Report on an unannounced inspection visit to police custody suites in

Northamptonshire Police

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

8–18 January 2018

This inspection was assisted by an inspector from the Care Quality Commission (CQC) in assessing health services under our memorandum of understanding.

Glossary of terms

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Printed and published by:
Her Majesty's Inspectorate of Prisons
Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services

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Force
Northamptonshire Police

Chief Constable
Simon Edens

Police and Crime Commissioner
Stephen Mold

Geographical area
Northamptonshire

Date of last police custody inspection
31 October - 3 November 2011

Custody cells	**Cell capacity**
Weekley Woods JC Justice Centre	22
Northampton Criminal Justice Centre	40

Annual custody throughput
1.1.17-31.12.17 - 10,897

Custody staffing
26 custody sergeants
25 civilian detention officers (CDOs) (employed by G4S)

Health service provider
Northamptonshire Healthcare NHS Foundation Trust

* Data supplied by the force.

Executive summary

S1 This report describes the findings following an inspection of Northamptonshire Police custody facilities. This inspection was conducted jointly by HM Inspectorate of Prisons (HMIP) and HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) in January 2018, as part of their programme of inspections covering every police custody suite in England and Wales.

S2 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.

S3 We last inspected custody facilities in Northamptonshire Police in 2011. This inspection found that of the 21 recommendations made during that previous inspection, five had been achieved, two had been partially achieved and 13 had not been achieved. One recommendation was no longer relevant.

S4 To aid improvement we have identified a number of key areas of concern and areas for improvement. This report provides five recommendations to the force (and the Police and Crime Commissioner) and highlights 31 areas for improvement. These are set out in full in section 6.

Leadership, accountability and partnerships

S5 Northamptonshire Police delivered custody services through a formal collaboration, under section 22 of the Police Act 1996, with three other forces – Leicestershire, Nottinghamshire and Lincolnshire. Under this agreement, senior staff shared responsibility for and oversaw delivery of the service for all four forces, with a clear organisational structure that covered each force. Responsibility for custody in Northamptonshire was delivered by a chief inspector although this was shared with Leicestershire, but there were no officers from Northamptonshire above the level of inspector dedicated to custody. It was, therefore, not clear who among Northamptonshire's own senior officer structure took responsibility for ensuring safe and respectful detention, for detainees, in its own custody suites.

S6 During our inspection we found that there was not always sufficient staffing on all shifts to ensure safe detention. This was particularly the case at the Weekley Woods custody suite, when limited staffing sometimes meant slow responses to cell call bells or that observations of detainees were not always conducted at the required frequency.

S7 In several areas, the force did not comply with code C of the Police and Criminal Evidence Act (PACE), covering the detention, treatment and questioning of suspects (cross ref S27). This was a significant concern that we expected the force to address as a matter of urgency. We also found some areas where custody staff were not following the College of Policing's *Authorised Professional Practice* (APP).[1]

S8 The force collected and monitored a range of performance information, but there were gaps in some key areas of custody provision and the data were not always reliable. Governance and monitoring of the use of force were limited, and could not show that when force was used this was proportionate and justified. There was no monitoring of equality and diversity information relating to custody to assess whether detainees were treated fairly.

[1] https://www.app.college.police.uk/

S9 The force was clearly focused on the diversion of vulnerable people from custody, and this was well understood by all the officers we spoke with. There was some positive work with partners to achieve this. There had been good progress in work with mental health services to divert people with mental ill health from custody. There were also policies to move children charged and refused bail from custody to alternative accommodation, although little progress had been made so far with most children remaining in custody.

Pre-custody: first point of contact

S10 Frontline officers had a good understanding of people's vulnerabilities and took account of this when deciding whether to arrest someone at an incident. They actively explored other options to avoid taking vulnerable people and children into custody.

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

S11 Custody staff treated detainees respectfully. They recognised, and in the main met, individual and diverse needs. Privacy for detainees when disclosing personal information was generally good. However, some working practices (such as detainees not being provided with alternative footwear and having to walk around the suite barefoot or just in their socks) adversely affected detainees' dignity and these needed to be addressed.

S12 The assessment and management of risk were generally good, with some good use of constant and close proximity observations for vulnerable detainees. However, the rousing of intoxicated detainees was not always appropriate, and some took place through the cell hatch rather than entering the cell, which did not comply with code C. Detainees' clothing that had cords and their footwear were removed routinely, rather than based on an individual assessment of whether this was appropriate; this had the potential to cause confrontation with detainees. There was also some unnecessary use of anti-rip clothing, and we saw some examples of detainees being interviewed in such clothing, which did not comply with code C.

S13 Detention was appropriate and properly authorised, and detainees were routinely informed about their basic rights while in custody. There were sufficient copies of the PACE codes of practice available for detainees, in line with their rights and entitlements. Custody staff communicated clearly with detainees and ensured their understanding by using interpreters and other communication aids as necessary. However, case progression was not always as quick as it could have been. Delays in the arrival of investigators, appropriate adults and interpreters sometimes meant that detainees spent unnecessarily long periods in custody.

S14 The arrangements to promote complaints processes and deal with detainee complaints while they were in custody were limited.

S15 Reviews of detention by inspectors to authorise continued detention were usually on time, but were not always carried out well. Some took place by telephone, with insufficient justification for this, and when inspectors did not speak with detainees because they were asleep, they were not always informed that a review had taken place; these were contrary to PACE code C.

S16 The arrangements for granting and managing bail and for detainees released under investigation were generally good.

In the custody cell: safeguarding and health

S17 The custody suites were clean and in a good state of repair, with few potential ligature points identified in the cells. The facilities offered a very good standard and environment for detainees.

S18 The force was unable to identify easily when force was used on detainees while in custody. Recording of incidents was inconsistent and not always in line with recommendations from the National Police Chiefs Council (NPCC). In the cases we looked at we found a mixed picture. Some incidents were handled well but others indicated lessons to be learned to improve. However, we did find some good examples where officers dealt well with challenging detainees and de-escalated the situation to avoid the use of force.

S19 Detainee care was mixed. There was very good attention to providing food and drinks, but the provision of showers, outside exercise and reading material was extremely limited.

S20 Custody staff had a good understanding of safeguarding, and children in custody were well cared for. However, some children and vulnerable adults waited too long before receiving support from an appropriate adult. Children often remained in custody overnight. Very few who had been charged and refused bail were moved to suitable alternative accommodation, as they should have been.

S21 There were insufficient performance measures to ensure detainees' health needs were being met. Some aspects of clinical governance were underdeveloped. Patient care was good and detainees generally received their prescribed medications. However, some detainees waited too long to see health practitioners, and they had inadequate access to drug and alcohol services.

S22 The number of individuals detained for their own or others safety under section 136 of the Mental Health Act[2] had reduced significantly. When they were detained they were taken to health based places of safety and not custody. Custody had not been used as an initial place of safety in the previous six months, which was a significant achievement.

S23 Detainees received reasonable access to initial help from mental health nurses while in custody. However, there were regular delays for detainees who subsequently needed a mental health assessment under the Mental Health Act and onward transfer to a mental health facility.

Release and transfer from custody

S24 Pre-release risk management planning was generally effective in ensuring detainees were released safely. However, recording of this process was mostly poor.

S25 Too many detainees remained in custody unnecessarily because the local magistrates' court cut-off time for accepting cases was too early, at approximately 1pm. Although there was some flexibility, requests by custody staff for detainees to attend court after this time were usually refused. Despite ongoing engagement with partners in Her Majesty's Courts & Tribunals Service, this situation had not improved.

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

Areas of concern and recommendations

S26 **Area of concern:** Chief officers in Northamptonshire Police had not taken sufficient accountability for ensuring that the collaboration arrangements with neighbouring forces delivered the required outcomes for detainees in its own force area.

Recommendation:
The force should take clear accountability for the delivery of custody services to Northamptonshire detainees, with effective scrutiny and oversight at senior officer level to ensure safe and respectful outcomes.

S27 **Area of concern:**
The force did not comply with code C of the Police and Criminal Evidence Act (PACE) in several areas, and it needed to address this as a matter of urgency.

Recommendation:
The force should take immediate action to ensure that it complies fully with code C of PACE, in particular with:
- annex H: rousing of intoxicated detainees should take place through the officer entering the cell;
- section 15.7: detainees should be informed where a review of their detention has taken place while they are asleep;
- section 15.14: where telephone reviews are carried out, the name of the inspector should be recorded along with the reasons why the review cannot be conducted in person;
- section 15.3.A: inspectors should consider reviews of vulnerable detainees in person;
- section 8.5: detainees should not be interviewed while they are wearing unsuitable replacement (anti-rip) clothing.

