



Inspecting policing
in the public interest

Report on a follow-up inspection visit to police custody suites in Cambridgeshire

31 May–3 June 2011

by

HM Inspectorate of Prisons and
HM Inspectorate of Constabulary

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1. Introduction

This report is part of a programme of inspections of police custody carried out jointly by our two inspectorates and which form a key part of the joint work programme of the criminal justice inspectorates. These inspections also contribute to the United Kingdom's response to its international obligation to ensure regular and independent inspection of all places of detention.¹ The inspections look at strategy, treatment and conditions, individual rights and health care.

This visit to police custody suites in Cambridgeshire was a follow-up to a previous critical inspection in November 2008, and was the second time we have gone back to a force about which we have expressed concerns. On our return, we were pleased to find that the force had taken our previous recommendations very seriously and we identified significant improvement in many areas, although some where we still had concerns.

There had been a great deal of work done strategically to address our previous findings and much effort had been made to improve the standard of the custody estate, including safety, general cleanliness and managing graffiti. Cambridgeshire was also involved in an interesting initiative to share custody facilities with Norfolk and Suffolk police and had access to a third of the cell space in the recently opened Kings Lynn custody suite. However, there were still areas which needed improvement, with some staff working in custody not being permanent and some day-to-day management arrangements were disjointed and confusing. Staffing levels at Huntingdon were a particular concern with only one sergeant and no detention officer on duty.

We found that detainees were treated professionally and with respect, although there was room for improvement in the focus on the specific needs of some vulnerable groups, such as juveniles. Detainees were generally well cared for and there was less of an "on request only" culture than we normally see. There was an appropriate balance between progressing cases and the rights and entitlements of detainees.

There was now a good focus on the safety of detainees, and in most cases we reviewed, risk management arrangements appeared proportionate, but we continued to have concerns about the consistency of rousing detainees under the influence of alcohol or drugs and the use of CCTV for the constant observation of very vulnerable detainees.

Primary health provision had improved since our previous visit and detainee care was now timely and of good quality. Substance use services were well developed, including for those with a primary problem with alcohol. While communication with providers of mental health services had improved, there was still no mental health in-reach service. The number of people being held in police custody under section 136 of the Mental Health Act was half that of the previous year but it was still too often where they inappropriately ended up.

Overall, provision of police custody in Cambridgeshire was much improved from our previous inspection and, in particular, we noted a much more positive staff culture focussed on the welfare of detainees and far more respectful and decent custody facilities. The main weaknesses related to staffing and management arrangements, together with a need for still further improvements to the support for detainees with mental health problems. Notwithstanding the many current challenges facing all police forces, we hope this report will

¹ Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment

help Cambridgeshire Constabulary and the Police Authority to resolve our remaining concerns and further develop provision.

Sir Denis O'Connor
HM Chief Inspector of Constabulary

Nick Hardwick
HM Chief Inspector of Prisons

July 2011

2. Background and key findings

- 2.1 HM Inspectorates of Prisons and Constabulary have a programme of joint inspections of police custody suites, as part of the UK's international obligation to ensure regular independent inspection of places of detention. These inspections look beyond the implementation of the Police and Criminal Evidence Act 1984 (PACE) codes of practice and *Safer Detention and Handling of Persons in Police Custody* 2006 (SDHP) guide, and focus on outcomes for detainees. They are also informed by a set of *Expectations for Police Custody*² about the appropriate treatment of detainees and conditions of detention, which have been developed by the two inspectorates to assist best custodial practice.
- 2.2 At the time of this unannounced inspection, Cambridgeshire had four custody suites designated under PACE for the reception of detainees, operating 24 hours a day. These dealt with detainees arrested as a result of mainstream policing. There were a further three custody suites which could be opened for use if the need arose. We visited them all during the inspection. The force had a cell capacity of 80 cells, with 23,117 new detainees being held in the year to May 2011. In the same period, 310 detainees had been held for immigration matters.
- 2.3 The custody suites and cell capacity of each was as follows:

Custody suite	Number of cells
Peterborough	29
Huntingdon	10
Cambridge	15
King's Lynn (located in Norfolk)	8 (for use by Cambridgeshire out of a total of 24)
March (part time)	11
Ely (part time)	3
St Neots (part time)	4

- 2.4 Police custody cells in Cambridgeshire were previously inspected between 24-26 November 2008. In the subsequent report we identified "considerable shortfalls in many aspects of strategic management and service delivery", and called for "urgent improvement" to bring the custody suites up to a satisfactory standard. We also indicated that we would return sooner rather than later to assess progress against our previous findings and recommendations. Comments in this report refer to all suites, unless specifically stated otherwise.

² <http://www.justice.gov.uk/inspectorates/hmi-prisons/expectations.htm>

Strategic overview

- 2.5 There had been much positive work in response to our previous inspection but the strategic management of custody needed to be improved. The custody suite estate had been much improved since the last inspection. Relationships between the Cambridgeshire Police Authority (CPA) and the force were positive, and there was an active Independent Custody Visitors (ICV) scheme.
- 2.6 Cambridgeshire Police operated a devolved model of custody with oversight from the head office investigations custody development unit (CDU). This meant that day-to-day management of custody was within the policing divisions, although there were plans to centralise the management. Not all staff were permanent, and lines of management responsibility and accountability were confused. Staffing arrangements were not always robust and there were variations in practice between the custody suites.
- 2.7 All staff had custody-specific training. Partnership arrangements were well developed and included Cambridgeshire sharing custody facilities at King's Lynn with Norfolk and Suffolk police forces.
- 2.8 Quality assurance arrangements were inconsistent.

