate Adult Network guidance leaflet to help non-trained appropriate adults to understand their role.

Children are well looked after in custody. Custody officers and staff interact with them in a child-friendly way, providing explanations and assurance about what happens or will happen. Generally, consideration is given to putting children in quieter areas of the suite or designated children's cells where available. We were told that a child may be able to spend some time in a consultation or interview with a parent or appropriate adult, rather than stay in their cell.

The force has easy-read rights and entitlements booklets, which we saw given out. There are also distraction packs in all the suites containing items to help children pass the time, including puzzles and footballs. We saw these being given out to some children.

Girls are assigned a female staff member to oversee their care needs, in line with legislative requirement. All children are given a named carer while in custody. The carer's role is to take an interest and speak with the child, encouraging a conversation about their home life and schooling, and any concerns they may have. This is known as the voice of the child. It is intended to provide a better understanding of the child's background and what could be done to improve outcomes for them, such as better safeguarding.

We saw good entries in custody records about the content of these discussions. The designated detention officers we spoke with were clear about their role as named carer and what it intends to achieve. This new role will help to support the force's approach to children in custody.

Custody officers recognise that custody is not a good environment for children and that they should be there for the shortest time possible. They are required to write a detailed justification of why a child has been detained, and additional justification when a child is held overnight. We saw some comprehensive entries on custody records to this effect.

Children are monitored very closely when they enter custody. Custody inspectors review each case. Children's cases are discussed every morning in meetings with the chief inspector, who reports on them and any concerns to the superintendent.

Children entering custody and those held overnight are also discussed during the force's regular oversight meetings with the other organisations it works with. This helps ensure that relevant organisations have oversight of children in custody.

Despite this strong focus on children and keeping their detention times as short as possible, we found it was not unusual for children to spend more than 12 hours in custody. This is likely to be due, in part, to delays in arranging appropriate adults.

When a child is detained overnight, the custody officer informs the emergency duty team at social services and sends an overnight detention form. A member of the force's central referral unit is available to discuss the case if needed.

Few children are charged and refused bail. When this happens, custody officers follow the jointly agreed procedures with children's social services. They request that social services provide secure or appropriate accommodation so that the child can be transferred out of custody. If this accommodation is not provided, there is an escalation procedure. However, there is no secure accommodation and very little

appropriate accommodation in the Kent area. We were also told that escalation is not pursued because it will not make any difference. Once an inspector has been notified, it is unlikely the escalation will go any further.

However, such cases are escalated and discussed at regular meetings between the chief inspector and a senior officer in social services to see if anything could have been done better and any lessons could be learned.

Information provided by the force for the year to 30 June 2021 showed that 37 children who were charged and refused bail should have been transferred out of custody to alternative accommodation arranged through social services, who have a statutory duty to provide it. Of the 37 children:

- 28 required secure accommodation but none were moved; and
- nine needed appropriate accommodation but only one was moved.

The force has worked with Medway local authority to provide appropriate accommodation for children charged and refused bail. Plans are progressing. From August 2021, the local authority will provide a house with trained foster carers to look after children and take them to the next available court hearings.

Areas for improvement

- The force should arrange appropriate adults for children and vulnerable adults as soon as possible so that they receive support from early on in their detention. It should monitor appropriate adult provision to ensure that detainee needs are met.
- The force should continue to work with its local authority partners to improve the provision of alternative accommodation for children charged and refused bail.

Governance of health care

Forensic medical services are provided by a team of registered forensic healthcare practitioners (FHPs) who are employed directly by the force. The FHPs provide all physical healthcare support and forensic testing. Mountain Healthcare offers a medical telephone helpline for FHPs which provides general oversight and individual case support on a 24/7 basis. Criminal justice liaison and diversion service mental health support for detainees is provided by Kent and Medway NHS and Social Care Partnership Trust.

There is no formal health needs analysis to identify the potential physical health needs of detainees and to determine what level of service may be needed. Service performance measures are in place. However, these are mostly concerned with police priorities – such as evidential requirements – with little focus on whether individual detainee health needs are met. Our observations and review of custody records showed that data on healthcare response times is not consistently collated.