S28 **Area of concern:**
The governance and oversight of the use of force in custody were inadequate, data were unreliable, and Northamptonshire Police did not record all instances where force was used in its custody suites. Not all uses of force were proportionate to the risk or threat posed.

Recommendation:
The force should strengthen its approach to the use of force by:
- ensuring that all instances where force is used in custody are properly recorded so that the data are accurate, and in line with recommendations from the National Police Chiefs Council (NPCC);
- monitoring the use of force, with cross-referencing to CCTV footage, to provide assurance that its use is fully justified and proportionate to the threat posed.

S29 **Area of concern:**
The collation and monitoring of data relating to key areas of custody were insufficient.

Recommendation:
The force should develop comprehensive performance monitoring across all key areas of custody services.

S30 **Area of concern:**
Children charged and refused bail continued to remain in custody, often overnight and for long periods, when they should have been transferred to alternative accommodation arranged through children's social services.

Recommendation:
The force should continue to work with local authority partners to avoid the overnight detention of children in custody by transferring them to suitable alternative accommodation.

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). 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 Inspectorate of Prisons and HM Inspectorate of Constabulary & Fire and Rescue Services 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*.[3] These standards are underpinned by international human rights standards and are developed by the two inspectorates, widely consulted on across the sector and 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
- 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*.[4]

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 Northamptonshire force we analysed a sample of 107 records. The methodology for our inspection is set out in full at Appendix II.

The joint HMIP/HMICFRS 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, at a minimum, every six years.

Wendy Williams
HM Inspector of Constabulary

Peter Clarke CVO OBE QPM
HM Chief Inspector of Prisons

[3] http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/inspection-criteria/
[4] https://www.app.college.police.uk/app-content/detention-and-custody-2/?s=

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

1.1 Northamptonshire Police had a clear organisational structure for custody. Custody services were delivered through a formal collaboration under section 22, Police Act 1996 with three other forces in the East Midlands – Leicestershire, Nottinghamshire and Lincolnshire. The strategic leadership for custody across all four forces was the responsibility of the assistant chief constable (ACC) of Leicestershire, supported by a chief superintendent head of the East Midlands Criminal Justice Service. Two chief inspectors had day-to-day responsibility for operational custody matters, with two forces each. One chief inspector from Leicestershire had responsibility for Northamptonshire and Leicestershire.

1.2 In Northamptonshire, one inspector had management responsibility for the force's own custody suites which was less than the number of inspectors in the other forces in the collaboration. Although the force was smaller than the other forces in the collaboration this left little resilience. There were 24 dedicated custody sergeants and two additional bail managers who undertook custody duties. G4S provided civilian detention officers (CDOs) under a contract managed through the forces' collaboration agreement.

1.3 Governance of the custody service was through regional arrangements. A regional monthly operations custody meeting was chaired by the head of EMCJS. All four forces in the Section 22 collaboration were represented at this meeting. The chief inspector, responsible for the custody provision in Northamptonshire and Leicestershire, met regularly and on an individual basis with the inspector responsible for custody in Northamptonshire.

1.4 While the regional arrangements provided an appropriate governance structure for custody services in Northamptonshire Police, there was insufficient direct oversight and scrutiny at the force's senior officer level. Senior officers had little involvement in issues that could have affected outcomes for those detained in custody in Northamptonshire, and it was unclear where strategic accountability lay within the force.

1.5 The leadership arrangements for the force had not sufficiently driven or supported improvements in custody services. Since our last inspection in 2011, progress had been limited, and the force had achieved only five of our 21 recommendations.

1.6 Our observations and examination of cases showed that there was not always sufficient staffing on all shifts, or existing resources were not used to best effect, to ensure safe detention. There was little day-to-day supervision in the suites, and there was a reliance on inspectors from outside of custody to carry out reviews of detention under the Police and Criminal Evidence Act (PACE), even when this meant that reviews took place by telephone rather than face-to-face with detainees, although the custody inspector was often in the suite.

1.7 The routine deployment of minimum staffing levels at the Weekley Woods suite sometimes affected detainees; for example, there were sometimes delays in responding to cell call bells. Detainee checks in this suite were also not always conducted in line with the observation levels set.

1.8 Custody sergeants were well trained to carry out their role. They all received accredited training before undertaking duties, and continuous professional development training was sufficiently focused on safe detention priorities. CDOs were trained by G4S as part of the regional arrangements.

1.9 Policy and guidance for custody staff were inconsistent. The force had adopted the College of Policing *Authorised Professional Practice* (APP) for custody. However, there was also a regional custody procedures policy, which contained some guidance that contradicted APP - for example, the removal of items from detainees without individual risk assessment. Some of the processes and practices we observed did not comply with either APP or force policy, and there was insufficient supervision by senior managers to identify and address this.

1.10 The quality assurance process to check custody records was not sufficiently robust. The dip sampling of records was not consistent, and did not always identify concerns, compliance with policies and procedures or drive improvements. However, the force completed quarterly audits that gathered a range of information to identify areas requiring improvement, and these were used to inform training requirements.

1.11 Northamptonshire Police was clearly focused on the diversion of vulnerable people from custody. This strategy was well understood by all the officers we spoke with, and their working practices sought to achieve this.

Areas for improvement

1.12 There should be sufficient staffing levels on all shifts to ensure the safe detention of all detainees.

1.13 *Authorised Professional Practice*, supported by clear local policies where required, should be available to staff, and quality assurance should be sufficiently focused on compliance testing.

Accountability

1.14 The collation and monitoring of performance data on custody were not sufficiently comprehensive. The monthly monitoring of performance did not cover all key areas of activity. For example, there were no data to monitor the overall time detainees were held in custody, or waiting times for Mental Health Act assessments. Some of the data provided for our case audits were also unreliable. Without comprehensive and accurate data, the force was unable to demonstrate that it could assess how well custody services were performing, identify trends or inform organisational learning. (See area of concern and recommendation S29.)

1.15 The quality of custody records was inconsistent, and some key information was often not included. For example, there were not always records of the time that requests for interpreters and appropriate adults were made or their time of arrival in the suites. Some entries lacked detail to show what actions had been taken. This made it difficult for the force to assess how detainee needs were met, or to demonstrate the level of care they received.

1.16 Although the force collated data on the use of force, it was unable to separate information on the incidents that occurred in its custody suites. Data provided for our case audits were unreliable, and not all instances where force was used had been being recorded in line with recommendations from the National Police Chiefs Council. (See area of concern and recommendation S28.)

1.17 The force did not have adequate mechanisms to assure itself, the Police and Crime Commissioner and the public that the use of force in detention and custody was always safe and proportionate. In addition to the data concerns described above, although there was some monitoring and oversight of use of force incidents, there was evidence of under-recording and inconsistent checking against CCTV footage.

1.18 In several areas, the force was not complying with code C of PACE, covering the detention, treatment and questioning of suspects. This included guidance on the rousing of intoxicated detainees not being adhered to (annex H), inspectors not recording the reason for reviews of detention being conducted by telephone (section 15.14) and detainees not being informed of a review of their detention while they were asleep (section 15.7). (See area of concern and recommendation S27.)

1.19 The force met the public sector equality duty through publishing comprehensive data on its website. There was an equality diversity and human rights (EDHR) strategy and a strategic EDHR board, chaired by the deputy chief constable, which provided a sound framework for governance and improvement. However, there had been no equality impact assessments of custody policies, although this was an objective in its 2017-20 action plan, and there was no specific monitoring of custody information. The force collated data, including the age, ethnicity and gender of detainees, but some of this was not easily retrievable from force systems and there was no analysis to assess whether all detainees were treated fairly or identify areas of potential disproportionate treatment.

1.20 The force facilitated access to external scrutiny and was open to challenge. There was a good relationship with the independent custody visitors (ICVs), who reported good and prompt access to the suites. Their frequent visits identified issues which the force responded to appropriately.

Area for improvement

1.21 The force should improve the quality of its custody records so it is clear when and what actions have been taken, and to provide clear evidence of the care that a detainee receives while in custody.

Partnerships

1.22 The force had a strategic focus on working with partners to protect and divert vulnerable people from custody, and this had resulted in clear policies. However, partners did not always have the capacity to meet their responsibilities and, in the case of children, to fulfil their statutory obligations.

