Report on an inspection visit to police custody suites in Nottinghamshire

12–16 March 2013

by

HM Inspectorate of Prisons and

HM Inspectorate of Constabulary

Glossary of terms

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Contents

1. Introduction

This report is part of a programme of inspections of police custody carried out jointly by our two inspectorates and which form a key part of the joint work programme of the criminal justice inspectorates. These inspections also contribute to the United Kingdom's response to its international obligation to ensure regular and independent inspection of all places of detention. The inspections look at strategy, treatment and conditions, individual rights and health care.

This inspection of police custody suites in Nottinghamshire is a follow-up of the one undertaken in September 2011. We made 24 recommendations, of which 11 had been achieved, eight partially achieved and five not achieved. The police force had made significant progress, especially in the conditions of the cells.

While there were good internal management and meeting structures, there needed to be more robust partnership arrangements covering mental health care, children and young people, and places of safety. Senior managers needed to ensure there were appropriate places of safety for vulnerable groups.

Detainees were treated with respect and we observed staff who were caring and compassionate demonstrating skill in dealing with potential conflict situations and vulnerable detainees. The force should review its policy on observations; detainees who have had their clothes removed for their own safety should be observed by staff of the same gender. Women who have had their clothes removed should not be observed by male staff. The provision of anti-rip clothing would easily address this issue.

We saw good interactions for risk management but custody records revealed gaps in recording. The force had implemented a policy that meant that all domestic abuse cases were dealt with in Mansfield, where the public protection unit was based, but there was little provision for detainees and their safe return home, especially if released late at night.

The police force had actively increased the use of voluntary attendance as an alternative to arrest, thereby reducing an unnecessary burden on custody. Nottinghamshire was part of a pilot scheme encouraging use of legal advice in the suite by some detainees who might otherwise have declined it in case it prolonged their stay in custody. This was a good initiative with positive outcome for detainees.

When we inspected Nottinghamshire, the force adhered to the Police and Criminal Evidence Act definition of a child, treating 17-year-olds as adults, whereas in all other UK law and treaty obligations 17-year-olds are treated as children. We therefore made our standard recommendation calling for appropriate adults to be available to support 17-year-olds as well as other children and young people. In April 2013, the High Court ruled that the PACE definition was incompatible with human rights law, and the government announced that it would accept this judgment. We welcome this move, but will continue to include this recommendation until there is a change in the law.

At the time of inspection, the force was reviewing its arrangements for health care. We were not confident that all detainees received an adequate level of care from the provider of primary care services, and care for those with mental health and/or substance misuse issues varied across the force. Not all staff were trained in using the resuscitation equipment. The force had recognised the problems with the provision of health services by Medacs, and was taking steps to address them. Despite these organisational concerns, there were some examples of excellent individual health care interactions with detainees.

In summary, considerable progress had been made against previous recommendations. The senior management had a responsible approach to improving custody provision, and the physical conditions of custody suites were vastly improved. Individual staff demonstrated a high level of commitment. The force needed to make provision for detainees' safe return home if policy dictated they be transported long distances. Health care generally was an area of concern, but the force was aware of the issues raised.

This report provides a number of recommendations to assist the force and the Police and Crime Commissioner to improve provision further. We expect our findings to be considered in the wider context of priorities and resourcing, and for an action plan to be provided in due course.

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May 2013

2. Background and key findings

2.1 This report is one in a series relating to inspections of police custody carried out jointly by HM Inspectorates of Prisons and Constabulary. These inspections form part of the joint work programme of the criminal justice inspectorates and contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorates of Prisons and Constabulary are two of several bodies making up the NPM in the UK.

2.2 The inspections of police custody look beyond the implementation of the Police and Criminal Evidence Act 1984 (PACE) codes of practice and that Association of Chief Police Officers (ACPO) *Authorised Professional Practice – Detention and Custody* at force-wide strategies, treatment and conditions, individual rights and health care. They are also informed by a set of *Expectations for Police Custody*[1] about the appropriate treatment of detainees and conditions of detention, developed by the two inspectorates to assist best custodial practice.

2.3 There were three custody suites in the Nottinghamshire Police force area, with a total cell capacity of 114. The force had held 37,310 detainees in 2012 and 103 detainees for immigration matters in the same period.

2.4 The designated custody suites and cell capacity of each were as follows:

Custody suite	Number of cells
Bridewell [Nottingham]	72
Mansfield	32
Newark	10

Strategy

2.5 Custody provision was centralised as part of the crime and justice directorate (CJD). We found there was good oversight with clear line management structure, roles and responsibilities. Funding had been approved for continued refurbishment of the current estate, and the improvement in the three suites since our last inspection was impressive.

2.6 Overall there were good meeting structures to oversee custody provision. Meetings were held regularly, with accountability for custody issues and risks at senior levels in the police service. A monthly custody user forum, chaired by a chief inspector, had a good cross-section of representatives, including custody staff. However, there had been no custody management meeting since October 2012 and this gap needed to be addressed.

2.7 Despite the significant progress in implementing our previous recommendations, the force lacked a central cell allocation process to match resources with demands – especially at Newark, where police officers were needed to help out in the custody suite at busy times. The force also needed to consider its practice of taking all those detained on domestic violence

[1] http://www.justice.gov.uk/inspectorates/hmi-prisons/expectations.htm

charges to the Mansfield suite, which particularly affected detainees not from the area as there was little provision to take them home.

2.8 We found that partnership arrangements relating to mental health and children and young people and places of safety needed to be progressed at a much more senior level to secure safe places for vulnerable people.

2.9 Training for custody suite staff was of a good standard with content linked to adverse incidents and complaints monitoring with a pass/fail standard. Quality assurance involved an inspector checking 10 custody records a month per inspector, but this could have been made more robust by including person escort records (PERs), CCTV checks and the handover process as part of the sampling.

Treatment and conditions

2.10 Detainees were generally treated with respect and courtesy. On several occasions we saw staff active in de-escalating potentially volatile situations, and communicating compassionately and carefully with people who were young or vulnerable. Bridewell was a busy custody suite and this sometimes contributed to staff not realising the needs of individuals with disabilities or those who required a greater level of care. On one occasion, we had to intervene to avoid a frail 70 year old man being placed in a holding booth with no seating. Staff could have been more proactive in responding to individual needs if there was better queue management and oversight of the suite, using the custody suites on all floors.

2.11 There were sufficient female detention officers (DOs) to deal with the number of female detainees. However, we observed an occasion when a male DO was tasked to monitor CCTV screens for two women detainees subject to cell observations following self-harm. Their clothing had been removed and one woman was naked from the waist up. In discussion with staff we established that they considered this to be inappropriate practice and had raised this with the management. There was no rip-proof clothing in any of the suites that could be offered in these circumstances, which would have resolved this dilemma and the dignity issues.

2.12 Diversity issues were normally considered properly, with, for example, provision for detainees with disabilities and provision for religious observance. All suites had limited private booking-in space, but staff lacked sufficient sensitivity when discussing information with detainees. Telephone and face-to-face interpreters were used for communicating with non-English speakers, although staff said there were problems in accessing some languages through the telephone service.

2.13 We observed an informed and thorough approach by staff in identifying and responding to risks in all the custody suites. There were appropriate checks when detainees presented with medication. In our custody record analysis and observations we saw that dynamic risk assessment was carried out and reviewed as circumstances changed, but we also identified gaps in recording. There was an appropriate mixture of responses according to detainee need, from constant watches to 60-minutes checks in cell.

2.14 Pre-release risk assessments (PRRA) were completed for all detainees on release but almost all showed that there were no perceived risks for the detainees being released. Despite this, half the detainees had some vulnerability on release. We saw a range of pre-release assessments for detainees being released into the care of mental health workers who were escorted home by officers and/or given directions to access public transport.