Treatment and conditions

- 2.9 Staff treated detainees professionally and with respect, and team working was well developed. Awareness of diversity issues was mixed but we observed some good practice.
- 2.10 There was generally an appropriate focus on the safety of detainees but some staffing arrangements risked undermining this. Risk management was usually proportionate although there were examples when rousing of detainees did not happen, and we had concerns about how constant watches were managed.
- 2.11 The physical environment of custody suites had much improved since our last visit; they were clean and free of graffiti. We found a few ligature points in cells. Staff were aware of fire evacuation arrangements but these had not been practised. Health and safety walk-throughs took place but the arrangements varied from site to site.
- 2.12 The attention given to the care and welfare of detainees was good. Reading materials were available and actively offered. The food provided was adequate.
- 2.13 Learning the lessons information from the Independent Police Complaints Commission (IPCC) was disseminated to staff. Use of force information was collated but not effectively analysed for trends.

Individual rights

- 2.14 We found a positive approach to balancing the rights of individuals with progressing investigations. Custody sergeants checked to ensure detention was appropriate and had a focus on alternatives to custody.
- 2.15 Detainees were not usually asked if they had dependants to care for while they were in custody. Pre-release risk assessments were completed, but the quality was variable. PACE

was adhered to. Detainees held for immigration matters were routinely held for two days or longer.

- 2.16 Arrangements to ensure the provision of appropriate adults (AAs) were variable. Arrangements for storing and managing DNA and forensic samples were good. Court cut-off times were too early.
- 2.17 Detainees were not told how to complain and when they did the arrangements for dealing with them were poor.

Health care

- 2.18 Primary care services were provided by G4S and there were good clinical governance arrangements. Some clinical rooms needed to be improved. The management of medications was generally good although there were some problems to resolve. All the custody suites had full resuscitation kits and staff were trained in their use.
- 2.19 Detainee health care was good. Waiting times for health staff were reasonable. Arrangements for providing symptomatic relief for substance users were good, but not for those on methadone, and detainees could continue to receive their prescribed medications. Health staff did not have access to the electronic computer records system.
- 2.20 Substance use services were well developed although support for detainees with alcohol problems was only signposted, and this was similar for juveniles.
- 2.21 Mental health diversion services were planned but not yet operating, and too many detainees were held in police custody under Section 136 of the Mental Health Act 1983.³

Main recommendations

- 2.22 The management of custody should provide clear lines of responsibility and accountability, and staffing levels should be sufficient to maintain the safety, care and welfare of detainees.
- 2.23 When risk assessment indicates the need for constant observation at the cell door or rousing, this should be rigorously implemented.
- 2.24 There should be mental health in-reach arrangements to enable detainees with mental health problems to be identified and diverted into mental health services as appropriate, and police custody suites should not be used as places of safety for Mental Health Act Section 136 assessments.

³Section 136 enables a police officer to remove someone from a public place and take them to a place of safety – for example, a police station. It also states clearly that the purpose of being taken to the place of safety is to enable the person to be examined by a doctor and interviewed by an approved social worker, and for the making of any necessary arrangements for treatment or care.

3. Strategy

Expected outcomes:

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

- 3.1 Our previous inspection of Cambridgeshire in November 2008 found that the constabulary and Cambridgeshire Police Authority (CPA) had a great deal of work to do to achieve compliance with *Safer Detention and Handling of Persons in Police Custody* (SDHP). This inspection showed evidence of an active response to that report. The CPA now had a strong working relationship with the force, its oversight was challenging but proportionate, and relationships were mutually supportive.
- 3.2 An assistant chief constable (ACC) was the strategic lead officer and portfolio holder for custody provision. Cambridgeshire Constabulary operated a devolved custody management structure across three divisions, with day-to-day management within the divisions and oversight from a custody development unit (CDU) based at headquarters (HQ). The force had plans to centralise the day-to-day management of custody but these had not yet been implemented.
- 3.3 The ACC maintained an overview of custody through a superintendent who was responsible for volume crime, criminal justice and custody. The superintendent was well supported by a chief inspector and the CDU. The CDU maintained central oversight of custody performance, contracts and policies and tried to maintain corporacy across the three divisions.
- 3.4 The custody suites at Huntingdon, Peterborough and Cambridge were CPA owned and had been recently refurbished. The March custody suite was mothballed, but would be inspected for safety and welfare standards before use. There was also access to a further custody suite at King's Lynn in Norfolk, shared with Norfolk and Suffolk constabularies. This was staffed by Norfolk Constabulary and managed by an inspector who was the custody manager. Police inspectors were custody managers (CMs) for the three main divisional custody suites.
- 3.5 Meetings in the CPA and force examined and managed performance and progress. The force was going through a restructuring in which one target was to reduce its detainee throughput through custody by 25%, and it was on course to achieve this. The reduction was being achieved through diversionary schemes, which included restorative justice, penalty notices for disorder and street bail. The Superintendent met monthly with the Chief Inspector to scrutinise performance.
- 3.6 An ACC sat on the Local Criminal Justice Board (LCJB), which included representatives from the Crown Prosecution Service (CPS), defence solicitors and the youth offending service (YOS). We were told that partnership relationships with the CPS were robust, and those with the United Kingdom Border Agency (UKBA) were good – there was a joint police/UKBA crime team working at Peterborough. The partners we spoke to reported good working relationships that were professional and mutually respectful.
- 3.7 There was a very active Independent Custody Visitors (ICV) scheme, with one CPA-employed scheme coordinator and one panel coordinator for each main custody suite. The CPA lead officer for custody saw and supported the ICVs quarterly and prepared quarterly reports on their visits for the Independent Custody Visitors Panel, which reports to the Scrutiny Committee. The deputy chief constable and ACC regularly attended panel meetings. ICVs had been provided with training but many were volunteers with jobs that did not allow them to

attend weekday training or meetings. This was a source of frustration. ICVs said that they felt very welcomed and supported by the force, staff and CPA, and there were good systems for gathering their feedback and quick resolution of matters raised.