1.23 Partnership working between the force and community mental health services was good and supported the diversion of people with mental ill health from custody. Joint working and several initiatives had led to support for people experiencing mental health crisis in the

community, and had contributed to a steady reduction in the numbers detained in custody under section 136 of the Mental Health Act.[5]

1.24 The force was working with Northamptonshire children' social services to implement the Home Office concordat on children in custody, although this had not been formally signed. However, too many children who were charged and had bail refused remained in custody overnight when, under the concordat, alternative accommodation should have been provided. There was little joint work to monitor progress and assess the outcomes for children as a result of these joint working arrangements. (See area of concern and recommendation S30.)

1.25 There was limited partnership work to provide diversion pathways to prevent vulnerable people from entering the criminal justice system or reoffending. Although there were some referral mechanisms to support individuals leaving custody, there were few diversion schemes to help the force achieve its strategic approach.

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

Section 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

2.1 Frontline officers had a good understanding of people's vulnerability and the wide range of factors that influenced this - such as alcohol and substance misuse or mental ill health - and how the different circumstances that a person finds themselves in can make them vulnerable. Positively, all children were regarded as vulnerable, but officers also recognised that the level of this varied depending on their lifestyles or family circumstances.

2.2 There was a force definition of vulnerability and it had provided training on various topics, including the Mental Capacity Act 2005, to assist officer understanding and approach to vulnerability. It was clear that officers were confident in taking account of vulnerability when deciding the action to take when dealing with an incident, and whether or not to arrest an individual and take them into custody.

2.3 The level and quality of information from the control room to officers attending incidents were inconsistent, especially at busy periods and from control room staff who were less experienced. Officers reported that they asked for further details, or accessed information directly themselves, about any individuals involved in an incident to ensure that they could adequately assess any vulnerability factors that would inform their decision making.

2.4 There was a strong focus on avoiding taking children into custody. Frontline officers actively considered and pursued alternatives, such as community resolutions,[6] and had positive working arrangements with the youth offending teams for referring children for support and diversion from the criminal justice system. When children were arrested, officers rigorously applied the necessity test for this, and expected to be strongly challenged by custody officers, to ensure that this was the most appropriate action.

2.5 Frontline officers told us they would always look for alternatives when dealing with incidents involving people with mental ill health, rather than taking them into custody. The primary concern was to address the health needs of the individual before dealing with any offence(s) they may have committed and to avoid arrest where possible, especially for minor offences. They received effective support from the mental health nurse in the force's control room and through the street triage. The nurse provided health information and advice to help officers determine the most appropriate action, and although this service was not available after midnight, officers told us it helped them avoid custody for some individuals with mental ill health.

2.6 The force's arrangements with its health partners had resulted in frontline officers taking individuals detained for their own or others' safety, under section 136 of the Mental Health Act (see footnote 5), to health based places of safety rather than custody. Frontline officers told us that they would only use custody as a place of safety in exceptional circumstances. Although this could result in officers spending significant time waiting with detainees at health

[6] The resolution of a less serious offence or antisocial behaviour incident through informal agreement between the parties rather than progression through the criminal justice process.

facilities for mental health assessments, they reported positive working relationships with health professionals to achieve the most appropriate outcome for the individual concerned.

2.7 Officers decided on how to transport a detainee, using police cars or vans as appropriate, depending on the circumstances and the risk posed by the detainee. There was no provision to transport people with mobility needs. Officers told us they would try and avoid custody as the first option, giving an example where a voluntary interview was arranged at the home of a suspect who used a wheelchair (avoiding the need for arrest and subsequent detention).

2.8 Although the force had a service level agreement with the ambulance service on the transportation of individuals detained under section 136, frontline officers reported many occasions where they transported such detainees to hospital using their marked police vehicles. They recognised this was not appropriate but, due to long waits for ambulances, often decided it was in the best interests of the individual in crisis to use their own cars.

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

3.1 Custody sergeants and civilian detention officers (CDOs) generally engaged with detainees respectfully in custody. Conversations were generally calm, patient and positive, with good interaction between custody staff and detainees throughout the various stages of custody, sometimes in challenging circumstances. Identification of vulnerable detainees and responding to their needs was well understood and embedded, in accordance with our inspection assessment criteria.

3.2 The force was clearly committed to supporting women coming into custody, and assigned them a female officer to speak to about their care if required. However, there were not always enough female staff to achieve this. The range of female hygiene items was limited to sanitary towels. Although these were readily available at both custody suites, they were not routinely offered to women detainees, as we expect, and they therefore had to request them.

3.3 However, we observed several working practices that affected the dignity of detainees. Most detainees walked about the custody suites either barefoot or in socks, despite the availability of alternative footwear; this fell below our standard of respectful treatment. Detainees also had to request toilet paper, which was not provided routinely or on the basis of an individual risk assessment. These were poor practices and detracted from the dignity detainees were entitled to.

3.4 The design of both custody suites provided sufficient privacy for detainees to disclose sensitive and confidential information during the booking-in process. There were also additional discrete booking-in rooms that offered complete privacy to vulnerable detainees, children or particularly sensitive cases, although custody staff did not use these facilities routinely for this purpose. Cells were fitted with intercoms and telephone calls from solicitors could be transferred there, providing good privacy for detainees.

3.5 Cell toilet areas were obscured on all closed-circuit television (CCTV) monitors, ensuring privacy for detainees, although detainees were not always told that this was the case.

Area for improvement

3.6 **Detainee dignity should be maintained at all times, and in particular, they should be provided with suitable alternative footwear, and offered toilet paper routinely rather than on request (subject to risk assessment).**

Meeting diverse and individual needs

3.7 Custody suite staff were knowledgeable and confident in their ability to identify and address most of the diverse needs of detainees in their care. They had been given some training on recognising and meeting the diverse needs of detainees, although this did not cover all the protected characteristics[7] included in the public sector equality legislation.

3.8 Books and artefacts to support some religions were available in the custody suites and they were stored respectfully. However, not all faiths were covered, for example, there were no Torahs for practising Jews.

3.9 There were some good facilities to meet the needs of detainees with physical disabilities or mobility issues. Custody suites had adapted shower and toilet facilities, and exercise yards were suitable for detainees with mobility needs or in wheelchairs. Most cells had cell call bell at a low level which could be easily reached. Hearing loops were available to help people with hearing difficulties, and most staff knew where they were kept and how to use them.

3.10 The force had also adopted the 'autism card' scheme (initiated by the police in conjunction with the health authority) and custody staff had received information about how this scheme operated., The card was issued to individuals and provided information about people in the community identified with autism, and included information and contact details of agencies and family.

3.11 Custody sergeants used professional telephone interpreting services to assist the booking in of detainees who did not speak English. They were, however, used rarely in the ongoing care and welfare of detainees. In our case audits, it was common for custody officers to arrange interpreters to attend just before the beginning of police interviews. Neither custody suite had dual-telephone handsets and staff relied on speaker phones to conduct conversations. This meant that other people in the suite could hear the calls, which provided little or no privacy for the detainee disclosing information about themselves. Although the Police and Criminal Evidence Act (PACE) codes of practice (annex M) require that essential documents are translated and provided to non-English speaking detainees as soon as practicable, we did not find any records of detainees being provided with or told about the availability of translated documents. Custody officers were not widely aware of the requirement. Staff knew the process for foreign national detainees to contact their embassies/consulates, and obtained the relevant contact details through the internet.

3.12 Documents detailing detainees' legal rights and entitlements were available in a range of languages, and custody sergeants knew how to access them on the force custody intranet. They were also available in Braille, which we do not often find in forces we inspect. Four members of staff were trained to level three in British Sign Language and were available to support detainees with hearing needs if required.

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[7] The grounds on which discrimination is unlawful (Equality and Human Rights Commission, 2010).

Areas for improvement

3.13 All custody staff should be trained to identify and meet the individual needs of detainees across all protected characteristics.

3.14 Women detainees should always have the opportunity to speak with a female member of staff to discuss their care needs.

3.15 Religious books and artefacts should be available to meet the needs of a wider range of faiths.

3.16 All suites should have working double-handset telephones to facilitate telephone interpreting and ensure privacy for the detainee.

Risk assessments

3.17 Detainees were generally booked in promptly by custody sergeants who completed a standard risk assessment form. A range of comprehensive questions focused appropriately on the welfare of the detainee and the identification of risk factors. Sergeants were skilled at building rapport and asking supplementary questions to ascertain more detailed information from the detainee. However, the additional information added to narrative boxes was mostly brief. Arresting officers were required to routinely check the police national computer (PNC) before the booking-in process and record key identification details and warning markers on a custody reception form, which was good practice. Sergeants and CDOs also did their own PNC checks where relevant, cross-referencing this information and previous custody records to inform the risk assessment process.