Formal clinical governance processes are under-developed. As a result, the force can only provide limited assurance that detainees have timely access to appropriate quality healthcare. Some of the detainee complaints the force provided us for this inspection related to concerns about medication and treatment. Although FHPs may be asked to comment on individual cases, there is no confidential health complaints system or process to learn from any issues raised or review emerging trends. However, more coherent clinical accountability arrangements are being introduced to address these concerns.

There is a clear team ethos among FHPs. Their collective working experience helps mitigate some of the gaps in clinical governance processes. Clinical records show that they provide good support and maintain a level of contact based on detainee need.

Clinical supervision arrangements are only just being rolled out. However, the FHPs we met are capable and confident individuals. Experienced and new staff have a range of competencies. All healthcare practitioners complete mandatory training, although there are few opportunities for continuing professional development.

COVID-19 control measures mean that most general health consultations take place in cells. FHPs go to cells unaccompanied so that they can see detainees on a one-to-one basis and with a degree of privacy. Treatment rooms are used for the most vulnerable and when it is necessary to take intimate samples.

Resuscitation equipment and FHP training to use it are appropriate.

Treatment rooms throughout the suites are generally adequate, though some worktops and sinks do not fully comply with infection prevention and control standards. One facility (North Kent) has audio-enabled CCTV which is inappropriate, but this was disabled during the inspection.

Area for improvement

The force should establish robust clinical governance processes that routinely monitor clinical outcome measures to ensure detainees receive timely and good quality healthcare.

Patient care

Two senior forensic healthcare managers provide clear and easy to access operational leadership for the FHPs. Medway custody suite has a dedicated FHP located on site. Elsewhere, one FHP covers two custody suites.

There is a gap in the rota, with no FHP service available between 5.00am and 7.30am. There are no vacancies and although FHPs are periodically drawn away from custody for extended periods – for example, to attend London hospitals and for other duties – there is no indication that cover is adversely affected.

Some custody staff expressed anxiety about FHP availability. They told us about occasions where detainees were transferred to hospital because of delays in an FHP attending. There is no information to show when or how often this happens because response times are not recorded. However, we saw FHPs working together

to ensure that detainee care was maintained between sites and shifts. We did not find any examples of poor outcomes for detainees. Generally, detainees can access an appropriate range of treatment and support.

A sample of clinical records indicate that FHPs complete good standard assessments with clear reasons for all interventions and support given. Communication and relations with custody staff are also good, with risk information shared where appropriate.

The force makes sure treatments such as simple pain relief and personal medication are available. Clinical policies cover an appropriate range of acute health conditions where immediate support may be required. We found some confusion about whether this includes access to methadone. The policy was recently changed to allow access to methadone, but the new arrangements have not been communicated effectively to all staff.

An appropriate range of patient group directions, such as for the symptomatic relief of opiate and alcohol withdrawal, is available to support detainees' health needs. Custody officers can access simple remedies following a telephone consultation with the FHP if they are off site. This includes nicotine replacement products for detainees who smoke, which is a good response to need.

Medicine management arrangements on site are mostly good. The force is improving stock monitoring. It is also introducing a revised procedure to dispose of unused detainee medication, which is not currently auditable. Controlled drugs are safely handled and well-managed on all sites. Medicine cabinets, though secure, are mostly located in the busy booking-in areas, which can be cramped and potentially distracting.

Substance misuse

Although there are no dedicated substance misuse workers based in any of the suites, liaison and diversion practitioners are available every day to support detainees with drug and alcohol problems. They provide active support, including signposting to community services and continuing one-to-one support after release from custody. Custody staff are rostered for at least one day a week to this type of community work, which is positive and proactive.

Mental health

Custody staff receive training on mental health issues. All custody officers we spoke with seem to be confident and knowledgeable on the subject. Governance and partnership arrangements between the Kent and Medway NHS and Social Care Partnership Trust, its liaison and diversion (L&D) practitioners and the force are good. Operational oversight is provided at inspector level.