- 3.8 All police staff had attended nationally accredited custody training before they were deployed into custody. Custody sergeants completed a three-week custody course and refresher first aid/personal safety training, but there was no other custody-specific ongoing refresher training.
- 3.9 Divisional CMs carried out dip sampling of custody records but this was inconsistent and there was no central oversight from HQ. The CDU did not do any dip sampling of custody records.
- 3.10 Chains of command for accountability and responsibility were overly complicated and not conducive to detailed supervision. Mostly, CMs did not have line management responsibility for custody sergeants, who were line managed by shift inspectors. The CMs also had other responsibilities which took them away from custody suites to perform other duties for 20% to 40% of their time. Custody sergeants did not manage the DOs who were managed by a senior DO or a CM. Therefore, management of performance issues was difficult and oversight was inadequate. (See main recommendation 2.22.)
- 3.11 Staffing of custody suites was not permanent. Each division provided custody sergeants from their patrol shifts ad hoc. Detention officers were provided for most shifts, but not all. Although some sergeants worked in the custody suites semi-permanently, others rotated through the duty rota and filled in as and when required. This required the force to train all patrol sergeants so they could fulfil custody officer duties, which was a very expensive way to provide custody sergeants.
- 3.12 If a DO was not available for some shifts or more resources were needed, sergeants could call in police constables from the patrol shifts to augment staffing rotas. There were a number of different shift systems in operation.
- 3.13 We noted that in Huntingdon a single sergeant sometimes operated on their own without the support of a DO or police constable. Our researcher analysed custody records for one of these periods, which provided evidence of situations where the sergeant was faced with several juvenile detainees who needed greater support and safety/welfare checks than one person could provide. This was potentially a high-risk situation for the detainees and an unacceptable risk to the sergeant and the force. (See main recommendation 2.22.)

Recommendation

- 3.14 Cambridgeshire police should undertake regular dip sampling of custody records, focusing on the management of risk of harm and the quality of detainee care.

4. Treatment and conditions

Expected outcomes:

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

Respect

- 4.1 Most detainees were brought to the custody suites in vans, and the vans we viewed were reasonably clean. Custody staff treated detainees with care and respect. We observed instances of custody staff going out of their way to be responsive to detainees' needs by carefully explaining why potentially unwelcome procedures were necessary and answering their questions fully. Use of first names was usual. Most detainees we spoke to told us they felt they had been treated well by custody staff and some were highly appreciative of them. Searches and the removal of detainees' property were conducted considerately. The layout of the booking-in areas offered reasonable privacy. Peterborough had a booking-in desk that offered greater privacy and could be used for processing vulnerable detainees. There was also a separate booking-in desk at King's Lynn that staff said they used for 'sensitive cases'.
- 4.2 There was room for improvement in the attention paid to detainees' diverse needs. Female detainees were told they could speak with a woman officer but they were not routinely offered hygiene packs (see paragraph 4.31 and housekeeping point 4.36). Although there was the Dawn Project in Peterborough, a women's centre whose role included the diversion of women from the criminal justice system, the project's staff did not come into the custody suite and custody staff showed little awareness of its work.
- 4.3 At most suites, custody sergeants told us that very young or vulnerable juvenile detainees could sometimes be allowed to wait with family members in an interview room instead of being placed in a cell, although this did not happen at Cambridge. Staff had not received training about children and young people, and awareness of their specific needs was too limited.
- 4.4 Huntingdon and Peterborough had copies of the Bible and Qur'an and prayer mats, which were stored in a respectful manner, although at Ely, the prayer mat could not be found. The direction of Mecca was indicated by an arrow on the ceiling of each cell.
- 4.5 The low bed plinths in the cells at some custody suites would cause difficulties for some detainees who were older or had disabilities. A hearing loop was available at King's Lynn and Cambridge but at the latter had apparently never been used. A wheelchair was available at Cambridge.

Recommendation

- 4.6 Staff should receive awareness training on child protection and safeguarding.

Safety

- 4.7 We observed custody sergeants conducting risk assessments carefully, asking detainees questions at a reasonable pace and putting supplementary questions where necessary, such as when self-harm was disclosed. The sensitive manner and skilled questioning of some

custody sergeants was very effective in engaging detainees' cooperation in assessing risk of harm. Many detainees told us they felt staff cared about them, and this view was confirmed by the solicitors with whom we spoke.

- 4.8 Risk management was proportionate and subject to regular review, although we had some concerns about the management of constant observations and close proximity. Some custody sergeants told us they sometimes avoided using these high levels of observation because they depleted the number of officers available for police patrols, and placed detainees needing them on constant CCTV observation instead, which was not in accordance with established guidance on safer detention.⁴ Similarly, we were not convinced that some staff understood the importance of obtaining full responses to questions when they made rousing checks on detainees. Our custody record analysis identified deficiencies in rousing, with entries such as 'appeared asleep' about detainees subject to rousing checks. It also showed that some detainees who were intoxicated were subject only to 60-minute observations. At Cambridge, spectacles were often removed from detainees regardless of the risks identified. At King's Lynn, constant observation was facilitated by the use of cells with glazed doors.
- 4.9 IPCC 'learning the lessons' briefings were available on the force's intranet through the 'custodian' policies database. However, the briefings were difficult to find, and few custody staff said they looked at them regularly. Staff carried ligature cut-down knives.
- 4.10 All suites held formal and comprehensive handover meetings between custody sergeants, but they did not include DOs, who had their own meeting, partly because sergeants and DOs worked different shifts.

Recommendation

- 4.11 Handover meetings should include all custody staff.

Housekeeping points

- 4.12 Detainees' spectacles should not be taken away unless a risk assessment indicates the need to do so.
- 4.13 The Independent Police Complaints Commission 'learning the lessons' briefings should be made more easily accessible and staff encouraged to use them.