3.18 Care plans, completed by custody sergeants, generally set appropriate levels of observations. making particularly good use of constant and close proximity observations (levels 3 and 4). However, in busy periods and where staffing levels were low, checks were sometimes delayed and cell bells not always answered promptly. While staff were aware of the importance of monitoring and rousing intoxicated detainees, they did not always conduct these appropriately. For example, they sometimes completed a rousing check through the cell door hatch rather than entering the cell to speak to the detainee, in breach of PACE code of practice annex H. (See area of concern and recommendation S27.)

3.19 Clothes with cords and footwear were routinely removed from detainees regardless of the risk posed, which was disproportionate. Anti-rip clothing was used too often to manage complex behaviour, and was not always justified or recorded. For example, we saw a woman taken to a cell and placed in anti-rip clothing within 15 minutes of arrival in the custody suite and before there had been sufficient time to persuade her to cooperate with the risk assessment process, and when the decision had been taken to place her on close proximity (level 4) observations (see also paragraph 4.14).

3.20 Although all custody staff had been issued with anti-ligature knives they did not always carry them, including when visiting cells, which compromised the safety of detainees. Anti-ligature knives were sometimes used inappropriately to cut clothing, which could result in them becoming blunt.

3.21 The majority of staff shift handovers were recorded and conducted well, with appropriate focus on detainee welfare, potential risks and case progression, but generally they did not include all staff, which was a risk to detainee care. There was good use of an aide memoire, completed by sergeants before the handover, to ensure all key issues were communicated.

Areas for improvement

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

3.23 All custody staff should carry anti-ligature knives or shears. (Repeated recommendation 4.23)

3.24 All custody staff should be involved collectively at shift handovers.

Individual legal rights

3.25 Custody sergeants generally authorised detention appropriately after arresting officers provided sufficient detail to explain the circumstances of and reasons for arrest. We found that in most cases, custody sergeants clearly explained to detainees the relevance of each right and entitlement, which were also provided in a four-page notice given to each detainee. Custody officers encouraged detainees to ask questions about what had been explained to them. Notices of legal rights and entitlements were available in a range of languages, in Braille and large font for detainees who were visually impaired, and in sign language at both custody suites.

3.26 Positively, no detainees were interviewed under the influence of alcohol or drugs or while they were medically unfit, and custody officers arranged for health care professionals to assess detainees ahead of interviews if there was any concern they may be unfit. However, we did observe two incidents where detainees attended interview dressed in anti-rip clothing as they had not been offered adequate alternative clothes. This practice did not comply with section 8.5, code C of the Police and Criminal Evidence Act (PACE).[8] (See area of concern and recommendation S27.)

3.27 Both custody suites had sufficient up-to-date copies of the PACE codes of practice (February 2017) for use by detainees, their representatives and custody staff. Although all detainees have the right to read a copy of the codes of practice while they are in detention, not all custody officers clarified this to detainees when booking them in.

3.28 We would expect to find detention being authorised in no more than a few minutes after the detainee arrives at the custody suite, other than in exceptional circumstances. Northamptonshire Police generally met this expectation, although there were some delays, particularly during the night when there was a high demand on policing services. We were satisfied that the force had impressed on its custody officers the need to avoid this small number of delays.

3.29 Northamptonshire Police's use of voluntary attendance[9] had dropped by 57% between 2015 and 2017 (down from 2,213 to 948 suspects). This compared with a 40% reduction in the number of people detained by the force in this period. The force was, however, unable to provide reliable data and could not account for such a drop, particularly when officers we spoke to believed they were now interviewing more suspects using voluntary attendance compared with recent years.

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8 'If it is necessary to remove a detainee's clothes for the purposes of investigation, for hygiene, health reasons or cleaning, replacement clothing of a reasonable standard of comfort and cleanliness shall be provided. A detainee may not be interviewed unless adequate clothing has been offered.'

9 Where suspects involved in minor offences attend a police station by appointment to be interviewed about these, avoiding the need for arrest and subsequent detention.

3.30 The force was unable to provide data on the average length of detention for detainees force-wide or in any of its suites, or data for pre-charge or post-charge detention. In our case audits, we found examples of detentions lasting many hours, and some appeared unnecessarily prolonged. Custody staff told us that this was due to delays in accessing appropriate adults and interpreters, and also because the force investigation team officers and staff were not available after 10pm.

3.31 Arrangements for dealing with DNA samples were satisfactory. These were stored away from other samples, monitored by G4S CDOs and collected regularly.

PACE reviews

3.32 We observed some good custody staff interaction and meaningful engagement with detainees during PACE reviews conducted face-to-face in custody suites. However, the PACE reviews procedure was not always purposeful enough or of benefit to detainees. Although all reviews were conducted by inspectors, many were completed without their presence in the custody suites, or even a discussion with individual detainees over the telephone. This was poor practice and did not meet the individual needs of detainees.

3.33 We also found that inspectors often completed reviews while detainees were sleeping or being interviewed. Although they recorded their expectation that custody officers would tell detainees that the review had taken place and offer them their rights and entitlements when they woke or returned from interview, this was done infrequently and often too late to make the review of any value to detainees. (See area of concern and recommendation S27.)

3.34 Most reviews by inspectors were recorded on or near the time they were due, but the contents tended to be standard cut-and-paste texts, and some had little relevance to the individual detainee under review.

Access to swift justice

3.35 Northamptonshire Police's use of pre-charge police bail was generally well managed. However, the detailed bail application and approval form on the local records management system did not allow officers to include the 'necessity' and 'proportionality' rationale, as required by the College of Policing guidance following the Police and Crime Act changes to bail in April 2017.

3.36 Senior officers made decisions correctly on the suitability of bail, and applied appropriate bail periods to individual cases. Bail conditions were used justifiably in all pre-charge bail cases and were proportionate to the circumstances of each detainee.

3.37 The force had a dedicated bail manager who oversaw the necessity for bail and advised officers seeking additional bail periods on the strict requirements of applications. In our case audit, we found evidence of regular reviews of bail and supervision of cases where detainees had been released under investigation. The force had developed performance management information on the few people on bail and the much larger number who had been released under investigation. Senior officers could scrutinise the regularity of supervision and ensure investigations were conducted quickly in the interests of detainees, as well as victims of crimes

Complaints

3.38 The rights and entitlements notice given to detainees contained a short paragraph on how to make a complaint. However, neither custody suite displayed posters or other notices to advertise how detainees and their representatives could make complaints against police.

3.39 Although officers of the rank of inspector or above generally record complaints against the police, in Northamptonshire we found that if an inspector was not available to meet a detainee who wanted to make a complaint, they were encouraged to telephone in their complaint to the police once they had left custody. This did not meet our expectation that complaints are taken and recorded before detainees leave custody.

3.40 In our case audits, we found evidence of detainees complaining about their treatment, but there were no records of detainees being advised they could make a formal complaint. In one case, the detainee told the custody officer he had been injured during his arrest, and he was assessed by a health care practitioner. Although the complaint of injury was recorded in the health care practitioner's notes and available to the custody officer, there was no record that the detainee had been told he could make a complaint.

Area for improvement

3.41 There should be effective arrangements in place to take and record complaints made by detainees and, where possible, these should be dealt with before the detainee leaves custody.

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

4.1 Physical conditions in the Northampton and Weekley Woods suites were very good. Weekley Woods had opened six months previously and was in good decorative order. Both suites were well maintained and standards of cleanliness were high. The contracted cleaners cleaned and tidied cells and communal areas daily. Civilian detention officers (CDOs) were also expected to clear and clean cells when necessary. When cells had biological hazards that required a deep clean, these were removed promptly and efficiently by an external contractor.

4.2 Cells were clean and in good condition. Cells included an in-cell toilet, a hand basin and an intercom system where telephone calls could be transferred directly to detainees. In between use, cell floors were mopped, and mattresses and pillows wiped down. During our cell checks in the Northampton suite we found few other potential ligature points in the cells - with the exception of one repeated potential ligature point in most in-cell toilets. We did, however, find further potential ligature points in all the communal showers in both suites. Following our cell checks, we provided the force with an illustrative report to enable it to take appropriate action to manage and mitigate the risks posed.