2.15 Handovers were generally done from sergeant to sergeant, who then visited and informed the detainees about the handover. DOs were not included in the handover. It is our expectation that handovers should include the whole team, allowing adequate discussion of risks, concerns and welfare of detainees.

2.16 Use of force was not recorded sufficiently to allow the identification of risks, patterns, or inform training and learning from incidents. At the time of the inspection, use of force was recorded on the custody record, which was not designed or used for data analysis.

2.17 The physical condition of the suites was excellent and well maintained. The force had made considerable efforts in responding to our previous recommendations and dealing with the problems we had identified.

2.18 Detainees were generally given adequate bedding, although not enough pillows were provided at Mansfield. There was no evidence or observation to show that showers were regularly used or offered to detainees who had been in custody for a long time. Exercise was available to detainees, and we saw it offered and used at Bridewell.

Individual rights

2.19 All sergeants reported they were willing to question the authorisation and appropriateness of detention. The force's performance statistics indicated that there had been greater use of voluntary attendance as an alternative to arrest and detention. In addition to family and friends, an appropriate adult service was available for young people and vulnerable adults seven days a week until 10pm. This was a good scheme and one of the better ones we have seen. Sergeants reported fewer detainees with immigration issues than at the previous inspection. Rights relating to detention were available in written and audio versions in 54 languages.

2.20 In Bridewell, a Home Office pilot scheme – Blast – allowed some detainees to access an on-site duty solicitor on weekdays between 9am and 5pm. Sergeants offered this service to people who had declined legal advice, perhaps because they thought this would delay their release from custody. Solicitors reported that take-up of this service was considerable at first but had since declined, and they believed that sergeants did not offer it regularly. However, the project was a good initiative.

2.21 Court cut-off times caused some concerns. Staff said they sometimes had difficulties in getting detainees to court, resulting in prolonged stays in custody, an extra burden on custody suites and poor outcome for detainees.

Health care

2.22 Primary health services were provided by Medacs and Nottinghamshire Healthcare NHS Trust. We were not confident that all detainees received an adequate level of care from the provider of primary care services, and care for those with mental health and/or substance misuse issues varied across the force. The force had recognised the problems with the provision of health services by Medacs, and was taking steps to address this. It was also working with NHS commissioners to commission health services on its behalf as soon as practicable.

2.23 Not all nursing staff were trained to use all the resuscitation equipment. Medications management was poor, with too many staff having access to keys, missing medication, and inadequate systems for the audit of missing medications. However, we saw efforts to ensure detainees were provided with their prescribed medications while in custody.

2.24 Mental health provision for detainees varied across the force area, with some good practice in Mansfield and Newark as part of a pilot scheme. There were two Mental Health Act section 136 suites[2] across the force, with two spaces each. We visited one suite and found excellent facilities. However, there were many examples of detainees brought into custody rather than the suite, with the inevitable delays in service as a consequence. This needed resolving at a strategic level.

Main recommendations

2.25 The force should review its policy or guidance on cell observations. Detainees who have had their clothes removed for their own safety should, as far as possible, be observed by staff of the same gender. Rip-proof clothing should be provided to detainees whose clothes have been removed.

2.26 Nurses should be trained to use the full range of resuscitation equipment. (Repeated recommendation 6.11)

2.27 The Police and Crime Commissioner or Chief Officer should engage with health care partners at a strategic level to reduce the number of detainees held in police custody under section 136 of the Mental Health Act 1983.

[2] Section 136 of the Mental Health Act 1983 enables a police officer to remove someone from a public place and take them to a place of safety – for example, a police station. It also states clearly that the purpose of being taken to the place of safety is to enable the person to be examined by a doctor and interviewed by an approved social worker, and for the making of any necessary arrangements for treatment or care.

3. Strategy

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

Strategic management

3.1 An assistant chief constable (ACC) provided strategic leadership on custody, with a centralised custody function through the crime and justice directorate (CJD). A chief superintendent was head of CJD and line managed a police staff head of criminal justice, who in turn line managed the police staff head of custody and chief inspector of custody operations.

3.2 The force estates strategy had led to a reduction to the current three full-time custody suites. Since our previous custody inspection in 2011, funding had been allocated to a refurbishment programme for the estate, which had led to the improved conditions. The Police and Crime Commissioner (PCC) had agreed further funding to maintain and refurbish the estate for the 2013-14 financial year.

3.3 Since the reduction to three custody suites there had been no occasions that had required the unplanned use of other suites or neighbouring forces' custody facilities. There were no stand-by suites.

3.4 Staffing levels in Bridewell and Mansfield suites during the inspection were generally adequate, although there were not enough staff in Newark during periods of high demand and operational staff with no custody training had to assist. Staffing comprised permanent custody sergeants and police staff detention officers (DOs), employed by Nottinghamshire Police. There were some custody sergeant vacancies, which the force had identified in its risk management processes and which needed to be addressed to ensure more effective custody provision for detainees.

3.5 Custody sergeants line managed DOs who looked after the ongoing care and welfare of detainees. DOs were trained to book-in detainees, although we only observed this once during the inspection. In the larger suites, DOs had specific roles and worked effectively to provide a good standard of care.

3.6 There were eight dedicated custody inspectors, two per shift in the north and south of the county, line managing the custody sergeants, who in turn line managed the DOs. There were also two custody site managers (inspectors, north and south) with no line management responsibilities. All inspectors were line managed by the chief inspector of custody operations and head of custody.

3.7 There was an effective meeting structure where custody matters were discussed and reviewed. The deputy chief constable (DCC) chaired a monthly forum where the force action plan was reviewed, and the ACC custody lead was responsible for, among other things, the progress of recommendations from our previous inspection in 2011. The ACC custody lead held a monthly operational support board, where managers were held to account and departmental risk registers and action plans reviewed. There was a custody risk register, with a process for risks to be escalated to the CJD risk register and the force risk register.

3.8 The ACC lead for custody held a fortnightly meeting with the head of CJOM, which considered outstanding custody matters. The ACC held a bimonthly CJOM board meeting, attended by the head of custody, to review performance, including near-misses, bail and constant watches. The head of CJOM's fortnightly senior management team meeting, attended by the head of custody, also covered custody issues. There was a six-monthly custody inspectors meeting chaired by the head of custody. This was not often enough to address changes and to engage managers, but the force was due to make the meetings more frequent.

3.9 There were twice weekly performance meetings chaired by an ACC and attended by the head of custody and the chief inspector of custody operations where custody performance and issues were discussed. There was a monthly custody user forum with a good cross-section of representation, including custody sergeants and DOs. The only gap in the meeting structure was for the custody management meeting, which had not taken place since October 2012. These meetings needed to take place and be more frequent.

Recommendation

3.10 The force should fill custody sergeant vacancies, as identified by its risk management processes, to ensure more effective custody provision for detainees.

Housekeeping point

3.11 Custody management meetings should be reintroduced and take place at frequent intervals.

Partnerships

3.12 There were satisfactory partnership arrangements and active strategic engagement with relevant criminal justice organisations. The chief constable chaired the local criminal justice board (LCJB), which was attended by the ACC custody lead. The chief superintendent CJD chaired the prosecution team performance meeting attended by criminal justice partners.

3.13 The ACC custody lead attended the health care commissioning board, which was overseeing the transfer to the NHS commissioning of health services for police custody. The force was undertaking a health needs analysis as part of the process. However, there were ongoing concerns about mental health provision, particularly the numbers detained under section 136 of the Mental Health Act 1983 who were held in police cells rather than a health service place of safety. The PCC or chief officer needed to engage with health care providers to improve this position (see main recommendation 2.27).