Use of force

- 4.14 Arresting officers' use of handcuffing was commendably judicious and many detainees were not handcuffed on arrival into custody. Custody sergeants were skilled in securing the cooperation of distressed or disturbed detainees. We observed the restraint of a detainee at Cambridge that was conducted in an exemplary fashion. The detainee was given ample opportunity to control himself after acting aggressively towards officers. When he had to be restrained, arresting officers and custody staff worked calmly and proportionately, using his first name and giving him clear instructions and every opportunity to calm down. The custody sergeant remained at the detainee's head to direct the process effectively.

⁴ National Centre for Policing Excellence (2006) *Guidance on Safer Detention and Handling of Persons in Police Custody*, London, Home Office

- 4.15 All staff had been trained in the approved techniques and received annual refresher training. Detainees saw a health care professional if they were injured or on request after force was used.
- 4.16 There was a use of force form that was submitted when force was used by arresting officers, but this was not used in custody. If force was used in custody, a note was made on the custody record but this could not be interrogated to provide management information. This meant that the analysis of use of force did not include any trends in custody.

Recommendation

- 4.17 Cambridgeshire police should collate use of force data from custody and examine it for trends in accordance with the Association of Chief Police Officers policy and National Policing Improvement Agency guidance.

Physical conditions

- 4.18 Cells at Peterborough, Huntingdon, Ely and King's Lynn were clean, free of graffiti and well decorated. Most were bright and well lit, although we were concerned that some cells at Peterborough had no natural light. Arrangements for cleaning and maintenance worked well at these custody suites. Toilets, washbasins, showers and booking-in areas were also clean and tidy. The suite at Ely was used only two days a week but was also very clean and bright.
- 4.19 Since the previous inspection in 2008, there had been a concerted effort to improve the physical conditions of the Cambridge suite. All the walls had been painted and there was no obvious graffiti. Corridors and cells were regularly cleaned, although there were still some dirty marks on the floor. In some parts of the suite, including some cells, there was a pervading unpleasant smell, which staff thought came from the drains. The custody suite was cramped and very untidy with boxes, towels and other items lying on the floor, which created a sense of disorder.
- 4.20 We found some ligature points in cells, as well as in the toilets attached to clinical rooms at Huntingdon, and pointed these out to the force during the inspection. Despite this, it was clear that there had been considerable efforts to improve the safety of cells since our last inspection.
- 4.21 Smoking in the custody suite or exercise area was not allowed. Fire evacuation policies were in place and suites were well equipped with plastic handcuffs and other evacuation equipment. The frequency of fire drills varied between suites, and not all kept records of them.
- 4.22 Cell call bells and panic alarms were checked weekly. We were told that staff explained the call bells to each detainee, but at Peterborough we saw staff placing a detainee in a cell without doing so. However, we observed staff responding to call bells promptly at all suites.
- 4.23 Health and safety 'walk-throughs' (checks) were not consistent or thorough, and the records we saw were limited to quantitative rather than qualitative observations. Detention officers (DOs) carried out some daily cell checks but CMs did not do weekly or monthly checks as outlined by safer detention guidance, and some told us that they relied on the checks carried out by the DOs. We found some evidence of health and safety quarterly checks but they were general and not custody specific. In general, there was a lack of records and audit trails.

Recommendations

- 4.24 The use of cells without natural light at Peterborough is inappropriate and should be kept to an absolute minimum.
- 4.25 Cambridgeshire police should address the safety issues around ligature points and, where resources do not allow them to be dealt with immediately, the risks should be managed effectively.
- 4.26 Fire practice evacuations should be held regularly at all suites and documented.
- 4.27 Health and safety walk-through arrangements should be thorough and consistently applied at all custody suites.

Housekeeping points

- 4.28 The source of the offensive smells at the Cambridge suite should be traced and eliminated.
- 4.29 The use of the cell call bells should be explained to every detainee.
- 4.30 The communal areas in Cambridge should be kept tidy and clear of unnecessary items.

Personal comfort and hygiene

- 4.31 All cells were equipped with a mattress and pillow that were clean and in good condition. There were plentiful stocks of blankets, and detainees could have more than one if they wanted. We observed staff bringing a blanket for a detainee who said she felt cold during booking-in. There were plenty of clean towels. Hygiene packs for women detainees were very good, but only available on request, although a sign about their availability was displayed at Huntingdon. Soap, razors, toothbrushes and other hygiene items were also in plentiful supply.
- 4.32 Toilet areas were either screened from cell CCTV monitors or the CCTV image was obscured. This was carefully explained to detainees. Small packs of toilet paper were available in each cell except at King's Lynn, where detainees had to ask for it.
- 4.33 We were concerned about the lack of privacy for detainees who wanted a shower. Showers were inadequately screened, particularly at Cambridge and Peterborough, where only one of the four showers had a door and it was too small to ensure privacy. The showers at Cambridge had an unpleasant odour. Although showers had hot water and appeared to be used, female detainees were unlikely to feel able to take a shower in such public environments. Indeed, detention officers at Cambridge told us that they could not recall a female detainee requesting a shower there.
- 4.34 We were impressed by the range of replacement clothing available to detainees. Those whose clothing contained cords that could not be removed were offered a two-piece paper suit, whereas detainees whose clothing was seized or heavily soiled were given tracksuit bottoms, T-shirts and plimsolls, of which there were plentiful stocks in a range of sizes. Replacement male and female underwear was also available, which was unusual. Staff confirmed that detainees would not go to court or be sent home in paper clothing. Several of the custody records we read failed to record details of clothing seized and the replacement provided.

Recommendation

- 4.35 Showers should be properly screened so that detainees can have a shower with dignity and in privacy.

Housekeeping points

- 4.36 Hygiene packs should be routinely offered to women detainees.
- 4.37 Toilet paper should be available in all cells.