4.3 Maintenance of the suites was generally managed well. CDOs carried out daily checks of all cells and the communal areas and completed a comprehensive daily checklist. Sergeants carried out an additional check of the suite's facilities as part of their shift handover. Any damage or faults identified by custody staff were recorded locally and then reported to the multi-force shared services system. Most faults were reported promptly but there were some delays in responses and completion of repairs. At the time of the inspection, we were unable to assess from force records the exact time that six cells had been out of use; this was because the local logs had not been dated. Custody staff were unsure of the follow-up procedure when the maintenance service had not repaired a fault swiftly.

4.4 The cell call bell system was checked daily by CDOs, and all the bells we pressed were working. Custody staff explained to detainees what the call bell was for and how to activate it from inside their cell. Despite this, some cell call bells were not answered promptly by staff (see paragraph 1.7).

4.5 Custody staff were aware of how and where to evacuate detainees in an emergency. Although there was evidence in the force's central records of evacuation drills in the previous six months, there were no logs in the custody suites and staff were not aware of when the most recent drills had taken place. Well-equipped emergency evacuation packs were easily accessible in both suites. The packs contained instructions and local procedures for how to evacuate in the case of an emergency. However, there were not enough

handcuffs inside the Northampton pack to evacuate all detainees safely there, with only 35 sets of handcuffs for the 40-cell custody suite.

4.6 Custody staff were trained to use and accessed a much wider range of emergency equipment than we usually see, including oxygen, which could improve detainees' outcomes in a medical emergency. However, there were no checklists and some key items were missing, despite regular recorded checks. At Weekley Woods, the emergency bags were locked in cupboards, which would delay access in an emergency. First aid kits were reasonably good, but were not standardised across the suites, and contained some expired or missing items.

Areas for improvement

4.7 Faults and damage to suites should be dated and recorded accurately in each suite so that custody staff can monitor response times from the maintenance contractor.

4.8 Custody staff in both suites should have easy access to standardised well-checked emergency and first aid equipment.

Safety: use of force

4.9 Oversight and governance of use of force in custody were inadequate. We would expect there to be reliable data on the use of force in custody, but the data available were force-wide and not disaggregated to identify the specific use of force on detainees held in custody. (See area of concern and recommendation S28.)

4.10 Data provided assured us that custody staff were in date with officer safety/protection training. The force custody policy placed a strong emphasis on staff wearing their personal protection equipment (PPE) at all times so that it was readily available if required. We consider this to be unnecessary in a controlled custody environment. However, in practice most custody sergeants were unaware of this policy and chose not to wear their PPE routinely, emphasising the use of de-escalation tactics instead, which was an appropriate response.

4.11 Custody sergeants had access to a range of restraint equipment, including not only handcuffs and limb restraints, but also body-cuffs, emergency restraint belts, spit hoods and head guards (similar to helmets used in contact sports). We were told that the latter were used frequently, and generally to prevent self-harm. However, head guards are used rarely in other forces, and we could find no guidance or policy on when much of the restraint equipment should be used or how long and to whom it should be applied (for example, children or pregnant women) This lack of governance meant limited accountability for staff who used this equipment. (See area of concern and recommendation S28.)

4.12 Through our case audits, custody record analysis and conversations with staff we identified 10 cases where force had been used since mid-December 2017. We reviewed these in depth and cross-referenced them against CCTV footage. Although the force used individual use of force forms, these were not always completed by all the officers directly involved in such incidents in custody. In addition, CDOs told us they submitted their own company use of force forms direct to G4S, which the force did not see unless requested. The majority of detention logs did not contain sufficient, if any, information to justify why force had been used in custody.

4.13 Our analysis indicated that many staff were patient, calm and reassuring when dealing with challenging detainees, and that force was generally only deployed as a last resort following efforts to de-escalate situations. We found learning points in half the 10 cases, and referred two, involving the use of body-cuffs and a head guard, back to the force for review. We also referred a third case back to the force as it occurred outside the force CCTV retention period and we were unable to check it against CCTV footage. The custody record in this case indicated that a body-cuff and head guard had been used during the detention of a 14-year-old girl. Other concerns about the incidents we reviewed on the CCTV footage included: force was not always proportionate to the threat posed; some techniques were poorly deployed; and there was poor attention to maintaining the dignity of some detainees. (See area of concern and recommendation S28.)

4.14 In six of the cases we reviewed, force was used to remove the detainees' clothes to replace it with anti-rip clothing. There was often insufficient justification for the removal of clothing or any entries to confirm that force had been used to remove clothing. We were concerned that the use of force was not always a last resort and could potentially have been avoided if the detainee's clothing had not been removed (see also paragraph 3.19).

4.15 Most detainees arrived in custody wearing handcuffs, mostly for compliant transportation. In the majority of cases these were removed quickly while the detainee was in the holding room, but they sometimes continued to be used on compliant detainees for too long, which was disproportionate to the threat posed in the controlled custody environment.

4.16 Force data showed that only 3% of detainees who arrived in custody were strip searched, which is lower than we normally see. In additional force data we found that authorisations for such a search and the result of these searches were not always recorded on the custody records, so we were not confident that all strip searches were warranted or sufficiently justified. In one case that we referred back to the force, drugs were not found on a detainee during an initial strip search but he was later found to have drugs in his possession in his cell.

Areas for improvement

4.17 Each member of staff involved in using force against a detainee should submit an individual Northamptonshire Police use of force form.

4.18 Detainees should only be strip searched if there are sufficient grounds to do so, and the justification for this should be clearly recorded on their custody record, along with the result of the search.

Detainee care

4.19 In our case audits, custody record analysis and observations during the inspection, most detainees were regularly offered food and drinks throughout their detention. There was a sufficient range of food available, including vegan, vegetarian, halal and kosher options. Kitchens were clean and the facilities adequate. Although families could not bring in food for detainees, staff said they would purchase specific dietary or medically required items that were not readily on offer in the suites.

4.20 Exercise yards were small on both sites but did have natural light and fresh air. Despite their availability, very few detainees were offered exercise during their detention, even when they had been held overnight. This fell short of our expectation that detainees are offered exercise outside.

4.21 Reading material was available in both suites but the range was inadequate for the needs of the diverse group of detainees. Although there were books in foreign languages, including Polish, Romanian and Arabic, there were not enough magazines, puzzles or books for children or young people, and the range of materials in English was limited. In our case audits and inspection of custody records, detainees were not routinely offered reading materials before entering their cell, and in too many cases that we observed detainees had to request books and magazines from custody staff.

4.22 The shower facilities in both suites were very good. They were well maintained and most provided adequate privacy. Despite this, in our case audits, custody records and observations, access to showers for detainees was poor. Showers were not routinely offered to detainees who had spent the night in a cell and were attending court, or to immigration detainees who had entered the country clandestinely having been concealed in lorries for long periods.

4.23 There were sufficient stores of replacement clothing for detainees, including jogging bottoms, T-shirts and sweatshirts in a wide range of sizes. Stocks were monitored weekly and replenished as necessary. However, the range of underwear was limited and of poor quality. The stores in both custody suites carried plimsolls in a range of sizes but they were not routinely offered to detainees when their shoes were removed (see paragraph 3.3).

Areas for improvement

4.24 Detainees should be routinely offered reading materials, access to outside exercise and showers.

4.25 There should be a range of replacement underwear for male and female detainees.

Safeguarding

4.26 All the officers and staff we spoke with had a good understanding of safeguarding children and vulnerable adults. Force policy clearly set out that safeguarding was everyone's responsibility, and there had been some training to support officers to identify and address concerns. There were procedures to make referrals for both vulnerable adults and children to specialist units in the force, and all officers knew how to make these. However, it was not always clear where the responsibility for safeguarding rested during the detainee's time in custody. Some custody sergeants made referrals directly, while others delegated or relied on arresting or investigating officers to deal with any concerns. This led to an inconsistent approach, and there was little recording of referrals on custody records to show that any necessary safeguarding actions were taken.

4.27 The arrangements for securing appropriate adults (AAs) did not always ensure early support for vulnerable adults and children in custody. Family members were sought in the first instance and, when possible, arresting officers arranged this at the time of arrest. Where family members were not available, or it was not appropriate for them to act as an AA, there was reliance on children's social services through the Catch 22 service for children and 'Crime to Christ', a charitable organisation for vulnerable adults.

4.28 Custody officers told us that the daytime service for children generally worked well, but the service for vulnerable adults varied as it depended on the availability of volunteers. There was no or very little provision for AAs to attend overnight. AAs from both schemes attended for the interview stage, which could be many hours after the detainee had come

into custody. This meant that vulnerable detainees and children did not always receive early support from AAs to help them understand their rights and entitlements, and the processes they would go through while in custody.