There is an L&D practitioner based in every suite, seven days a week. A senior registered practitioner provides oversight, supervision and specialist input for two or three suites. All detainees are screened by the senior practitioner. The team aims to see all detainees, although they prioritise children and women.

Though demand can stretch resources, L&D practitioners are valued by custody staff. The L&D team is motivated and skilled. They provide good support to vulnerable detainees arriving in custody. Support includes:

- help with housing and other social problems;
- providing specialist assessments and support to detainees with complex mental health problems; and
- providing post-custody help for people to make use of community services.

A specific women's assessment tool is used to identify their needs and vulnerabilities.

Custody is rarely used as a place of safety under section 136 (one case has been reported in last 12 months). However, a significant number of detainees have been taken from custody to a hospital place of safety under section 136. This suggests that initial decision-making by frontline officers could be better informed if they were able to easily obtain advice and assistance from specialist mental health workers. If a detainee's mental health deteriorates in custody, the Mental Health Act referral pathway is not working effectively to get them the help they need quickly enough.

Access to out-of-hours mental health support is variable, including the availability of the crisis team. Custody staff told us that a lack of support can mean long waits for detainees because organising a mental health assessment, finding a hospital bed and arranging transport take a long time. Some detainees with significant mental ill-health have remained in custody for lengthy periods. We found one detainee nearing 24 hours in custody and another who had spent nearly 48 hours there.

Community demand for health-based section 136 facilities is significant, with a high number of section 136 detentions (1,577 cases reported over the last 12 months). Frontline officers rely on the 836 telephone advice line (previously there were street triage arrangements) when making section 136 decisions. Not being able to talk to an advisor and/or agree alternatives to section 136 results in detentions which could potentially be avoided.

The local 836 provider told us that it intends to centralise operations to make better use of resources.

Area for improvement

The force should identify and monitor delays in Mental Health Act assessments for detainees who need them. It should work with relevant organisations to analyse the reasons for delays so that detainees are diverted appropriately and spend as little time as possible in custody.

Section 5. 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

The force has a clear focus on ensuring detainees are released safely.

Custody officers communicate well with detainees to complete pre-release risk assessments. They generally make appropriate use of initial risk assessments and care plans to ensure all identified risks are addressed or mitigated before release. Particular attention is given to managing the safe release of children and vulnerable detainees. Where necessary, relevant organisations or services such as the Criminal Justice Liaison and Diversion Service (CJLDS) are involved. However, some custody records lack sufficient detail (for example, on how a detainee will get home safely after release) and did not reflect what we observed happening.

The force gives detainees without means travel warrants or petty cash to help them get home safely. When these options aren't suitable, for example for children or vulnerable people, police officers sometimes take detainees home. This depends on availability.

Not all custody officers are aware of the enhanced safeguarding arrangements for those arrested under suspicion of committing serious sexual offences. However, they exchange information with the investigating officers in charge of these cases and use it when completing the pre-release risk assessment.

Generic information about support organisations, such as the Samaritans, is supplied by the CJLDS and routinely given to detainees on release. However, this is only available in English.

Designated detention officers complete digital person escort records (dPERs). These vary in quality. They do not always include sufficiently detailed information such as warning markers and medication.

Some practices lack appropriate custody officer scrutiny and do not follow APP guidance. For example:

- custody officers do not supervise or take any part in the transfer of detainees physically attending court or recalled to prison; and
- designated detention officers routinely complete the pre-release risk assessment for detainees discharged or released by the video remand court. (See 'Courts', below.)

Areas for improvement

Custody officers should:

- oversee the release of all detainees, including those being transferred to court or prison. They should ensure that the person escort records are fully completed, with appropriate risk and health information; and
- complete pre-release risk assessments with detainees discharged or released by the video remand court, to ensure all identified risks have been addressed or mitigated before release.

Courts

Video remand hearings, which use video and digital technology, allow detainees in police custody suites to appear in court via a virtual link. At the time of our inspection, such hearings operated in three of the force's custody suites. A fourth was set up on a temporary basis to deal with detainees suspected of being in contact with an individual who had tested positive for COVID-19, to minimise the risk of infection by avoiding unnecessary travel.