Catering

- 4.38 There was a good range of microwave meals available, with cereals at breakfast time. Food temperature probes were not routinely used at all the custody suites. Hot and cold drinks were offered to detainees at regular intervals. Detention officers did not have food hygiene training.

Housekeeping points

- 4.39 The temperature of microwave meals should be checked and recorded.
- 4.40 Custody staff should have food hygiene training.

Activities

- 4.41 We saw a good supply of reading materials in all the custody suites, including books in foreign languages. However, there were few magazines of interest to young people.
- 4.42 All suites had exercise yards and we saw detainees taking outdoor exercise at Huntingdon, but in contrast at Peterborough staff told us they rarely had time to provide outdoor exercise to detainees. Visits were available at King's Lynn and Peterborough, where there were good facilities, but were not encouraged at Cambridge. The exercise yard at the temporarily closed March suite had a very low ceiling grille that could easily provide multiple ligature points, and should not be used for unaccompanied detainees.

Recommendation

- 4.43 All detainees who are in custody for a substantial period should be offered outdoor exercise, and the exercise yard at March should be made safe if the suite is to be re-opened.

Housekeeping points

- 4.44 Reading materials suitable for a range of detainees, including young people, should be available.
- 4.45 Visits should be facilitated for detainees held for long periods.

5. Individual rights

Expected outcomes:

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

Rights relating to detention

- 5.1 Custody sergeants questioned arresting officers about the reasons for arrest. The force had a target to reduce the numbers of detainees going through custody suites by 25% (see paragraph 3.5), although a focus on alternatives to custody was not always evident during our observations of custody sergeants, and at Huntingdon a solicitor told us they were underused.
- 5.2 Police custody suites were not used as a place of safety under Section 46 of the Children Act 1989.⁵
- 5.3 We observed detainees being told they could inform someone of their arrest, and staff facilitated telephone calls promptly.
- 5.4 We were told that the force had a good relationship with the UK Border Agency but, despite this, the usual length of time that immigration detainees were held in the custody suites was two days. Between January and May 2011, 310 immigration detainees had been processed through Cambridgeshire custody suites. UKBA now informed police about any operations in advance, enabling sufficient cellular accommodation and interpreters to be available.
- 5.5 Leaflets about legal rights were available in several languages and were easily accessible. However, there were none adapted for detainees with learning difficulties or limited literacy. Custody staff had little awareness of online signed resources for reading rights to people who were hard of hearing. None of the suites had access to information in Braille. Telephone interpreting services were available and used through two-handset telephones.
- 5.6 None of the detainees we observed being booked-in were asked about any dependency obligations. Custody staff said that detainees would normally volunteer information about any responsibilities towards children but we were concerned that less obvious obligations, such as those of young people caring for older relatives, could be missed.
- 5.7 The custody record system in use incorporated a pre-release risk assessment prompt that custody sergeants had to complete. While most pre-release risk assessments were very basic, staff told us that they did consider how detainees who were released on bail or the subject of no further action would get home. In some instances, detainees were given a rail warrant or were taken home by police officers. This was a particular issue at King's Lynn due to the suite's distance from the Cambridgeshire communities it served. Here there had been commendable efforts to provide rail tickets, and a contract with a local taxi firm enabled vulnerable detainees to be helped home without money changing hands. However, not all staff were familiar with these arrangements.
- 5.8 Some suites had a useful list of local organisations for detainees assessed as in need of help.

⁵ Section 46(1) of the Children Act 1989 empowers a police officer, who has reasonable cause to believe that a child would otherwise be likely to suffer significant harm, to remove the child to suitable accommodation and keep him/her there.

Recommendations

- 5.9 All detainees should be asked if they have any obligations to dependants while they are in custody.
- 5.10 Senior police officers should engage with UK Border Agency to ensure that the time that immigration detainees spend in police custody is minimised.

Housekeeping point

- 5.11 Information about detainees' rights and entitlements should always be available in a range of formats that meet specific needs.

Rights relating to PACE

- 5.12 We observed detainees being told clearly about the PACE Codes of Practice during booking-in, and adequate copies were available. Booking-in areas displayed posters reminding detainees of their right to legal advice, as well as information about local solicitors. When detainees declined the services of a solicitor, we observed staff assuring them that they could change their mind later if they wished. Reasons for detainees declining legal advice were not recorded in the custody record, but reasons for a change of mind were noted.
- 5.13 The custody records we sampled confirmed that detainees under the influence of alcohol or drugs were not interviewed until fit.
- 5.14 We observed several reviews of detention by inspectors. All were on time. All investigations with detainees at the time of the inspection were found to be progressing appropriately with no unreasonable delays. However, one custody record gave cause for concern about a review. The detainee had had a 'silent' review as he was asleep. This was followed by a second review without his involvement because he spoke no English, although there was a suitable interpreter in the suite at the time.
- 5.15 With the exception of Ely, cordless telephones were available for detainees to use in their cells to speak to their solicitor in private. At King's Lynn, an intercom system linked to the telephone enabled detainees to speak privately in their cells with their solicitors.
- 5.16 There were sufficient consultation rooms at most suites except at Cambridge. The shortage in Cambridge resulted in delays because solicitors could not interview their clients when they needed to. The duty solicitor schemes appeared to operate effectively.
- 5.17 Custody sergeants told us they tried to use family members as appropriate adults (AAs) for juveniles. Where this was not possible, they contacted the youth offending service (YOS), who provided a service seven days a week – although AAs were not always available during the late evening and the night. The YOS required solicitors' availability to be confirmed before their staff attended the custody suite, to avoid unreasonably long waits for staff, but we observed one instance where the need to coordinate solicitor and AA attendance caused considerable delays in a juvenile's access to an AA. Delays in securing the attendance of AAs were also indicated in our custody record analysis. AAs for vulnerable adults were difficult to obtain at all Cambridgeshire suites. We were told that the YOS sometimes agreed to provide a service to vulnerable adults as well, but there was no formal arrangement. Custody sergeants described

the position as problematic. At King's Lynn, the AA service used local volunteers and provided a better service to vulnerable adults, although there was no provision after 8pm. The force adhered to the PACE definition of a child instead of that in the Children Act 1989, which meant that those aged 17 were not provided with an AA unless otherwise deemed vulnerable.⁶