4.29 Custody officers were confident in determining whether a vulnerable adult required the support of an AA. They used their own experience and professional judgement but also liaised with the health care practitioners to inform their decision.

4.30 The force did not monitor waiting times for AAs so could not show how well detainee needs were met. There was limited recording on custody records to show when AAs were requested and when they arrived in the suite; the main source of this information was the time when the rights and entitlements were re-read with the AA present. The cases we looked at showed a wide variation in waiting times for AAs to arrive, including family members acting as AAs. There were delays in both requests for AAs and then their time of arrival. In some cases, the wait was less than an hour but in others up to 18 hours, which was too long.

4.31 The number of AAs required was monitored monthly, and quarterly audits recorded whether AAs were present at the various stages of the custody process. This provided some information to help the force identify areas where improvement was needed.

4.32 In general, children were engaged with and cared for well in custody. Risks were managed well, and where children were known to other agencies there were discussions about how their best outcomes could be achieved. Girls were routinely assigned a female officer to care for their welfare needs, in line with legislation. Specific policies for children in the overarching custody policy identified their particular needs and how to meet these.

4.33 There were facilities to keep children away from adult detainees through discrete booking-in rooms and two designated cells at Weekley Woods. However, these facilities were not always used and there was little recording on custody records to show how often they were. There was no priority for children waiting to be booked in, and although there were visit rooms where parents could see their children, custody officers told us they rarely facilitated this. Children were not always spoken to by the police inspectors who reviewed their detention, and there was not always good reason or justification for this, which was poor practice (see also paragraph 3.32).

4.34 Custody officers had a clear focus on avoiding the detention of children and minimising their time in custody. We found examples of detention being refused, cases being progressed quickly, including overnight, and the use of bail or release under investigation to achieve these outcomes. Custody officers decided on action that had the least impact on the child.

4.35 There was monthly monitoring of children entering custody by age band, gender, first time in custody and the number charged and refused bail. However, the time that children spent in custody and the number of children detained overnight before charge were not monitored. This limited the force's ability to show how well its approach was minimising the impact of custody on children, and whether some individual cases of overnight detentions were avoidable. In a significant proportion of the cases we looked at, children were detained overnight. Our custody record analysis showed that 13 children spent an average of just over 12 hours in custody and seven were held overnight.

4.36 There were policies and procedures for children who were charged and refused bail to be transferred from custody to other accommodation arranged through children's social services, which have a statutory responsibility to ensure that children are moved in these circumstances. These cases were monitored by the force, and juvenile detention certificates were completed for the court for all children who had not been moved.

4.37 Despite these arrangements, which included an escalation process to senior officers in the force and in the local authority, there had been little progress. Force data showed that in the year to 31 December 2017, alternative accommodation had been requested in 38 of the 40 cases of children charged and refused bail, but only six were moved to secure accommodation. The force was unable to provide information to show whether any children were moved to other non-secure accommodation. There was no joint monitoring with partner agencies to improve the situation, and children continued to spend significant time in custody pending their court appearance. (See area of concern and recommendation S30.)

Area for improvement

4.38 The arrangements for appropriate adults should ensure early and effective support for all children and vulnerable adults in custody.

Governance of health care

4.39 Northamptonshire Healthcare NHS Foundation Trust provided primary health services. Joint working between the force and the trust was effective and supported by regular governance and contract monitoring meetings, but there were not enough clear performance measures in the contract to ensure that detainees' health needs were met. However, the force was re-procuring its health provision with support from NHS England, and the new contract due from June 2018 contained more robust performance measures. A recent peer review of the forensic practitioner service was informing service improvement, but overall clinical audits were not sufficiently comprehensive or targeted. Lessons learned from health incidents were disseminated to health staff.

4.40 The trust provided a primarily doctor-led (forensic practitioner) service, with four nurses providing additional daytime input. An embargo on recruitment during the re-procurement had reduced the hours of nursing cover from 7am to 11pm daily to 7am to 7pm. Nurses were based at the Northampton suite daily, with occasional embedded cover at Weekley Woods when staffing allowed.

4.41 Forensic practitioners provided 24-hour cover in six-hour shifts, but they started their shifts from home, which created delays of up to 90 minutes in attending the suites for those who lived furthest away. Custody forensic practitioners occasionally covered staffing gaps for the local sexual assault referral centre, which created additional delays.

4.42 The agreed response times were not monitored. Staff reported, and we observed, that some detainees had excessive waits for health professionals, particularly at night, at Weekley Wood generally and at peak demand times. In our custody record analysis, detainees requiring a health professional waited an average of two hours 56 minutes.

4.43 Training opportunities for nurses were too limited, which severely restricted their clinical practice compared with nurses in other forces we have inspected. This significantly increased the need for forensic practitioners to attend, and extended detainee waiting times. Clinical and managerial supervision were not sufficiently frequent. Health policies were available on the intranet but few were specific to the custody environment.

4.44 Very good local clinical leadership was provided for forensic practitioners, including effective information sharing and professional development through a secure online forum and regular meeting/learning events. Forensic practitioners completed agreed mandatory training annually, including life support and safeguarding, but this was not monitored.

4.45 Detainees could complain about health services through the trust's systems, but this was not advertised and the few complaints submitted had gone through the police system, which was not sufficiently confidential.

4.46 The clinical environment was very good, and included disposable privacy curtains and separate forensic sampling rooms. Cleaning was generally satisfactory. We were told that external infection control audits had been completed in the last year, but these were not provided. All clinical rooms contained appropriate clinical equipment and in-date stock.

4.47 Health staff had easy access to emergency equipment, but it was not standardised across the suites or sufficiently tailored to the environment.

Areas for improvement

4.48 There should be robust health care governance processes, including relevant local policies, training, clinical supervision, outcome measures and clinical audits, to ensure the health needs of detainees are consistently met.

4.49 Detainees who need to see a health care professional should be seen promptly within agreed response times that are linked to clinical and forensic priorities.

4.50 Detainees should be able to complain about health services through a well-advertised, confidential health complaints system.

4.51 Health staff should have easy access to standardised emergency equipment in both sites that is tailored to the environment.

Patient care

4.52 Custody staff referred detainees to health professionals based on identified need or a detainee's request. Additionally, ex-armed forces veterans were automatically referred for assessment. We observed effective joint working between custody and health staff. Custody staff said that the health care provided was good but reported some long delays. The care and interactions we observed were good and consultations were private. Professional telephone interpreting was used when required for detainees who spoke or understood little English. Women detainees could request a female health care professional or chaperone, but this was not advertised.

4.53 We were concerned to observe nurses routinely holding cell keys and visiting cells on their own to see and collect detainees, which created significant risks. When we raised this, trust managers reported this practice would stop immediately.

4.54 All health professionals completed clinical records on an electronic system, which supported effective continuity of care and information governance. The clinical records we examined were generally good. However, health professionals generally just copied the clinical entry on to the police system, and this often contained too much detail for custody staff, could lead to breaches of medical confidentiality (see paragraph 5.5 and area for improvement 5.7) and did not always include clear care plans for custody staff to follow. There was some quality sampling of clinical records, but this was not systematic or regular enough for effective governance.

4.55 Drug cupboard keys were stored securely and were only accessible to health staff. In both suites, the same agreed stock medicines were stored tidily. Nurses checked expiry dates

regularly and, with one exception, all stock was in date during the inspection. However, none of the medicines, including those that were highly tradeable were counted regularly, which meant that usage, prescribing and errors could not be adequately monitored. Trust managers addressed this during our inspection, in response to our concerns. Medicines that were discarded were not monitored, which again meant discrepancies could not be identified.

4.56 Police tried to retrieve medication from detainees' homes, where appropriate, and health staff assessed the detainee and checked the medicine before administration, which was good. Prescription pads were stored securely in the Northampton suite, and allowed doctors to prescribe non-stock items easily, but monitoring of these prescriptions was weak.

4.57 Symptomatic relief for drug and alcohol withdrawal was prescribed appropriately. Nurses could only administer a single dose under a patient group direction (authorising appropriate health care professionals to supply and administer prescription-only medicine), which was too restrictive. We observed that medication to treat opiate and/or alcohol withdrawals was sent with detainees going to court, which was good practice.

4.58 Detainees on methadone prescriptions for opiate addiction could continue their prescription in custody if clinically appropriate, which was positive. Detainees could have their prescribed angina or asthma reliever spray in possession, subject to an individual risk assessment, which was excellent. Nicotine replacement therapy was not available, which might have exacerbated the distress of detention for those who smoked.