3.14 There was an independent custody visitors (ICV) coordinator in the PCC's office. The ICV scheme consisted of one panel and was active, with a regular schedule of visits. ICVs told us that they were generally admitted to custody suites quickly and questioned police officers on how detainees were treated. ICVs had not identified any particular trends or problems. Ad hoc issues were dealt with and communicated effectively through a monthly report and quarterly meetings. There was consistent police representation from the CJD at the quarterly meetings. ICVs commented on a recent positive increased morale in custody suites. The scheme had received an Investing in Volunteers Award, which was a significant achievement.

Learning and development

3.15 All custody sergeants and DOs had taken a five-week custody-specific training course before undertaking custody duties. The course was linked to the national custody officer learning programme of the College of Policing. The shift pattern for custody staff allowed for four annual training days, one of which was an annual custody refresher training day for all custody staff. The refresher course included national safer detention guidance, the quality assurance process, adverse incidents and complaints monitoring and analysis. This was a comprehensive and robust approach to training.

3.16 An overarching custody policy included standard operating procedures based on ACPO's *Authorised Professional Practice – Detention and Custody*, which was accessible to all staff on the custody intranet. The force was actively consulting on some policies due for review. The Independent Police Complaints Commission (IPCC) *Learning the Lessons* document was also available on the intranet. A quarterly custody newsletter was used effectively to communicate a wide range of custody issues. Staff awareness of the custody intranet site was mixed and needed to be improved.

3.17 The 'adverse incident' process involved the completion of an electronic form by custody sergeants or DOs, which custody inspectors forwarded to the occupational health department. Immediate issues were dealt with by email and reviewed at the weekly criminal justice and custody senior management team meeting. All adverse incidents were analysed and reported at the quarterly health and safety meeting, attended by the head of criminal justice. However, it was unclear how information on these incidents was communicated to frontline staff.

3.18 There was a quality assurance process for sampling custody records. The force audit unit randomly generated 10 custody records a month for each inspector. This process was completed on a corporate template, but tended to be a tick-box approach, and the examples we saw showed no evidence of any qualitative feedback. The examples also did not provide an audit of feedback to individual officers, although there was evidence from one inspector of feedback that was recorded in a sergeant's personal development review. Although we were told that trends and themes from the process were used to inform custody refresher training, the lack of qualitative information would limit this.

3.19 Person escort records (PERs) were no longer included in the sampling process. We observed incorrect information that was endorsed on a PER, which resulted in the delay of the transfer of a detainee to the prison escort contractor and the failure to identify warning markers from the police national computer. Sampling of custody records was not cross-referenced to CCTV recordings. The installation of new CCTV systems provided the opportunity to include this in the process. There was no quality assurance of shift handovers.

Recommendation

3.20 Information on adverse incidents should be clearly communicated to frontline staff.

Housekeeping points

3.21 Staff awareness of the custody intranet site should be improved.

3.22 Quality assurance processes should include the cross-referencing of sampled custody records to CCTV recordings, and include person escort records and shift handovers.

4. Treatment and conditions

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

Respect

4.1 Most detainees we saw were brought into custody suites in police cars, although we saw a few arrive in police vans. We looked at one van at Newark, which had a secure area in the back. A detainee, who had been violent and continued to be belligerent, had been conveyed 28 miles to Newark from Worksop in this secure vehicle. Staff said that it was universally unpopular, with staff and detainees, to travel such long distances to custody suites, especially with violent detainees, as this raised the safety issue for both detainee and arresting officers. The force also needed to review its provision for the safe return of vulnerable detainees who were transported a long way from home.

4.2 Staff engaged with detainees in a professional and courteous manner. At all custody suites, custody sergeants dealt with very vulnerable detainees with patience and sensitivity. Custody sergeants gave vulnerable and fractious detainees the opportunity to calm down and go through the booking-in process.

4.3 The booking-in areas in the Mansfield and Bridewell custody suites were large and at times busy and crowded. There was insufficient privacy and although we saw some sergeants trying to compensate for this, others seemed unaware of potential sensitivities. Booking-in desks at Newark were portioned, although the throughput was much lower with less risk to confidentiality.

4.4 At Bridewell, small clear-fronted holding booths were routinely used to lodge detainees awaiting transfer to the court (they were next door to the court cells). Seating had recently been removed from these booths, and there had been no consideration of how long detainees might be held in these conditions. We observed three detainees who were held for between two and three hours in these booths. We observed another detainee, an elderly and frail man in his 70s, also being lodged in one of these booths, even though there were more appropriate adapted cells (see paragraph 4.6). We felt it necessary to intervene and custody staff subsequently moved him into a holding cell with a seated area. Staff could have responded to individual needs more proactively if there were better queue management and oversight, using all floors of the suite.

4.5 At Newark and Mansfield, staff showed a reasonable awareness of diversity, and ensured that female detainees had a nominated officer to care for them. At Newark, the one detention officer and one custody sergeant on each shift worked closely together and were able to tailor their responses to detainees brought into the custody suite. At Bridewell, officers often treated all detainees the same and failed to recognise that some had specific needs that might affect their time in the custody suite.

4.6 We observed one detainee in a wheelchair being booked-in at Bridewell. He was not taken to the slightly lower discrete desk (see paragraph 4.4) but was booked-in at the general desk, with a large height difference between him and the custody sergeant. As well as the issue of respect, this did little to facilitate good communication. We later spoke to this detainee in his cell and he said that he had been treated well but he had not been asked about his mobility

restrictions or, for example, whether he could get to the toilet unaided or lie on the bench or reach the call bell.

4.7 All female detainees were asked if they might be pregnant and if they wanted to speak to a female member of staff about any welfare issues. There were designated cells for female detainees at Bridewell and technically elsewhere, but in practice, at times of high demand all cells were used irrespective of the sex of the detainee. Staffing at Bridewell and Mansfield had a good gender mix so there was always a female DO available to search or speak with a female detainee. During the inspection there were only two male custody staff on duty at Newark, and they told us that they would have to request a female member of staff to attend the suite if needed.

4.8 At Bridewell we observed two female detainees, located in separate corridors, who had been harming themselves. Both detainees had their clothing removed and at one point both were in their cells without any clothing from the waist up. At this time a male detention officer was conducting constant observations of four detainees, including the two women, via CCTV (level three observations - Approved Professional Practice (APP) requires such observations to be a constant and uninterrupted watch by camera, tasked to one person). Despite the women's state of undress, there had been no consideration of getting a female DO to do this observation. A male officer was asked by a custody sergeant to conduct close proximity observations outside the cell of one of the female detainees, who was still naked from the waist up. This was not appropriate and the officer was, rightly, reluctant to do this. The matter was eventually resolved and a female DO spoke with the detainee and persuaded her to put on a T-shirt.

4.9 There were four designated cells for children and young people under 17 at Bridewell but none at Mansfield or Newark. At Newark we were told that children and young people would be permitted to wait on a bench in the booking-in area or in a side room with their appropriate adult, if there were no risk issues and they were soon due to be interviewed. At Bridewell, this was facilitated if staffing and space allowed, and we saw this happen. We observed children and young people under 17 being brought into the custody suites with their appropriate adult for interview, and custody sergeants using appropriate language so that the young person could understand. They also ensured that the appropriate adult understood what was going to happen.

4.10 Custody sergeants asked all detainees, both male and female, thoroughly and clearly whether they had dependants, and we observed efforts to make arrangements, in consultation with the detainee, for children who needed to be collected from school. Sergeants had a good awareness of safeguarding issues affecting young people or vulnerable adults.

4.11 All detainees were asked when they were booked in if they had any religious dietary needs. Prayer mats, a Qur'an, and several Bibles were available at all custody suites and stored respectfully. Bridewell had a room that detainees could use to pray in. It was not clear if detainees were made aware of this room or how often it was used. During the inspection the key to this room could not be located. Cells did not have the direction of Mecca indicated, although there were compasses attached to the prayer mats.