The eligibility criteria for attending video remand hearings include detainees who have breached their bail conditions or are arrested on a warrant for failing to appear in court. Detainees charged with a new offence and denied bail are transferred to court custody to appear in person.

Detainees transferred to court are generally collected promptly in the morning. However, staff told us and we observed that there are occasions when the transfer is delayed due to the limited number of cells in the court custody facilities. We saw a few occasions when a planned transfer was cancelled, which meant that the detainees therefore appeared at the video remand hearing later in the day and spent longer in police custody as a result. There were also often delays in cases being heard promptly in scheduled video remand hearings, which prolonged the detainee's detention.

Although out of the control of Kent Police, some detainees who are remanded or receive custodial sentences after a video remand hearing are kept in police custody longer than necessary – sometimes overnight or over a weekend. This is a poor outcome for them because it deprives them of their additional rights as a prisoner (prisoners have more rights and entitlements than detainees). The force is working with the courts and escort provider to improve the situation, but more should be done.

Area for improvement

Kent Police should continue to work with HM Courts and Tribunals Service and Prisoner Escort & Custody Services to ensure that detainees are not held in police custody for longer than necessary.

Section 6. Summary of causes of concern, recommendations and areas for improvement

Causes of concern and recommendations

Cause of concern: Managing custody services

There is a lack of direction over how custody services are provided, which means that officers and staff aren't always deployed effectively. In particular:

- designated detention officers carry out some duties they are not authorised to do;
- work is sometimes duplicated when designated detention officers book detainees into custody;
- non-custody staff are sometimes relied on to carry out tasks which are not their responsibility; and
- local policing inspectors carry out reviews of detentions to fit around their other commitments rather than the detainee's needs.

This leads to inconsistent practices, and potentially different and sometimes poor outcomes for detainees.

Recommendation

The force should clarify its expectations of all officers and staff performing or involved in custody duties. It should provide enough oversight in custody suites so that officers and staff are used in the most effective and efficient way to ensure consistent and timely outcomes for detainees in all suites.

Cause of concern: Detainee safety

The force is not managing detainee safety well enough:

- observation levels for detainees under the influence of alcohol or drugs are often set too low;
- the details of interactions with detainees who need to be roused (during checks) from the influence of alcohol or drugs are not always properly documented;
- checks on detainees are often carried out by looking through spyholes, and some are late with no reasons recorded why;
- detainee cell checks are sometimes grouped together and recorded on each individual's custody record, which is poor practice;
- different designated detention officers carry out checks so there is little continuity to assess changes in a detainee's demeanour;
- constant watches of detainees by CCTV or in person are not always carried out or recorded well enough;
- not all custody staff attend handovers; and
- not all custody officers visit the detainees they are responsible for at the start of their shift, and when visits are made there is little interaction with the detainee.

These practices do not follow APP guidance and potentially place detainees at significant risk of harm.

Recommendation

The force should take immediate action to mitigate the risk to detainees by ensuring that its risk management practices follow APP guidance and are carried out and recorded to the required standard.

Areas for improvement

Leadership, accountability and partnerships

- The force should ensure that all custody staff follow the College of Policing Authorised Professional Practice – Detention and Custody, as well as its own guidance, so that detainees receive an appropriate and consistent level of treatment and care.
- The force should strengthen its approach to performance management by collecting and monitoring information for all its main services and to show the outcomes achieved for detainees.
- The force should improve its oversight of the use of force so that it can show that when force is used in custody suites it is proportionate and justified. This should be based on comprehensive and accurate information.
- The force should improve the quality of its custody records by ensuring that all necessary information is fully recorded. Quality assurance should be strengthened to assess the standard of recording.
- The force should ensure that all custody procedures comply with legislation and guidance.

First point of contact

The force should ensure that frontline officers dealing with incidents involving people with mental ill-health can access timely and good quality information from mental health professionals to support their decision-making.