4.59 The trust supplied custody sergeants with some medicines, including painkillers, glucose gel for low blood sugar and asthma inhalers, which allowed detainee access to prompt treatment when health professionals were not on site. However, guidance on their use was too limited and sergeants did not always seek forensic practitioner approval before administration, which was unsafe. The storage of these medicines, monitoring of their use and date checking were also inadequate.

Areas for improvement

4.60 Health staff should record a summary of their consultations in the custody record in language that a lay person can understand and which clearly outlines the care that custody staff should provide.

4.61 Detainees who smoke should have prompt access to nicotine replacement therapy, if clinically appropriate.

4.62 All authorisation, storage and administration of medication to detainees should meet current professional standards, and there should be effective stock reconciliation systems.

Good practice

4.63 *Medication to treat opiate and alcohol withdrawals that was due while the detainee was at court was sent with them, which ensured that their symptoms were managed effectively and that they could participate more effectively in their court hearing.*

Substance misuse

4.64 Support for detainees with substance misuse issues had deteriorated since our last inspection. There was no longer any visiting drug and alcohol practitioners or target drug testing on arrest schemes. This meant detainees were not actively offered harm minimisation information or support to engage with services, which was likely to result in poorer outcomes for detainees with these needs. Custody and health staff could refer detainees to local community services or for support via the court-based liaison and diversion service, but this did not happen often.

Area for improvement

4.65 Detainees with drug and alcohol needs should have easy access to harm minimisation interventions, and active support to engage with relevant services after their release.

Mental health

4.66 Custody staff we spoke to demonstrated a good understanding of mental health issues and reported they received some useful training updates.

4.67 There was no longer a mental health liaison and diversion service in the custody suites but there was one based at the court, which also provided some community support after release. The four custody nurses were all mental health nurses, which gave detainees and custody staff reasonable access to specialist assessment during the day, and they could refer detainees directly into relevant services.

4.68 We were unable to obtain data from either the force or the approved mental health professional service on assessments completed in the custody suites under the Mental Health Act. Reports from health, mental health and custody staff, and our case audits, indicated that detainees requiring such an assessment regularly experienced excessive delays, primarily due to difficulties in obtaining an appropriately qualified doctor. There were also often additional delays in accessing suitable mental health beds and obtaining an ambulance to convey the patient to hospital. In one extreme case in August 2017, a detainee was held in custody for 90 hours from the time an assessment under the Mental Health Act was requested until they were transferred to a mental health facility, due to factors outside the force's control, which was deplorable. Case records indicated that escalation processes were used appropriately when delays occurred.

4.69 Children were referred to the specialist child and adolescent mental health service if required, although we were told the need was low.

4.70 No person had been detained in custody as an initial place of safety under section 136 of the Mental Health Act[10] in the previous six months, which was positive.

4.71 Partnership working between the force and community mental health providers was very good, supported by regular effective meetings. Several initiatives - including street mental health triage, a crisis residential house and mental health cafes - supported people

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

experiencing mental health crisis to access appropriate support, and for some this included diverting them from custody.

Area for improvement

4.72 Detainees with mental health needs should receive prompt assessments, and agreed transfers to hospital facilities should take place promptly.

Good practice

4.73 *A range of initiatives, including street triage, a crisis house and mental health cafes, supported people experiencing a mental health crisis to access appropriate and prompt support, which improved their outcomes.*

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

5.1 In our case audits and in the custody records reviewed, pre-release risk assessments were generally poorly completed, containing little information on the detainee's possible risks, including those identified on their arrival in custody and how they had been managed.

5.2 The standard pre-release template did not contain sufficient questions to ensure safe release of detainees. For example, it did not record how detainees travelled home, which was particularly important as the custody suites were some distance from residential areas. In one custody record, a child was recorded as having been released at 4.27am with no indication in the pre-release risk assessment or the detention log of where that child had gone on release.

5.3 Despite these limitations, the pre-release processes we observed were good, and custody sergeants generally focused on the safe release of detainees. This included ensuring children and vulnerable detainees were taken home by officers or offered a known taxi service to take them into the centre of town, although this was not offered at the Weekley Woods suite. No travel warrants were available for detainees on release.

5.4 All detainees were given a detainee release leaflet on release with the name of the officer dealing with their case, contact telephone number, station and custody record number, together with a list of useful support service numbers. This was a good initiative, although only available in English.

5.5 The quality of the person escort records (PERs) we checked varied. Most were completed to a good standard but some lacked basic information. For example, one failed to identify that a detainee had not eaten for over 36 hours while held in police custody, and another did not record that the detainee had refused to accept his insulin injection before attending court; such failures in recording increased detainees' risk levels. Although this information was contained in loose-leaf medical reports attached to the PERs, the details should have been clearly marked up on the PER.

Areas for improvement

5.6 Pre-release risk assessments should record all risks identified during the detainee's custody, and how these and any additional release risks are to be managed on release.

5.7 Person escort records should clearly record all known risks for the detainee.

Courts

5.8 Custody staff told us that Northampton Magistrates' Court did not normally accept detainees for court appearance after 12 to 1pm on weekdays. This was too early and resulted in detainees remaining in police custody for longer than necessary. We were told that some detainees had been refused to attend even earlier than that, although a few staff said there was some limited flexibility and they would always contact the court to see if a detainee could be accepted. An escalation process had been introduced to negotiate acceptance at court for vulnerable detainees, such as children and vulnerable adults, but staff said this was not always successful. There had been little improvement in this situation since our previous inspection.

5.9 We observed detainees at both suites being transported to court with medication prescribed by forensic practitioners to manage their medical conditions while in court custody, which was good practice (see paragraphs 4.58 and 4.64).

Area for improvement

5.10 **Northamptonshire Police should liaise with the court service to ensure court cut-off times are reasonable to minimise the time that detainees are held in police custody.** (Repeated recommendation 5.20)

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

Areas of concern and recommendations

6.1 **Area of concern:** Chief officers in Northamptonshire Police had not taken sufficient accountability for ensuring that the section 22 collaboration arrangements with neighbouring forces delivered the required outcomes for detainees in its own force area.

Recommendation: The force should take clear accountability for the delivery of custody services to Northamptonshire detainees, with effective scrutiny and oversight at senior officer level to ensure safe and respectful outcomes. (S26)

6.2 **Area of concern:** The force did not comply with code C of the Police and Criminal Evidence Act (PACE) in several areas, and it needed to address this as a matter of urgency.

Recommendation: The force should take immediate action to ensure that it complies fully with code C of PACE, in particular with:
- annex H: rousing of intoxicated detainees should take place through the officer entering the cell;
- section 15.7: detainees should be informed where a review of their detention has taken place while they are asleep;
- section 15.14: where telephone reviews are carried out, the name of the inspector should be recorded along with the reasons why the review cannot be conducted in person;
- section 15.3.A: inspectors should consider reviews of vulnerable detainees in person;
- section 8.5: detainees should not be interviewed while they are wearing unsuitable replacement (anti-rip) clothing. (S27)

6.3 **Area of concern:** The governance and oversight of the use of force in custody were inadequate, data were unreliable, and Northamptonshire Police did not record all instances where force was used in its custody suites. Not all uses of force were proportionate to the risk or threat posed.

Recommendation: The force should strengthen its approach to the use of force by:
- ensuring that all instances where force is used in custody are properly recorded so that the data are accurate, and in line with recommendations from the National Police Chiefs Council (NPCC);
- monitoring the use of force, with cross-referencing to CCTV footage, to provide assurance that its use is fully justified and proportionate to the threat posed. (S28)

6.4 **Area of concern:** The collation and monitoring of data relating to key areas of custody were insufficient.

Recommendation: The force should develop comprehensive performance monitoring across all key areas of custody services. (S29)

6.5 **Area of concern:** Children charged and refused bail continued to remain in custody, often overnight and for long periods, when they should have been transferred to alternative accommodation arranged through children's social services.