4.12 There were no hearing loops or Braille material at any custody suite.

4.13 Custody sergeants and DOs were aware of the needs of transgender detainees when they were searched, and asked them if they had a preference for the gender of DO doing the search.

Recommendations

4.14 Booking-in areas should provide sufficient privacy to facilitate effective communication between staff.

4.15 The booking-in process in the Bridewell custody suite should be more efficient and use all available capacity on available floors to reduce queues on the ground floor.

Housekeeping points

4.16 Detainees should only be held in the Bridewell holding booths for short periods.

4.17 Staff should receive guidance about conducting constant observations via CCTV of detainees who might have had their clothing removed.

4.18 Hearing loops should be supplied in the booking-in areas.

Safety

4.19 We observed custody sergeants carrying out the initial risk assessment thoroughly, in particular with detainees who had mental health concerns. Custody sergeants explained the purpose of the assessment to the detainees. They asked probing questions if detainees divulged that they had harmed themselves in the past, and sometimes asked to look at detainees' arms for any marks. Our custody record analysis confirmed that all detainees were risk assessed on arrival into custody.

4.20 At Newark and Mansfield we observed good communication between custody sergeants and detention officers. However, this was not always the case at Bridewell. Here, some DOs worked directly alongside custody sergeants – conducting cell visits, assisting with searching and generally looking after the welfare of detainees – while others conducted 'general duties', which included level three observations completing paperwork and answering cell call bells. Sergeants did not assume full control of the suite and while DOs were competent to deal with incidents, sometimes the lack of oversight led to poor communication about detainees.

4.21 The different levels of observations of detainees generally correlated with the risk assessment. At Bridewell, DOs carried out level three (CCTV) observations in a separate room for no more than 30 minutes at a time. A notice in the room outlined their duties and DOs were reminded whilst conducting these observations, not to read newspapers or use the telephone. This location enabled the DO to concentrate on the CCTV without interruption. At Newark and Mansfield, level three observations took place at or next to the custody desk by a dedicated DO or police officer.

4.22 In our custody record analysis, the level of observation that detainees were placed on was generally appropriate, but sometimes the recorded rationale was unclear. Observation levels were generally met. Our analysis showed that observation levels were altered as the detainee's situation changed. This included reducing the level of observation as detainees became less intoxicated, moving a detainee in custody for the first time from 30-minute to 60-minute visits, and increasing the observation level for a detainee when she made comments about wishing to harm herself.

4.23 Children and young people under 17 were generally placed on 30-minute observations. During the inspection, some police officers were engaged in level four observations (close proximity). At Bridewell, the officer undertaking this task told us that she had been briefed by the outgoing officer rather than the custody sergeant. The officer did not record any interaction with the detainee or any observations about their mood. However, at Newark we saw a custody officer clearly brief a police officer tasked with such an observation and a log commenced.

4.24 Staff had a good understanding of rousing procedures for detainees who were intoxicated. Custody sergeants, in liaison with health care professionals, took the decision when rousing should cease.

4.25 All the cells in all custody suites were covered by CCTV. At Newark, there were two cells designated as `vulnerable` cells at the front of the custody suite, which were generally reserved for detainees requiring closer observations or later to take forensic samples. Boards covering the windows could be removed so the occupant could be supervised from the booking-in area, which we observed happening.

4.26 Staff on most shifts carried anti-ligature knives. There was no rip-proof clothing in any custody suite (see main recommendation 2.25).

4.27 Arrangements for staff handovers were poor. At Bridewell, custody sergeants were each allocated responsibility for a number of cells on the ground floor and handed over information about the detainees in those cells to the incoming custody sergeant. Detention officers handed over to each other separately. It was unclear why all incoming and outgoing custody staff could not have a collective handover. At Newark and Mansfield the practice was the same, although less of an issue at Newark due to the small number of staff.

4.28 Pre-release risk assessments (PRRA) were completed for all detainees on release but almost all showed that there were no perceived risks for the detainees being released. Despite this, half the detainees in the sample (15) had to be released into the care of mental health workers or escorted home by officers. This suggested there may have been additional risks that were not recorded.

4.29 We heard of many examples at Mansfield where detainees were released to make their way home to the Newark and Worksop areas. Nottinghamshire Police policy was, wherever possible, to convey all those detained for domestic abuse allegations in the Mansfield, Newark and Worksop areas to the custody suite at Mansfield – the base for the public protection unit that specialised in domestic abuse cases. Travel warrants were not available for these detainees on release, who had to rely on police officers taking them home, relatives picking them up, or simply finding their own way on public transport.

Recommendations

4.30 Frequency of observations of detainees should be strictly adhered to so that risk can be managed adequately.

4.31 Handovers should be comprehensive and attended by detention officers and police custody staff, with the area in which the handover takes place cleared of other staff and detainees. (Repeated recommendation 4.16)

4.32 The recording of pre-release risk assessment should be improved and cover the advice or support offered to detainees before their release, including means of getting home.

Housekeeping point

4.33 Custody sergeants at Bridewell should have improved oversight of the work of the detention officers.

Use of force

4.34 All staff had been trained in approved safety techniques and received annual refresher training. We observed good communication between custody sergeants and officers relating to detainees.

4.35 There was a requirement to record all use of force. However, staff were unsure about the level of force that could be used which required recording. For example, a detainee was brought into the custody suite handcuffed, and in a very belligerent state. Staff needed to remove his clothing for forensic purposes but the detainee would not comply. He was forcibly restrained by four officers and his clothing removed and replacement clothing put on. He was taken to another cell by several officers and still handcuffed. This was done in a very professional manner and in line with use of force training that all staff had received. Another example was the incident described in paragraph 4.8. On neither occasion was a use of force form completed, When we queried these incidents with the custody staff, it was clear that they were fully aware of the use of force form, but had not considered submitting one. Staff needed further guidance about when it was appropriate to submit the form. Use of force forms were not collated or analysed by the force to identify trends or practice points.

4.36 We did not observe any strip searches authorised by custody sergeants but we were told that they would be considered for detainees who had committed specific drug-related offences and might have drugs secreted, and for detainees who had warning markers on the PNC for concealing prohibited items.

Recommendation

4.37 Nottinghamshire police should collate the use of force in accordance with Association of Chief Police Officers' policy, and custody staff should be given training or advice on when to submit a use of force form.

Physical conditions

4.38 The condition of the custody suites was good and most, if not all, cells had been redecorated since the last inspection, when we were very critical of their poor condition, especially at Bridewell. Considerable effort had been made by Nottinghamshire Police to refurbish and maintain all three suites to a good standard.

4.39 There were cleaning regimes in all the suites and we were told that responses to maintenance requests were reasonably swift. This was most evident at Bridewell, where a full-time janitor had been employed. In addition to the cleaning staff, we also observed detention officers cleaning cells, mopping floors and wiping down mattresses and pillows when cells became vacant. The toilets in the cells were clean, and notices in all cells warned occupants they would be charged if they damaged the cells. Before a detainee was released, a detention officer inspected the cell to ensure that there was no damage, and this was recorded on the custody log. This was an effective system of ensuring that the cells were kept relatively clean and well maintained.

4.40 There were records in all custody suites of weekly checks of the cells and detention rooms, as well as emergency life saving equipment. Checks included cell call bells, quality of mattresses and pillows, and potential ligature points arising from cell damage, wear or fault. Custody staff said that cells were checked daily and recorded on the custody records. However, cell call bells were usually only checked weekly.