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

- The force should improve its approach to detainee dignity and privacy by:
  - having arrangements to allow private or sensitive information to be disclosed in a confidential environment and advising the detainee of this early on in the booking-in process; and
  - ensuring that detainees can shower in sufficient privacy at all custody suites.
- The force should strengthen its approach to meeting the individual and diverse needs of detainees by ensuring that:
  - there is consistently suitable provision for detainees with disabilities, including extra thick mattresses and arrangements for detainees to access an adapted shower and toilet when needed;
  - a suitable range of menstrual care products are freely available at all suites;
  - the two-way handsets are used for interpretation so that confidential information cannot be overheard;
  - interpreting services are used at all points during detention where important information needs to be given or requested;
  - all detainees are asked to self-define their ethnicity when being booked into custody; and
  - a female member of staff is available to make early contact with any female detainee and can perform the role effectively.
- The approach to risk should be improved by ensuring that:
  - cell hatches are always fully closed;
  - custody officers only remove detainees' corded clothing or other items after an individual risk assessment, with the reason for removal fully recorded; and
  - custody staff maintain control and oversight of custody keys.
- The force should ensure that detainees have their cases dealt with promptly and effectively so that they do not spend longer than necessary in custody.
- Reviews of detention should be carried out to a consistent standard and in the interests of the detainee.

In the custody cell, safeguarding and health care

- The force should address the safety issues involving potential ligature points. Where resources do not allow them to be dealt with immediately, the risks should be managed to ensure that custody is provided safely.
- Signs in cells should advise detainees whether the water is suitable for drinking.
- There should be thorough daily and weekly maintenance checks. These should be conducted and recorded consistently.
- The force should adhere to legal requirements for fire regulations, particularly for emergency evacuations.
- The force should improve its care for detainees by:
  - increasing the range of reading material available in all suites, especially for children and those whose first language is not English, and offering it routinely;
  - ensuring that those going to court in the morning have been offered breakfast; and
  - improving hygiene through ready availability of toilet paper and handwashing facilities, and through active offers of showers, especially when detainees are held for extended periods.
- The force should arrange appropriate adults for children and vulnerable adults as soon as possible so that they receive support from early on in their detention. It should monitor appropriate adult provision to ensure that detainee needs are met.
- The force should continue to work with its local authority partners to improve the provision of alternative accommodation for children charged and refused bail.
- The force should establish robust clinical governance processes that routinely monitor clinical outcome measures to ensure detainees receive timely and good quality healthcare.
- The force should identify and monitor delays in Mental Health Act assessments for detainees who need them. It should work with relevant organisations to analyse the reasons for delays so that detainees are diverted appropriately and spend as little time as possible in custody.

Release and transfer from custody

- Custody officers should:
  - oversee the release of all detainees, including those being transferred to court or prison. They should ensure that the person escort records are fully completed, with appropriate risk and health information; and
  - complete pre-release risk assessments with detainees discharged or released by the video remand court, to ensure all identified risks have been addressed or mitigated before release.
- Kent Police should continue to work with HM Courts and Tribunals Service and Prisoner Escort & Custody Services to ensure that detainees are not held in police custody for longer than necessary.

Section 7. Appendices

Appendix I: Methodology

Police custody inspections focus on the experience of, and outcomes for, detainees from their first point of contact with the police and through their time in custody to their release. Our inspections are unannounced and we visit the force over a two-week period. Our methodology includes the following elements, which inform our assessments against the criteria set out in our *Expectations for Police Custody*.

Document review

Forces are asked to provide a number of important documents for us to review. These include:

- the custody policy and/or any supporting policies, such as the use of force;
- health provision policies;
- joint protocols with local authorities;
- staff training information, including officer safety training;
- minutes of any strategic and operational meetings for custody;
- partnership meeting minutes;
- equality action plans;
- complaints relating to custody in the six months before the inspection; and
- performance management information.

We also request important documents, including performance data, from commissioners and providers of health services in the custody suites and providers of in-reach health services in custody suites, such as crisis mental health and substance misuse services.