Recommendation: The force should continue to work with local authority partners to avoid the overnight detention of children in custody by transferring them to suitable alternative accommodation. (S30)

Areas for improvement

Leadership, accountability and partnerships

6.6 There should be sufficient staffing levels on all shifts to ensure the safe detention of all detainees. (1.12)

6.7 *Authorised Professional Practice*, supported by clear local policies where required, should be available to staff, and quality assurance should be sufficiently focused on compliance testing. (1.13)

6.8 The force should improve the quality of its custody records so it is clear when and what actions have been taken, and to provide clear evidence of the care that a detainee receives while in custody. (1.21)

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

6.9 Detainee dignity should be maintained at all times, and in particular, they should be provided with suitable alternative footwear, and offered toilet paper routinely rather than on request (subject to risk assessment). (3.6)

6.10 All custody staff should be trained to identify and meet the individual needs of detainees across all protected characteristics. (3.13)

6.11 Women detainees should always have the opportunity to speak with a female member of staff to discuss their care needs. (3.14)

6.12 Religious books and artefacts should be available to meet the needs of a wider range of faiths. (3.15)

6.13 All suites should have working double-handset telephones to facilitate telephone interpreting and ensure privacy for the detainee. (3.16)

6.14 Detainees' clothing and footwear should only be removed on the basis of an individual risk assessment. (3.22)

6.15 All custody staff should carry anti-ligature knives or shears. (3.23, repeated recommendation 4.23)

6.16 All custody staff should be involved collectively at shift handovers. (3.24)

6.17 There should be effective arrangements in place to take and record complaints made by detainees and, where possible, these should be dealt with before the detainee leaves custody. (3.41)

In the custody cell, safeguarding and health care

6.18 Faults and damage to suites should be dated and recorded accurately in each suite so that custody staff can monitor response times from the maintenance contractor. (4.7)

6.19 Custody staff in both suites should have easy access to standardised well-checked emergency and first aid equipment. (4.8)

6.20 Each member of staff involved in using force against a detainee should submit an individual Northamptonshire Police use of force form. (4.17)

6.21 Detainees should only be strip searched if there are sufficient grounds to do so, and the justification for this should be clearly recorded on their custody record, along with the result of the search. (4.18)

6.22 Detainees should be routinely offered reading materials, access to outside exercise and showers. (4.24)

6.23 There should be a range of replacement underwear for male and female detainees. (4.25)

6.24 The arrangements for appropriate adults should ensure early and effective support for all children and vulnerable adults in custody. (4.38)

6.25 There should be robust health care governance processes, including relevant local policies, training, clinical supervision, outcome measures and clinical audits, to ensure the health needs of detainees are consistently met. (4.48)

6.26 Detainees who need to see a health care professional should be seen promptly within agreed response times that are linked to clinical and forensic priorities. (4.49)

6.27 Detainees should be able to complain about health services through a well-advertised, confidential health complaints system. (4.50)

6.28 Health staff should have easy access to standardised emergency equipment in both sites that is tailored to the environment. (4.51)

6.29 Health staff should record a summary of their consultations in the custody record in language that a lay person can understand and which clearly outlines the care that custody staff should provide. (4.60)

6.30 Detainees who smoke should have prompt access to nicotine replacement therapy, if clinically appropriate. (4.61)

6.31 All authorisation, storage and administration of medication to detainees should meet current professional standards, and there should be effective stock reconciliation systems. (4.62)

6.32 Detainees with drug and alcohol needs should have easy access to harm minimisation interventions, and active support to engage with relevant services after their release. (4.65)

6.33 Detainees with mental health needs should receive prompt assessments, and agreed transfers to hospital facilities should take place promptly. (4.72)

Release and transfer from custody

6.34 Pre-release risk assessments should record all risks identified during the detainee's custody, and how these and any additional release risks are to be managed on release. (5.6)

6.35 Person escort records should clearly record all known risks for the detainee. (5.7)

6.36 Northamptonshire Police should liaise with the court service to ensure court cut-off times are reasonable to minimise the time that detainees are held in police custody. (5.10, repeated recommendation 5.20)

Examples of good practice

6.37 Medication to treat opiate and alcohol withdrawals that was due while the detainee was at court was sent with them, which ensured that their symptoms were managed effectively and that they could participate more effectively in their court hearing. (4.63)

6.38 A range of initiatives, including street triage, a crisis house and mental health cafes, supported people experiencing a mental health crisis to access appropriate and prompt support, which improved their outcomes. (4.73)

Section 7. Appendices

Appendix I: Progress on recommendations from the last report

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

Strategy

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

Main recommendations

There should be consistent quality assurance of custody processes, such as custody record and prisoner escort record dip sampling. (2.19)
Not achieved

Detainees with mental health problems should be diverted to the appropriate services, and section 136 suites should be used as a priority for their assessment. Police custody should only be used exceptionally for this purpose. (2.20)
Achieved

Recommendation

Senior managers in Northamptonshire Police should liaise with the court service and the prisoner escort company to agree on the management of cell space and detainees, with clear demarcation and handover of responsibility. (3.11)
No longer relevant

Treatment and conditions

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

Recommendations

Staff should be trained in providing for the specific needs of minority groups, in particular women, juveniles and people with disabilities. (4.8)
Partially achieved

Visits to cells should be undertaken only by custody staff, or if necessary accompanied by them. (4.21)
Achieved

All custody staff should be involved in the same shift handover and, wherever possible, this should be away from the booking-in area and be recorded. (4.22)
Not achieved

All custody staff should carry anti-ligature knives or shears. (4.23)
Not achieved (repeated as area for improvement 3.23)

Cells should be clean and free of graffiti, and ligature points should be removed or managed where resources do not allow their immediate removal. (4.35)
Partially achieved

The audible signal on the call bell panel at Weston Favell should be reinstated, and cell bells should be responded to promptly. (4.36)
Not achieved

All detainees held overnight, or who require one, should be offered a shower and be able to use one in reasonable privacy. (4.43)
Not achieved

Custody sergeants should ensure that meals are provided to detainees regularly and that offers of meals are always recorded in the detention log. (4.48)
Achieved

Detainees, especially those held for longer periods, should be offered outside exercise, and all exercise yards should be kept clean and free from ligature points. (4.52)
Not achieved

Individual rights

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

Recommendations

Subject to investigative considerations, all detainees should be offered a free telephone call. (5.7)
Achieved

All custody staff should complete comprehensive pre-release risk assessments, especially for vulnerable detainees. (5.8)
Not achieved

The use of telephone reviews should be kept to a minimum, and detainees informed of them within a reasonable time of waking. (5.17)
Not achieved

Appropriate adults should be available without undue delay, including out of hours, to support juveniles aged 17 and under and vulnerable adults in custody. (5.18)
Not achieved

Northamptonshire Police should engage with the local authority to ensure the provision of secure beds for juveniles who have been charged but cannot be bailed to appear in court. (5.19)
Not achieved

Northamptonshire Police should liaise with the court service to ensure court cut-off times are reasonable to minimise the time that detainees are held in police custody. (5.20)
Not achieved (repeated as area for improvement 5.10)

Detainees should be routinely informed of how they can make a complaint about their care and treatment. (5.22)
Not achieved

Health care

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

Recommendations

All medicine stock should be recorded appropriately in accordance with the Misuse of Drugs Regulations 2001 with regular checks and any missing stock investigated. (6.10)
Not achieved

Clinical records in custody suites should be stored securely in line with the Data Protection Act and Caldicott principles on the use and confidentiality of personal health information. (6.20)
Achieved

Appendix II: 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*.[11]

Document review

Forces are asked to provide a number of key 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.

Key documents, including performance data, are also requested 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 key 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.[12] 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.[13]

Case audits

We carry out in-depth audits of approximately 40 case records 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 issues to assess how well detainees are treated and cared

[11] http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/inspection-criteria/

[12] 95% confidence interval with a sampling error of 7%.

[13] A statistically significant difference between the two samples is one that is unlikely to have arisen by chance alone, and can therefore be assumed to represent a real difference between the two populations. In order to appropriately adjust p-values in light of multiple testing, $p<0.01$ was considered statistically significant for all comparisons undertaken. This means there is only a 1% likelihood that the difference is due to chance.

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 their physical conditions, 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 obtain 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 key staff

During the inspection we carry out interviews with key 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 key people involved in the commissioning and delivery of 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 coordinator 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, in order 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 III: Inspection team

Kellie Reeve	HMI Prisons team leader
Fionnuala Gordon	HMI Prisons inspector
Fran Russell	HMI Prisons inspector
Fiona Shearlaw	HMI Prisons inspector
Norma Collicott	HMI Constabulary and Fire & Rescue Services inspection lead
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Patricia Nixon	HMI Constabulary and Fire & Rescue Services inspection officer
Vijay Singh	HMI Constabulary and Fire & Rescue Services inspection officer
Majella Pearce	HMI Prisons health services inspector
Matthew Tedstone	Care Quality Commission inspector
Anna Fenton	HMI Prisons researcher
Laura Green	HMI Prisons researcher