4.41 Although the condition of Bridewell was now much improved, there were problems with the design of the building. Several cells lacked natural light, and some cells on the ground floor were in recesses off small corridors, which affected good sightlines and made some areas very confined.

4.42 It was very common to see non-custody staff taking keys and going to cells, either to take detainees to or from interview or sometimes responding to call bells. Our expectation is that only trained custody staff should visit cells. However, due to low staffing levels, especially at Newark, this could not have been achieved without significantly affecting the operation of the suite. This was less of an issue at Bridewell, which had higher staffing levels.

4.43 At all three suites, the use of cell call bells was explained to all detainees when they were placed in a cell. We saw custody staff responding promptly to cell call bells.

4.44 All suites had a fire evacuation policy and fire safety audits completed in the current year, but there was no record of fire evacuation exercises. Sets of handcuffs were available for evacuation. Smoking was not permitted in the custody suites.

Housekeeping points

4.45 All cell call bells should be checked daily.

4.46 Visits to cells should be undertaken only by custody staff, or if necessary accompanied by them.

Detainee care

4.47 Every cell in the Bridewell and Newark custody suites had a mattress and pillow or a combined mattress/pillow, but supplies of these varied in Mansfield. All mattresses and pillows were wiped clean between use by the detention officers. We found a good stock of clean anti-rip blankets, which were distributed throughout the day and night. All cells, except 'vulnerable' cells (see paragraph 4.25) and those for children and young people under 17, had in-cell sanitation and handwashing facilities. Suites had a clean toilet area with handwashing facility, soap and towel in the same corridor as the children and young people's cells. The other communal hand washbasins and toilets were in good condition. We observed that toilet paper was handed out only when a detainee requested it, which was inappropriate.

4.48 Showers were clean in all suites. Those at Bridewell were reasonably private, but the showers at Newark and Mansfield needed careful supervision to ensure privacy, particularly for female detainees. Custody staff at all suites told us that showers were facilitated if requested by detainees, and sometimes offered to those held overnight. In our custody record analysis, only two detainees (7%) were recorded as having access to washing facilities while in custody – one, a 13-year-old boy, was detained for less than one hour, and the other, a woman, was detained for up to seven-and-a-half hours. There was no reference in any other logs to detainees being offered showers, although one was held for over 23 hours before going to court and a second for 28 hours before transfer to an immigration removal centre. We spoke to

a couple of detainees who had been detained overnight, and neither had been offered a shower.

4.49 Toiletries, such as toothpaste and soap, were available. There was a variety of sanitary products for women but they were not routinely offered, although there was a notice about their availability in the booking-in areas.

4.50 Replacement clothing, including underwear, was available at all suites but there were limited stock at Newark.

4.51 Food preparation areas were clean. We observed meals given to detainees at designated mealtimes and we were told that meals would be provided outside these times if needed. All suites had a stock of microwave meals, which met a range of dietary requirements.

4.52 In our custody record sample, 21 detainees (70%) had been offered at least one meal while in custody. Nine of these (43%) had accepted at least one meal, and the remaining 12 (57%) refused the meals offered. The custody logs showed that meals were only offered at designated mealtimes, with breakfast between 7am and 9.30am, lunch between noon and 1pm, and an evening meal between 5pm and 6pm. One detainee at Mansfield was given a halal meal but there was no reference to other specific meals in the custody logs. The food preparation areas were clean.

4.53 There were clean exercise yards in all the suites, and we saw several people using these at Bridewell. We were told that exercise at Newark and Mansfield was only facilitated if a detention officer had the time to stand in the yard with the detainee or observe them on the CCTV.

4.54 There was very limited reading material for detainees, mostly old newspapers and magazines, and nothing in foreign languages, easy-read formats or specifically for younger people. Only two detainees in our sample (7%) were given reading material during their detention – one was detained for seven hours and 20 minutes and the other for 21 hours and 42 minutes. Family visits were not routinely permitted at Bridewell or Mansfield, but we were told at Newark that they were facilitated if it was felt they would assist the detainee. An example given was a detainee held over the weekend and likely to be remanded into custody, whose partner was permitted to come and see him. Mansfield had some excellent closed visit facilities but we were told that they were never used.

Recommendation

4.55 All detainees held overnight, or who require one, should be offered a shower, which they should be able to take in private. (Repeated recommendation 4.36)

Housekeeping points

4.56 There should be sufficient pillows in all the custody suites.

4.57 Toilet paper should be routinely provided in each cell.

4.58 Hygiene packs should be routinely offered to female detainees.

4.59 Custody suites should stock a suitable range of reading material for detainees, including young people, non-English speakers and those with limited literacy.

4.60 Where appropriate, visits should be facilitated for children and young people, vulnerable adults or those held for long periods.

5. Individual rights

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

Rights relating to detention

5.1 We observed detainees being booked-in shortly after arrival at the custody suites, although at Bridewell, the high numbers of detainees meant that some waits could be up to 40 minutes. Custody sergeants checked the reasons for detention with arresting officers to ensure there were appropriate grounds. Sergeants told us they were confident in refusing detention when the circumstances did not merit arrest. Alternatives to custody were available, such as restorative justice programmes and voluntary attendance, and many operational police officers who we spoke to were very familiar with these approaches.

5.2 Custody sergeants were clear about their obligations to ensure that cases proceeded quickly, and we did not see many detainees who had been held for an excessive time. In our custody record analysis, only one detainee had been held for more than 24 hours (just over 28 hours).

5.3 Staff assured us the custody suites were never used as a place of safety for children under section 46 of the Children Act 1989.[3]

5.4 Reviews of detainees in custody were undertaken by custody inspectors, one of whom covered Bridewell (Nottingham) and one who covered Newark and Mansfield (county). The majority of reviews we observed were done face-to-face, and detainees could make clear representations about their continued detention. We also saw some telephone reviews, which were also carried out in accordance with PACE. Most were carried out on time or earlier including one detainee at Bridewell who was reviewed one hour after detention. Most detainee reviews not held face to face did not log if the detainee had been reminded of their rights.

5.5 The number of immigration detainees held in custody suites in Nottinghamshire had more than halved, from 212 in 2010 to 103 in 2012. We were told that staff had a good relationship with UK Border Agency staff.

5.6 At the time of the inspection, the force adhered to the PACE definition of a child instead of that in the Children Act 1989,[4] which meant those aged 17 were not provided with an appropriate adult (AA) unless they were otherwise deemed vulnerable. Family members or friends were usually contacted in the first instance to act as an AA. When it was not possible to contact them, the privately provided 'TAAS' (The Appropriate Adult Service) scheme provided cover for both children and young people and vulnerable adults every day between 8am and 10.30pm, and staff reported no difficulties with attendance times. At Bridewell, we observed an AA from the scheme attending during office hours within 30 minutes of being contacted.

5.7 In our custody record analysis, there were five young people aged under 17 (17%). Four had an AA present while they were read their rights, and two who were interviewed had their AA

[3] Section 46(1) of the Children Act 1989 empowers a police officer, who has reasonable cause to believe that a child would otherwise be likely to suffer significant harm, to remove the child to suitable accommodation and keep him/her there.

[4] In all other UK law and international treaty obligations, 17-year-olds are treated as children. In April 2013, the High Court ruled that the PACE definition was incompatible with human rights law.

present. One detainee had been arrested at 10.30pm for being drunk and disorderly, and did not have an AA present when his rights were given. He wanted his mother to be contacted but she was not located until 10.05am the following morning, and she attended custody shortly thereafter. The risk assessment was repeated in her presence but there was no additional record of rights attached to the custody log that contained the AA's signature. The young person was not charged and was released shortly afterwards but had been in detention for almost 12 hours before an AA attended. Another young person had to wait over five hours for an AA to attend. After four hours of efforts to trace her mother, custody staff contacted the scheme provider who attended within the hour.