Data review

Forces are asked to complete a data collection template, based on police custody data for the previous 36 months. The template requests a range of information, including:

- custody population and throughput;
- demographic information;
- the number of voluntary attendees;
- the average time in detention;
- children; and

- detainees with mental ill health.

This information is analysed and used to provide contextual information and help assess how well the force performs against some main areas of activity.

Custody record analysis

A documentary analysis of custody records is carried out on a representative sample of the custody records opened in the week preceding the inspection across all the suites in the force area. Records analysed are chosen at random. And a robust statistical formula provided by a government department statistician is used to calculate the sample size required to ensure that our records analysis reflects the throughput of the force's custody suites during that week. This has a 95 percent confidence interval with a sampling error of 7 percent. The analysis focuses on the legal rights and treatment and conditions of the detainee. Where comparisons between groups or with other forces are included in the report, these differences are statistically significant.

A statistically significant difference between the two samples is one that is unlikely to have arisen by chance alone, and can be assumed to represent a real difference between the two populations. To appropriately adjust p-values in light of multiple testing, $p<0.01$ was considered statistically significant for all comparisons carried out. This means there is only a one percent likelihood that the difference is due to chance.

Case audits

We carry out in-depth audits of approximately 40 case records (the number may increase depending on the size and throughput of the force inspected). We do this to assess how well the force manages vulnerable detainees and specific elements of the custody process. These include looking at records for children, vulnerable people, individuals with mental ill health, and where force has been used on a detainee.

The audits examine a range of factors to assess how well detainees are treated and cared for in custody. For example, the quality of the risk assessments, whether observation levels are met, the quality and timeliness of Police and Criminal Evidence Act (PACE) reviews, if children and vulnerable adults receive timely support from appropriate adults and whether detainees are released safely. Where force is used against a detainee, we assess whether it is properly recorded and if it is proportionate and justified.

Observations in custody suites

Inspectors spend a significant amount of their time during the inspection in custody suites assessing detainees' physical condition, and observing operational practices and how detainees are dealt with and treated. We speak directly to operational custody officers and staff, and to detainees to hear their experience first-hand. We also speak with other non-custody police officers, solicitors, health professionals and other visitors to custody to get their views on how custody services operate. We look at custody records and other relevant documents held in the custody suite to assess the way in which detainees are dealt with, and whether policies and procedures are followed.

Interviews with staff

During the inspection we carry out interviews with officers from the force. These include:

- chief officers responsible for custody;
- custody inspectors; and
- officers with lead responsibility for areas such as mental health or equality and diversity.

We speak to people involved in commissioning and running health, substance misuse and mental health services in the suites and in relevant community services, such as local Mental Health Act section 136 suites. We also speak with the co-ordinator for the Independent Custody Visitor scheme for the force.

Focus groups

During the inspection we hold focus groups with frontline response officers, and response sergeants. The information gathered informs our assessment of how well the force diverts vulnerable people and children from custody at the first point of contact.

Feedback to force

The inspection team provides an initial outline assessment to the force at the end of the inspection, to give it the opportunity to understand and address any issues at the earliest opportunity. Following this, a report is published within four months giving our detailed findings and recommendations for improvement. The force is expected to develop an action plan in response to our findings, and we make a further visit approximately one year after our inspection to assess progress against our recommendations.

Appendix II: Inspection team

- Norma Collicott: HMICFRS inspection lead
- Patricia Nixon: HMICFRS inspection officer
- Anthony Davies: HMICFRS inspection officer
- Vijay Singh: HMICFRS inspection officer
- Andy Reed: HMICFRS inspection officer
- Viv Cutbill: HMICFRS inspection officer
- Kellie Reeve: HMIP team leader
- Fiona Shearlaw: HMIP inspector
- Martin Kettle: HMIP inspector
- Steve Eley: HMIP health and social care inspector
- Mathew Tedstone: CQC inspector
- Sutinderjit Mahil: HMICFRS (shadow inspector)
- Joanne White: CQC (shadow inspector)
- Joe Simmonds: HMIP researcher
- Helen Ranns: HMIP researcher

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