- 5.18 The handling and processing of DNA taken from detainees was good, with very few samples (all recent) stored in the freezer. We identified only one issue at Peterborough where some forensic samples had been incorrectly stored.
- 5.19 Court cut-off times were around 2pm on weekdays and 10am on Saturdays. At Peterborough, the court specified that the detainee must be in the court premises before the cut-off time, and there were no exceptions. We were concerned about such inflexibility. For example, a detainee at Peterborough who had been refused bail by the custody sergeant had missed the cut-off deadline by a few minutes and had to remain in police custody until the following morning. At King's Lynn, we were told that the cut-off time was sometimes as early as 10am.
- 5.20 Detainees and solicitors could easily obtain a copy of the detainee's custody record.

Recommendations

- 5.21 Appropriate adults should be available without undue delay to support juveniles aged 17 and under and vulnerable adults in custody, including out of hours.
- 5.22 Cambridgeshire police should liaise with court managers to ensure that court cut-off times do not result in unnecessarily long stays in custody.

Rights relating to treatment

- 5.23 Detainees were not routinely told how to make a complaint in line with the Independent Police Complaints Commission 2010 statutory guidance. Complaints were rarely recorded while a detainee was in custody unless there was any evidential value to be obtained, for example, in allegations of assault. Otherwise, all detainees were advised to attend the enquiry desk on their release to see the inspector. There was no process for following up these initial complaints if the detainee was remanded in custody. There were no specific systems to record and investigate complaints of racism.

Recommendation

- 5.24 Detainees should be routinely informed about how they can make a complaint about their care and treatment, and be able to do this before they leave custody.

⁶ Although this met the current requirements of PACE, in all other UK law and international treaty obligations, 17-year-olds are treated as juveniles. The UK government has committed to bringing PACE into line as soon as a legislative slot is available.

6. Health care

Expected outcomes:

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

Clinical governance

- 6.1 Health services were provided by G4S Forensic Medical Services (UK) Ltd (G4SFMS). There were several providers of substance use services across the force area. Mental health services were mainly provided by Cambridgeshire and Peterborough NHS Foundation Trust and Peterborough and Stamford Hospitals NHS Foundation Trust. A police superintendent managed the respective health and substance use services contracts. The police said that working relationships with their suppliers were very good, and custody staff expressed general satisfaction with the health services available to detainees. The force, along with adjacent police forces and NHS partners, was exploring the possibility of providing more integrated offender supervision and health care. This was part of a national initiative to increase opportunities for diversion from custody for people with physical and mental health problems.
- 6.2 G4SFMS had robust clinical governance arrangements. There were clear lines of management and accountability that included systems for regular checking of staffs' professional credentials. Nurses and paramedics, known as health care professionals (HCPs), and forensic medical examiners (FMEs) had a comprehensive induction programme and regular continuing professional development study days. There were opportunities for staff to receive clinical supervision and a programme of annual appraisal. FMEs were from a variety of backgrounds including general practice, psychiatry and other medical specialties, including forensic medicine. Not all FMEs were approved clinicians under Section 12 of the Mental Health Act.
- 6.3 The HCPs who we observed were courteous, caring and respectful. There had been no complaints about health care from detainees in the last year. There were occasional complaints from custody officers that were invariably about waiting times.
- 6.4 There were clinical rooms at all the custody suites. Most were of an adequate size, but the one at Cambridge was very small and had no toilet or sink. King's Lynn was new and purpose built. Several examination couches had cracks or holes in the fabric and there were no paper roll couch covers. There was good attention to the privacy and confidentiality of detainees during consultations with the doors being closed, although privacy screens were not available in every room. Clinical rooms were regularly cleaned, although we did not see a cleaning schedule. Some of the older rooms had ingrained dust at skirting level. Sharps bins were not secured to the wall or signed and dated on start of use. There was no evidence that an infection control audit had been carried out; some furniture did not comply with standards. Most rooms required redecoration.
- 6.5 Clinical rooms were locked when not in use. With the exception of rooms used by substance use workers, patient information leaflets were not available. No health screening or promotion materials were displayed, although we saw advice on chlamydia screening at Peterborough.
- 6.6 Medicines management was good. Medicines were supplied by G4SFMS and stored in locked cupboards and safes. There were accurate stock records and weekly audits of stock balances. HCPs were able to supply and administer a reasonable range of medications using patient

group directions. Custody staff administered medicines prescribed remotely by FMEs following receipt of faxed prescriptions. The original prescriptions were subsequently filed in the detainees' health care records. Stock medicines for administration by custody staff were kept in separate locked cabinets in the reception offices. Custody staff opened manufactured medicine packages to obtain smaller amounts of tablets to put in labelled bags for detainees, which represented secondary dispensing. We observed some cabinets that were left open with loose tablets and blister packs in them. There were locked cabinets for the disposal of unused tablets. Medications were left unattended on a desk in the clinical room at King's Lynn. We found out-of-date pharmacological reference materials in several clinical rooms.

- 6.7 Emergency equipment available in the custody suites included first aid kits, oxygen and automatic external defibrillators (AEDs), which were easily accessible. The custody staff we spoke to were up to date with their first aid and resuscitation training and had received instruction in the use of AEDs. Some of the custody suites had life signs monitoring cells (which sent out an alarm if there were no breathing or movement for an identified period of time). Equipment was checked regularly and the checks were logged. The force had established a clinical governance group to quality assure first aid provision. The group included a representative from the East of England Ambulance Service.