5.8 During the booking-in, staff gave detainees a very detailed and informative leaflet summarising their rights and entitlements. A similar version could be downloaded and printed for non-English speakers in their own language (54 were available), and could be played through an audio version, but custody staff were not aware that an easy-read pictorial format was also available on their website. The rights and entitlements documentation was not available in Braille. There were five foreign nationals (17%) in our custody record sample, and it was clear that four had been given their foreign national rights, but this was not clearly recorded in the fifth case. Only one of these detainees requested that their embassy be informed of their detention, and the custody log recorded that their embassy had been faxed.

5.9 We observed several foreign national detainees being booked-in. A professional telephone interpreting service was used during the booking-in process through double handset telephones, which allowed a three-way conversation. Staff told us that the telephone interpreting service was increasingly unable to provide interpreters for some languages. We observed a Lithuanian detainee who had been arrested at 2.45am who did not receive his rights and entitlements until 12.25pm due to the non-availability of an interpreter in his language. Staff told us that a face-to-face interpreter service was available for interviews. In our custody record analysis, one detainee who was recorded as not able to read or write in English was provided with an interpreter during his booking-in. However, the custody log later indicated that he 'appears to hold a good conversation and does understand', and he was subsequently interviewed without an interpreter present. In a second case, interpreting services were used to book-in and interview a foreign national detainee.

Recommendation

5.10 Appropriate adults should be available at all times without undue delay to support detained children and young people aged 17, provided that informed consent has been given.

Housekeeping points

5.11 Reviews of detainees should be carried out on time.

5.12 Where a detainee's rights and entitlements are not given on arrival at the custody suite, or where a detainee is reviewed while asleep, custody records should be endorsed to show that the detainee was informed or reminded of their rights when they awoke.

5.13 Custody staff should be made aware that detainees' rights and entitlements are available in an easy-read pictorial format on the force website to give to detainees.

Rights relating to PACE

5.14 We observed detainees being told during their booking-in that they could read the PACE codes of practice. Not all staff were aware that the copies of the code they held were out of date and had been superseded by a 2012 edition. At Bridewell, we observed an old copy of the code being issued to a detainee.

5.15 We were told at Bridewell that the second phase of a Home Office pilot project, 'Blast', was in place. Under this scheme, an on-site duty solicitor was available to detainees on weekdays between 9am and 5pm. The scheme (which did not apply to arrest on warrants, breach of bail or bail backs to the station) aimed to encourage detainees to accept legal advice, as this service was sometimes refused by detainees who believed that they would have a longer stay in custody waiting for a solicitor to attend. We saw the scheme operating effectively. Two detainees who took it up were able to consult with the duty solicitor within five minutes of their agreement. Solicitors involved in the scheme said that initial uptake had been considerable, but the numbers had fallen and they felt that custody staff were not as active as they should have been in offering it. The pilot project had yet to be evaluated but seemed to be a good initiative.

5.16 None of the Nottinghamshire suites displayed the Criminal Defence Service poster advising on free legal advice.

5.17 Solicitors said they thought custody staff adhered to PACE and were positive about how they and their clients were dealt with. However, several voiced concern about the lack of soundproofing in the solicitor consultation rooms at the Bridewell suite.

5.18 In most cases solicitors were contacted quickly, but sometimes contact was not made swiftly. For example, one detainee who arrived into custody intoxicated was placed on 30-minute rousing, which was reduced about five hours later, but there was a further three-hour delay before staff contacted the detainee's solicitor. The detainee had not been seen by a health care professional during this time and so was not deemed unfit to process, but there was nothing recorded to indicate why staff had waited approximately eight hours before contacting the detainee's solicitor. In another case, a detainee's solicitor was not contacted until 3.5 hours into their detention, with no reason recorded for this delay.

5.19 We observed detainees being told they could inform someone of their arrest. In our custody record analysis, all detainees were offered the opportunity of having someone informed of their arrest. Although 10 detainees (33%) requested this, it only took place in five cases. In the other five cases, either the nominated person had not been contacted or the custody logs did not make it clear that they had been contacted.

5.20 DNA samples taken from arrested persons were correctly stored and collected from all suites almost every day.

5.21 Detainees were transported to court on time with court cut-off times of 2.15pm on weekdays and 11am at weekends, with some flexibility from day to day. We saw one detainee who was accepted at court at 3pm. A prisoner escort contractor was available to transport detainees for both morning and afternoon courts. If the contractor was unable to meet its contract for transportation to afternoon courts, police officers said they would take detainees in police vehicles to ensure they did not remain in custody longer than necessary.

Housekeeping points

5.22 There should be sufficient up-to-date copies of the PACE codes of practice in all custody suites.

5.23 Suites should display the Criminal Defence Service poster on free legal advice.

5.24 The solicitor consultation rooms at the Bridewell suite should be soundproofed.

5.25 When requested, solicitors should be contacted with no undue delay.

5.26 Police should inform a person nominated by the detainee of their arrest, and record this in the custody log.

Rights relating to treatment

5.27 The notice of rights and entitlements, which all detainees received on being booked-in, detailed the processes for making a complaint. Custody staff told us that if a detainee wished to make a complaint, they would immediately advise the custody inspector. Custody inspectors confirmed they would note complaints from detainees while they were still in custody. In addition, custody staff at both Mansfield and Newark had access to copies of the Independent Police Complaints Commission (IPCC) literature to give detainees if they were undecided about whether they wished to proceed with a complaint. The force collected data on complaints and analysed patterns and trends. This information was shared with staff working in and managing custody.

6. Health care

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

Governance

6.1 Primary health services were provided by Medacs, and Nottinghamshire Healthcare NHS Trust (the Trust) provided mental health services across the force area. Substance misuse services were provided by the Trust in the county area and the Nottingham criminal justice integrated team (CJIT) team at Bridewell. We were not confident that all detainees received an adequate level of care from the provider of primary care services, and care for those with mental health and/or substance misuse issues varied across the force. The force had recognised the problems with the provision of health services by Medacs, and was taking steps to address them. It was also working with NHS commissioners to commission health services on its behalf as soon as practicable.

6.2 There was a lack of contract oversight and management. There were inadequate clinical governance arrangements for Medacs staff, including a lack of staff training, clinical supervision, appraisals and support. Several of the nursing staff were bank or agency staff and we were not satisfied that they had all received adequate training to be working on their own in the custody suites. Our previous recommendation on the need for clinical meetings and clinical supervision had not been achieved.

6.3 The contract stated that there were two nurses and one doctor on duty for the force area at all times, but we were told of many occasions when this was not the case.

6.4 The clinical rooms were reasonable, but not all were located in the right place and they were cluttered, untidy and did not meet all infection control measures, despite our previous recommendation. The clinical room on the upper floor of the Bridewell suite had no handwashing facilities, only the room at Mansfield had a couch roll, and none of the sharps bins were signed or dated.

6.5 Resuscitation kits were comprehensive and checked regularly. They included oxygen, suction and pulse oximitery (for measuring oxygen in blood). Each suite had an automated external defibrillator, held behind the custody desk for ease of access. All the custody staff we spoke to were trained to use the equipment and were confident in doing so. Not all nursing staff were trained to the same standard (see main recommendation 2.26).

Recommendations

6.6 Clinical meetings should be reinstated, clinical supervision should be available for all clinical staff and a programme of clinical audit should be established to monitor the quality of patient care. (Repeated recommendation 6.9)

6.7 Action should be taken to refurbish the environment and reduce infection control risks. Cleaning services in health care should meet professional standards of cleanliness and infection control. (Repeated recommendation 6.10)

Patient care

6.8 Detainees were asked whether they wanted to see a health care professional when they were booked in. At Bridewell and Mansfield, nurses were on site so were sometimes available immediately. In all instances, custody staff contacted Medacs call centre to request a health professional so that the time of arrival could be monitored. In our analysis of custody records, six detainees (20%) had been seen by a health care professional. Medical records were held electronically on the national strategy for police information systems (NSPIS), the police IT system. The majority of logs recorded the time the health care professional was requested and the time they were seen. The longest wait was approximately two hours and 39 minutes, and the average waiting time was 58 minutes.

6.9 Several types of clinical records were used. Some of the permanent nurses had access to the Medacs clinical IT system. However, this did not provide a means of recording patient consent to share information, so some supplemented the electronic system by also recording written or verbal consent on a clinical pro forma. Other nurses only used the paper pro forma and doctors used a different pro forma. The nurses' paper records were stored at Bridewell or Mansfield; in both suites we found records in unlocked cupboards. There was nowhere to store the records at Newark. Doctors took their records away with them, which contravened the Medacs policy on the taking and storage of contemporaneous records. Some clinical records we looked at were poor, although those on NSPIS had sufficient information.

6.10 We saw and were told about some examples of excellent nursing care, with staff making efforts to ensure patients were dealt with and referred appropriately.

6.11 Detainees were able to receive prescribed medication if required. Permanent nursing staff worked to patient group directions, enabling them to supply and administer prescription-only medicine, although it was unclear whether all had received adequate training on their use. In our sample, 10 detainees (33%) said they were on medication on arrival in custody, four of whom required this medication while in custody, and two detainees at Mansfield received some or all of their medication.

6.12 We saw evidence of detainees who had a prescription for opiate-substitution medication receiving it while in custody. The health care professional also made efforts to arrange for the detainee's methadone prescription to be collected before they were taken to court. When this was not possible, alternative medication was provided. In one good example, a nurse who saw a detainee who was displaying mild signs of alcohol withdrawal and was also dependent on methadone held a telephone consultation with her doctor to authorise her to take her own medication for alcohol withdrawal while in custody.

6.13 We had concerns about the stock management and storage of medications, including those liable to abuse. We identified that there were medications missing, and also found previous examples of missing medications that were not known to either Medacs managers or the police. Not all the discrepancies could be attributed to poor recording. In one instance, 84 paracetamol tablets were unaccounted for. We told the local accountable officer about the discrepancies for scheduled drugs.

6.14 Drug reference guides were woefully out of date. As a consequence, staff could not identify a detainee's medications, which was a concern.

Recommendations

6.15 All clinical records should include consent from the detainee to share information with relevant personnel, and should be stored in accordance with Caldicott guidelines on the use and confidentiality of personal health information.

6.16 All medications should be stored safely and securely, and any discrepancies in stock should be thoroughly investigated.

Substance misuse

6.17 Provision for detainees with substance misuse issues varied across the force area. Detainees were routinely offered the assistance of drugs workers during the initial risk assessment. In Mansfield and Newark, Nottinghamshire county criminal justice interventions team (CJIT), part of the NHS Trust, provided a comprehensive service. The team was available every day. As well as taking referrals from the police following positive drug tests, it also checked NSPIS to see if anyone already known to services was in custody. The team saw detainees with both drugs and alcohol issues, and had one worker specifically for those with alcohol problems. The team could see clients quickly following their release from custody and supported them appropriately. In the previous six months, the team had seen 868 clients in police custody, of whom 527 (60) were new to the team. Just under one-third of those seen reported alcohol as their primary substance of misuse.

6.18 At Bridewell, services were provided by the CJIT team employed by the probation service. Workers only saw detainees with class A drug use. They referred other detainees with substance misuse issues on to other services, but did not follow them up.

6.19 In both services, needle exchange was available, but was not well advertised and was rarely used.

Recommendation

6.20 There should be comprehensive and appropriate services for drug and alcohol users across the force area.

Mental health

6.21 Provision for detainees with mental health issues varied across the force area. At Mansfield, there was an excellent pilot criminal justice liaison team, run by the Trust. It had access to NSPIS so checked every detainee against the Trust's own records to see if they had had previous contact with mental health services. The team saw, referred and supported people in custody. The pilot had yet to be evaluated, but staff said they were in favour of the scheme being available across the force area.

6.22 Bridewell had to rely on the Trust's crisis team to handle detainees with mental health needs. We found examples of unacceptably long waits for the team, at all times of the day and night.

6.23 Police staff had received some training in mental health issues, but most said that they would value more.

6.24 In 2012, there had been 248 cases where people were held under section 136 of the Mental Health Act[5] in police custody. In 2011 the figure was 272. In both years, this was approximately 26% of the total of section 136 detentions in the county. There were two section 136 suites in Nottinghamshire, each with two spaces. We visited one of the suites and found excellent facilities. We were told that each suite only ever accepted one patient at a time, due to staffing constraints.

6.25 We witnessed the inappropriate use of police custody for individuals detained under section 136 and were given many other examples. Staff told us of a 'daily battle' with other agencies to move section 136 detainees to appropriate facilities (see main recommendation 2.27). However, we saw them looking after such detainees professionally and with empathy.

6.26 Police staff met with the local health trust at an intermediate operational group, which reviewed any mental health issues that had not been resolved locally and made recommendations on multi-agency policy and procedure. However, the force had recognised that issues of inappropriate use of police stations to hold people with mental health needs were often not raised at this forum

Recommendation

6.27 The comprehensive service for detainees with mental health issues should be available across the force area as soon as practicable.

[5] Section 136 of the Mental Health Act 1983 enables a police officer to remove someone from a public place and take them to a place of safety – for example, a police station. It also states clearly that the purpose of being taken to the place of safety is to enable the person to be examined by a doctor and interviewed by an approved social worker, and for the making of any necessary arrangements for treatment or care.

7. Summary of recommendations

Main recommendations

7.1 The force should review its policy or guidance on cell observations. Detainees who have had their clothes removed for their own safety should, as far as possible, be observed by staff of the same gender. Rip-proof clothing should be provided to detainees whose clothes have been removed. (2.25)

7.2 Nurses should be trained to use the full range of resuscitation equipment. (2.26, repeated recommendation 6.11)

7.3 The Police and Crime Commissioner or Chief Officer should engage with health care partners at a strategic level to reduce the number of detainees held in police custody under section 136 of the Mental Health Act 1983. (2.27)

Recommendations

Strategy

7.4 The force should fill custody sergeant vacancies, as identified by its risk management processes, to ensure more effective custody provision for detainees. (3.10)

7.5 Information on adverse incidents should be clearly communicated to frontline staff. (3.20)

Treatment and conditions

7.6 Booking-in areas should provide sufficient privacy to facilitate effective communication between staff. (4.14)

7.7 The booking-in process in the Bridewell custody suite should be more efficient and use all available capacity on available floors to reduce queues on the ground floor. (4.15)

7.8 Frequency of observations of detainees should be strictly adhered to so that risk can be managed adequately. (4.30)

7.9 Handovers should be comprehensive and attended by detention officers and police custody staff, with the area in which the handover takes place cleared of other staff and detainees. (4.31, repeated recommendation 4.16)

7.10 The recording of pre-release risk assessment should be improved and cover the advice or support offered to detainees before their release, including means of getting home. (4.32)

7.11 Nottinghamshire police should collate the use of force in accordance with Association of Chief Police Officers' policy, and custody staff should be given training or advice on when to submit a use of force form. (4.37)

7.12 All detainees held overnight, or who require one, should be offered a shower, which they should be able to take in private. (4.55, repeated recommendation 4.36)

Individual rights

7.13 Appropriate adults should be available at all times without undue delay to support detained children and young people aged 17, provided that informed consent has been given. (5.10)