Recommendations

- 6.8 There should be robust infection control procedures for all the clinical rooms, supported by regular audits of infection control.
- 6.9 The practice of secondary dispensing by custody officers should cease.

Housekeeping points

- 6.10 There should be no holes or cracks in the fabric of examination couches, and all suites should use paper couch rolls.
- 6.11 Patient information leaflets should be available in the clinical rooms.
- 6.12 Loose tablets and blister packs should be disposed of and not kept in medicine lockers.
- 6.13 Medicines should not be left unattended in the clinical rooms.
- 6.14 Out-of-date pharmacy reference materials should be discarded and replaced by up-to-date materials.

Patient care

- 6.15 There was a 24-hour service managed through two 12-hour shifts. G4SFMS provided two HCPs and a FME per shift across the force area, with additional medical staff at peak times. New detainees were asked if they wanted to see a health care professional, or custody officers referred them to one if they presented any health-related concerns. Custody staff rang a call centre to request assistance. The call centre alerted clinical staff to the request and the clinical staff determined the type of response required. Urgent responses were expected within 60 minutes, non-urgent within 90 minutes, and fitness for transfer consultations, 120 minutes.

- 6.16 G4SFMS provided the force with a comprehensive range of monthly statistics relating to its contract and the police verified the data. There had been 6,311 call outs in the year to the end of June 2011. Of these, 79.53% were responded to within time but 5.29% were beyond the contracted time and invoked a financial penalty. In our sample of custody records, the average waiting time for an FME was 41 minutes and the longest wait was 70 minutes.
- 6.17 Detainees could see a HCP or FME of the gender of their choice, although this usually entailed further waiting. Alternatively, a chaperone could be provided.
- 6.18 In our survey of custody records, six detainees (20%) required continuation of medicine. Custody staff made some attempts to retrieve medications from the detainee's home, if required. There was little consistency for detainees on methadone maintenance so that few detainees had opiate substitution therapy continued. Symptomatic relief was available for those withdrawing from substances.
- 6.19 The detainee's consent was routinely sought for assessment and for sharing health care information with the GP and others. HCPs and FMEs used paper records to record consultations and then, because they did not have access to NSPIS (national strategy for police information systems), completed a detained person's medical form that was inserted into the custody records. This was a needless duplication. There were steps to allow HCPs and FMEs access to NSPIS. We sampled 30 clinical records at several sites and they were completed to a good standard. Records were stored in line with the Data Protection Act and Caldicott principles on the use and confidentiality of personal health information. One FME told us that while he deposited all clinical records in the clinical room safe, he made a note of some patient details for his own records.

Recommendation

- 6.20 If it is clinically indicated, methadone should be available to detainees in line with national guidelines.

Housekeeping point

- 6.21 Health care professionals should have access to NSPIS to input clinical information to assist custody officers.

Substance use

- 6.22 In our survey of custody records, 10 out of 30 (33%) detainees were brought into custody intoxicated. There was mature and active multi-agency working to ensure services were integrated across the force area, and the force worked with a variety of drugs and alcohol intervention providers, including Peterborough Nene and Cambridgeshire drugs intervention programmes (DIPs).
- 6.23 DIP workers visited each suite at least once every weekday. At Peterborough, a service was available at weekends. Out of hours, custody or G4SFMS staff telephoned the community drug offices to make an appointment if a detainee wanted to see a worker, or completed a referral form. Custody officers said that the system worked well, but in our custody record survey a detainee who self-reported as an alcoholic and requested to speak to a DIP worker did not meet them until approximately 34 hours into detention.

- 6.24 The DIPs had comprehensive information-sharing agreements with the police to get detainees with drug and alcohol problems into treatment programmes. Peterborough Nene DIP offered an intensive drug testing on arrest programme, which was achieved in 98% of cases (against a target of 96%). Cambridgeshire DIP offered services to class A drug users and had recently demonstrated an impressive 79% reduction in detainees' spending on substance misuse following completion of the full programme and reduced levels of crime.
- 6.25 DIP workers provided initial assessments and harm minimisation advice for detainees with drug issues and saw them following release, when relevant. CRI and Addaction also provided community-based interventions. Juveniles and adults with alcohol addiction were signposted to appropriate services.
- 6.26 Needle exchange was not available in custody suites, although harm reduction packs, including details of needle exchange facilities in Cambridgeshire, were given to substance users before release at Cambridge and were planned for Peterborough.

Mental health

- 6.27 There were regular mental health liaison meetings and the police emphasised that engagement by mental health partners had improved since our last inspection. The liaison group had produced several police/NHS joint operational protocols, and work was under way to develop new protocols with the ambulance service. There was a multi-agency Bradley coordinating forum⁷ that was mapping services at the time of our inspection. Staff we spoke with were not aware of an offender mental health strategy for Cambridgeshire, and no strategy was made available to us. We could not locate a multi-agency information-sharing protocol.
- 6.28 Five out of 30 (17%) detainees in our analysis of custody records had mental health problems. Custody staff and G4SFMS staff believed the general incidence to be higher. There was no assertive mental health in reach into the police custody suites and so opportunities for diversion were limited. There was systematic sharing of information about detainees with mental health problems in the Huntingdon police/NHS mental health pilot scheme. Custody staff or G4SFMS staff could telephone local crisis resolution and home treatment teams for advice on detainees with suspected mental health problems, which occasionally resulted in a Mental Health Act assessment by the emergency duty team. In a recently introduced innovative scheme at Cambridge, the Samaritans offered face-to-face support to detainees with emotional problems. Young people with suspected mental health problems were referred to the YOS. YOS mental health workers came to assess the young person or offered an appointment for assessment following release from custody.
- 6.29 There was high use of Section 136 of the Mental Health Act, with 250 cases in the year to the end of March 2011. This was a dramatic reduction from over 500 in the previous year, which followed a concerted campaign to use the section more appropriately. We were told that dedicated NHS Section 136 suites at Cambridge and Peterborough were available to detainees, although there was no data about their frequency of use. The police and NHS partners had produced a revised draft Section 136 protocol, which unambiguously stated that police custody should only be considered as a place of safety as a last resort. Nonetheless, police custody suites were used extensively, and inappropriately, as places of safety. (See main recommendation 2.24.)