Health care

7.14 Clinical meetings should be reinstated, clinical supervision should be available for all clinical staff and a programme of clinical audit should be established to monitor the quality of patient care. (6.6, repeated recommendation 6.9)

7.15 Action should be taken to refurbish the environment and reduce infection control risks. Cleaning services in health care should meet professional standards of cleanliness and infection control. (6.7, repeated recommendation 6.10)

7.16 All clinical records should include consent from the detainee to share information with relevant personnel, and should be stored in accordance with Caldicott guidelines on the use and confidentiality of personal health information. (6.15)

7.17 All medications should be stored safely and securely, and any discrepancies in stock should be thoroughly investigated. (6.16)

7.18 There should be comprehensive and appropriate services for drug and alcohol users across the force area. (6.20)

7.19 The comprehensive service for detainees with mental health issues should be available across the force area as soon as practicable. (6.27)

Housekeeping points

Strategy

7.20 Custody management meetings should be reintroduced and take place at frequent intervals. (3.11)

7.21 Staff awareness of the custody intranet site should be improved. (3.21)

7.22 Quality assurance processes should include the cross-referencing of sampled custody records to CCTV recordings, and include person escort records and shift handovers. (3.22)

Treatment and conditions

7.23 Detainees should only be held in the Bridewell holding booths for short periods. (4.16)

7.24 Staff should receive guidance about conducting constant observations via CCTV of detainees who might have had their clothing removed. (4.17)

7.25 Hearing loops should be supplied in the booking-in areas. (4.18)

7.26 Custody sergeants at Bridewell should have improved oversight of the work of the detention officers. (4.33)

7.27 All cell call bells should be checked daily. (4.45)

7.28 Visits to cells should be undertaken only by custody staff, or if necessary accompanied by them. (4.46)

7.29 There should be sufficient pillows in all the custody suites. (4.56)

7.30 Toilet paper should be routinely provided in each cell. (4.57)

7.31 Hygiene packs should be routinely offered to female detainees. (4.58)

7.32 Custody suites should stock a suitable range of reading material for detainees, including young people, non-English speakers and those with limited literacy. (4.59)

7.33 Where appropriate, visits should be facilitated for children and young people, vulnerable adults or those held for long periods. (4.60)

Individual rights

7.34 Reviews of detainees should be carried out on time. (5.11)

7.35 Where a detainee's rights and entitlements are not given on arrival at the custody suite, or where a detainee is reviewed while asleep, custody records should be endorsed to show that the detainee was informed or reminded of their rights when they awoke. (5.12)

7.36 Custody staff should be made aware that detainees' rights and entitlements are available in an easy-read pictorial format on the force website to give to detainees. (5.13)

7.37 There should be sufficient up-to-date copies of the PACE codes of practice in all custody suites. (5.22)

7.38 Suites should display the Criminal Defence Service poster on free legal advice. (5.23)

7.39 The solicitor consultation rooms at the Bridewell suite should be soundproofed. (5.24)

7.40 When requested, solicitors should be contacted with no undue delay. (5.25)

7.41 Police should inform a person nominated by the detainee of their arrest, and record this in the custody log. (5.26)

Appendix I: Inspection team

Maneer Afsar	HMIP team leader
Gary Boughen	HMIP inspector
Vinnett Pearcy	HMIP inspector
Fiona Shearlaw	HMIP inspector
Paul Davies	HMIC inspector
Mark Ewan	HMIC inspector
Elizabeth Tysoe	HMIP health services inspector
Keith Williamson	Care Quality Commission inspector
Rachel Murray	HMIP researcher
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Appendix II: Progress on recommendations from the previous report

The following is a list of all the recommendations made at the previous inspection. The reference numbers at the end of each recommendation refer to the paragraph location in the previous report. If a recommendation has been repeated in the main report, its new paragraph number is provided in the right-hand column.

Main recommendations	
The management information available, including quality assurance of near misses/adverse incidents, should be improved in order to ensure that outcomes for detainees are adequate. (2.19)	Achieved
Management arrangements should provide sufficient oversight to ensure clarity of roles, responsibility and required outcomes. (2.20)	Achieved
The quality and consistency of initial risk assessments should be improved to ensure the safety of detainees, and the use of closed-circuit television (CCTV) for 'constant' watches, where observation is intermittent, should cease. (2.21)	Achieved
Cells should be clean, free of graffiti, well maintained and properly heated and ventilated, and improvement of the environment at Nottingham should be treated as an urgent priority. (2.22)	Achieved
Recommendations – Treatment and conditions	
Booking-in areas should provide sufficient privacy to facilitate effective communication between staff and detainees and there should be clear policies and procedures to meet the specific needs of juvenile detainees and those with disabilities. (4.6)	Partially achieved
The quality of the CCTV at Mansfield and Nottingham should be improved. (4.14)	Achieved
Intoxicated detainees should be roused, and this should be clearly recorded in the custody record and log. (4.15)	Partially achieved
Handovers should be comprehensive and attended by detention officers and police custody staff, with the area in which the handover takes place cleared of other staff and detainees. (4.16)	Partially achieved (Recommendation repeated, 4.31)
Nottingham police should collate the use of force in accordance with the Association of Chief Police Officers policy and National Policing Improvement Agency guidance. (4.20)	Partially achieved
The padded cell at Nottingham should be permanently taken out of use. (4.27)	Achieved

Health and safety walk-through arrangements should be thorough and consistently applied at all custody suites and should include a structured approach to the identification of ligature points as part of the daily cell checks. (4.28)	Achieved
The call bell system at Nottingham should be replaced or refurbished. (4.29)	Achieved
All detainees held overnight, or who require one, should be offered a shower, which they should be able to take in private. (4.36)	Partially achieved (Recommendation repeated, 4.55)
Food offered to detainees should be of adequate quality and calorific content to sustain them for the duration of their stay. (4.41)	Partially achieved
Detainees, particularly those held for more than 24 hours, should be offered exercise, and the exercise yards should be made fit for purpose. (4.45)	Partially achieved
Recommendations – Individual rights	
Nottinghamshire police should further develop and promote alternative-to-custody approaches and custody officers should ensure that the 'necessity test' for arrest is meaningfully undertaken. (5.9)	Achieved
Nottinghamshire police should liaise at a senior level with the UK Border Agency to ensure that there are no undue delays in transporting immigration detainees to placements identified in the immigration custody estate. (5.10)	Achieved
Pre-release risk assessments should be detailed, meaningful and based on an ongoing assessment of detainees' needs while in custody, and the custody record should reflect the position on release and any action that needs to be taken. (5.11)	Partially achieved
Appropriate adults should be provided for juveniles aged 17 and Nottinghamshire Police should engage with the local authority to ensure the provision of safe beds for juveniles who have been charged but cannot be bailed to appear in court. (5.20)	Not achieved
Detainees should be routinely informed about how they can make a complaint about their care and treatment and be able to do this before they leave custody. (5.24)	Achieved
Recommendations – Health care	
Clinical meetings should be reinstated, clinical supervision should be available for all clinical staff and a programme of clinical audit should be established to monitor the quality of patient care. (6.9)	Not achieved (Recommendation repeated, 6.6)
Action should be taken to refurbish the environment and reduce infection control risks. Cleaning services in health care should meet professional standards of cleanliness and infection control. (6.10)	Not achieved (Recommendation repeated, 6.7)

Nurses should be trained to use the full range of resuscitation equipment. (6.11)	Not achieved (Recommendation repeated, 2.26)
The mental health needs of detainees should be met across all custody suites and the criteria for referral to the section 136 suites, and any unresolved concerns, should be communicated regularly to operational staff to ensure that detainees are treated in the most suitable environment; police custody should only be used for this purpose as a last resort. (6.33)	Not achieved