⁷ Set up in response to the Lord Bradley report on people with mental health problems or learning disabilities in the Criminal Justice System (2009).

- 6.30** Police custody officers and support staff confirmed that they received mental health awareness training as part of their induction and continuing professional development.

7. Summary of recommendations

	Main recommendations	To Cambridgeshire Police
7.1	The management of custody should provide clear lines of responsibility and accountability, and staffing levels should be sufficient to maintain the safety, care and welfare of detainees. (2.22)	
7.2	When risk assessment indicates the need for constant observation at the cell door or rousing, this should be rigorously implemented. (2.23)	
7.3	There should be mental health in-reach arrangements to enable detainees with mental health problems to be identified and diverted into mental health services as appropriate, and police custody suites should not be used as places of safety for Mental Health Act Section 136 assessments. (2.24)	

	Recommendations	To Cambridgeshire Police
Strategy		
7.4	Cambridgeshire police should undertake regular dip sampling of custody records, focusing on the management of risk of harm and the quality of detainee care. (3.14)	
Treatment and conditions		
7.5	Staff should receive awareness training on child protection and safeguarding. (4.6)	
7.6	Handover meetings should include all custody staff. (4.11)	
7.7	Cambridgeshire police should collate use of force data from custody and examine it for trends in accordance with the Association of Chief Police Officers policy and National Policing Improvement Agency guidance. (4.17)	
7.8	The use of cells without natural light at Peterborough is inappropriate and should be kept to an absolute minimum. (4.24)	
7.9	Cambridgeshire police should address the safety issues around ligature points and, where resources do not allow them to be dealt with immediately, the risks should be managed effectively. (4.25)	
7.10	Fire practice evacuations should be held regularly at all suites and documented. (4.26)	
7.11	Health and safety walk-through arrangements should be thorough and consistently applied at all custody suites. (4.27)	
7.12	Showers should be properly screened so that detainees can have a shower with dignity and in privacy. (4.35)	

- 7.13 All detainees who are in custody for a substantial period should be offered outdoor exercise, and the exercise yard at March should be made safe if the suite is to be re-opened. (4.43)

Individual rights

- 7.14 All detainees should be asked if they have any obligations to dependants while they are in custody. (5.9)
- 7.15 Senior police officers should engage with UK Border Agency to ensure that the time that immigration detainees spend in police custody is minimised. (5.10)
- 7.16 Appropriate adults should be available without undue delay to support juveniles aged 17 and under and vulnerable adults in custody, including out of hours. (5.21)
- 7.17 Cambridgeshire police should liaise with court managers to ensure that court cut-off times do not result in unnecessarily long stays in custody. (5.22)
- 7.18 Detainees should be routinely informed about how they can make a complaint about their care and treatment, and be able to do this before they leave custody. (5.24)

Health care

- 7.19 There should be robust infection control procedures for all the clinical rooms, supported by regular audits of infection control. (6.8)
- 7.20 The practice of secondary dispensing by custody officers should cease. (6.9)
- 7.21 If it is clinically indicated, methadone should be available to detainees in line with national guidelines. (6.20)

Housekeeping points

Treatment and conditions

- 7.22 Detainees' spectacles should not be taken away unless a risk assessment indicates the need to do so. (4.12)
- 7.23 The Independent Police Complaints Commission 'learning the lessons' briefings should be made more easily accessible and staff encouraged to use them. (4.13)
- 7.24 The source of the offensive smells at the Cambridge suite should be traced and eliminated. (4.28)
- 7.25 The use of the cell call bells should be explained to every detainee. (4.29)
- 7.26 The communal areas in Cambridge should be kept tidy and clear of unnecessary items. (4.30)
- 7.27 Hygiene packs should be routinely offered to women detainees. (4.36)
- 7.28 Toilet paper should be available in all cells. (4.37)

- 7.29 The temperature of microwave meals should be checked and recorded. (4.39)
- 7.30 Custody staff should have food hygiene training. (4.40)
- 7.31 Reading materials suitable for a range of detainees, including young people, should be available. (4.44)
- 7.32 Visits should be facilitated for detainees held for long periods. (4.45)

Individual rights

- 7.33 Information about detainees' rights and entitlements should always be available in a range of formats that meet specific needs. (5.11)

Health care

- 7.34 There should be no holes or cracks in the fabric of examination couches, and all suites should use paper couch rolls. (6.10)
- 7.35 Patient information leaflets should be available in the clinical rooms. (6.11)
- 7.36 Loose tablets and blister packs should be disposed of and not kept in medicine lockers. (6.12)
- 7.37 Medicines should not be left unattended in the clinical rooms. (6.13)
- 7.38 Out-of-date pharmacy reference materials should be discarded and replaced by up-to-date materials. (6.14)
- 7.39 Health care professionals should have access to NSPIS to input clinical information to assist custody officers. (6.21)

Appendix I: Inspection team

Sean Sullivan	HMIP team leader
Gary Boughen	HMIP inspector
Paddy Craig	HMIC inspector
Peter Dunn	HMIP inspector
Paul Eveleigh	HMIC inspector
Paul Tarbuck	HMIP health care inspector
Helen Carter	HMIP health care inspector
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