Report on an unannounced inspection visit to police custody suites in

Leicestershire

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

3–13 February 2020

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

Any enquiries regarding this publication should be sent to HM Inspectorate of Prisons at 3rd floor, 10 South Colonnade, Canary Wharf, London, E14 4PU, or hmiprisons.enquiries@hmiprisons.gsi.gov.uk, or
HM Inspectorate of Constabulary and Fire & Rescue Services at 6th Floor, Globe House, 89 Eccleston Square, London SW1V 1PN, or contact@hmic.gsi.gov.uk

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

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

Contents

Contents

Glossary of terms

We try to make our reports as clear as possible, and this short glossary should help to explain some of the specialist terms you may find. If you need an explanation of any other terms, please see the longer glossary in our 'Guide for writing inspection reports', available on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

IS91 warrant of detention
This is served on an immigration detainee when there is no reasonable alternative course of action – for example, if there is a likelihood they may abscond; their removal from the UK is imminent, etc.

Section 136 of the Mental Health Act 1983
Enables a police officer to remove from a public place someone who they believe to be suffering from a mental disorder and in need of immediate care and control, and take them to a place of safety. In exceptional circumstances, and if they are 18 or over, the place of safety may be police custody.

PACE code C 2019
The code of practice for the detention, treatment and questioning of persons by police officers.

PACE code G 2012
The code of practice for the statutory power of arrest by police officers.

Fact page

Note: Data supplied by the force.

Force	Leicestershire Police
Chief Constable	Simon Cole QPM
Police and Crime Commissioner	Lord Willy Bach
Geographical area	The city of Leicester and the counties of Leicestershire and Rutland
Date of last police custody inspection	8–17 September 2014

Custody suites	**Cell capacity**
Euston Street	36 cells
Keyham Lane	17 cells
Beaumont Leys	14 cells

Non-designated suite	
King Power Football Stadium	3 cells

Annual custody throughput	13,739 (1 February 2019 to 31 January 2020)
Custody staffing	1 chief inspector 6 inspectors 27 custody officers 25 custody detention officers
Health service provider	Mitie Care and Custody

Executive summary

S1 This report describes the findings following an inspection of Leicestershire Police custody facilities. The inspection was conducted jointly by HM Inspectorate of Prisons (HMIP) and HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) in February 2020, 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 Leicestershire Police in 2014. This inspection found that, of the 31 recommendations made during that previous inspection, nine had been achieved, nine had been partially achieved and 13 had not been achieved.

S4 To aid improvement, we have made two recommendations to the force (and the Police and Crime Commissioner) addressing key causes of concern, and have highlighted an additional 18 areas for improvement. These are set out in Section 6.

Leadership, accountability and partnerships

S5 Leicestershire police delivered its custody services as part of a well-established collaboration between four forces in the East Midlands. As part of the wider governance arrangements, Leicestershire Police had its own governance structure, which provided accountability for its custody services. It encouraged and facilitated access to a range of external scrutiny, including an effective independent custody visitor scheme. The force had made some progress in improving outcomes for detainees in some areas and we were confident that the force would use the findings from the inspection to address the concerns identified and drive the necessary improvements.

S6 The force had a clear priority to divert vulnerable people away from custody. It worked well with partners to support children and individuals with complex needs. Some good outcomes were achieved for those with mental ill health and some good care was shown to detainees through a caring approach by officers and staff.

S7 Senior managers had little oversight of how demand for custody services was managed. Staff were not always effectively deployed and were sometimes overstretched, relying on non-custody staff to cover duties to meet detainees' needs. This had an impact on detainee care and some detainees spending longer than necessary in custody.

S8 Initial and ongoing training for custody officers was effective, but ongoing training for custody detention officers, under contract with G4S, was not as good. Adverse incidents were properly recorded and reviewed, with good evidence of learning being identified and shared as a result. The force followed the College of Policing *Authorised Professional Practice* for – *Detention and Custody*, and had a number of additional local custody policies and guidance documents. However, not all practices followed either guidance.

S9 Not all practices consistently met the requirements of codes C or G of the Police and Criminal Evidence Act (PACE) codes of practice, notably concerning the authorisation and review of detention.

S10 The force collated comprehensive data in relation to its custody services. However, there were some gaps, and some data were unreliable, which made it difficult for the force to monitor effectively how well it was delivering some of its custody services.

S11 A regional team conducted comprehensive quarterly audits of custody records but little local quality assurance took place outside of this. Custody records did not always contain sufficient detail, and the reasons why decisions were made were not always adequately recorded.

S12 The force could not provide assurance that the use of force in relation to detention and custody was always safe and proportionate. Governance and oversight were limited, and effective scrutiny was hindered by a lack of reliable data. Not all incidents were recorded on the custody record and not all staff completed use of force forms, as required by the National Police Chiefs Council.

S13 Officers and staff engaged patiently with detainees to avoid the need to use force on them. In the cases we looked at, including some on closed-circuit television, when force had been used it had generally been proportionate and necessary, and managed well.

S14 The force demonstrated a good commitment to meeting the public-sector equality duty. The strategic equality action plan included specific custody-related objectives.

Pre-custody: first point of contact

S15 Frontline officers identified and dealt with children and vulnerable people well, diverting them away from custody when possible. There was good support to help these officers deal with individuals with mental ill health, through the mental health triage car. They told us that they generally did not experience long waits to take people detained under section 136 of the Mental Health Act 1983 (see Glossary of terms) to a health-based place of safety, which we rarely find in our inspections and was a good outcome for these detainees.

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

S16 Custody staff booking-in detainees engaged respectfully with them and took the time to build up a good rapport. There was limited privacy for detainees at the booking-in desks, and they were not routinely offered the opportunity to speak to a member of staff in private. Some personal information could easily be seen by others in the suites. Detainee clothing that had been removed was sometimes left on the floor in cell corridors, which was disrespectful.

S17 Custody officers had a good understanding of how to meet the broad range of detainees' diverse needs, with some good individualised care provided. There was a wide range of religious observance materials and some good help for those who did not speak English. However, provision to meet the needs of female detainees was mixed, and the facilities for detainees with disabilities were not adequate to meet their needs fully.

S18 The approach to identifying risks was generally good but there were some weaknesses in their ongoing management. Initial observation levels were generally set appropriately but did not always reflect presenting risks, particularly for detainees under the influence of alcohol and/or drugs, who were not always roused as they should have been. However, observation checks on detainees were mostly carried out on time and, where rousal checks had been specified, they were conducted correctly.

S19 Footwear and clothing with cords continued to be routinely removed, rather than individually assessing the need for this. Rather than using anti-rip clothing to manage detainees' risk, this was done instead through increased levels of observation – which was a better approach. All custody staff carried anti-ligature knives and responded to cell call bells promptly. The content of handovers was appropriate but they did not involve health care professionals and were not conducted collectively.

S20 The approach to ensuring that detainees received their legal rights in custody was not always good enough and some practices did not meet the requirements of the PACE codes of practice. There were some unnecessary waits to book detainees into custody, and they were not routinely advised of the grounds and necessity for their arrest before their detention was authorised.

S21 Overall, detention times were similar to those in other forces we have recently inspected. However, some cases were not progressed as quickly as possible owing to the non-availability of investigating officers and delays in Crown Prosecution Service decisions to prosecute.

S22 Custody officers explained detainees' rights in custody well but did not always offer or issue the written leaflets that detailed them. However, custody officers issued translated documents to non-English-speaking detainees, as required by annex M of PACE code C.

S23 The conduct of PACE reviews of detention was good. Most reviews were carried out on time and in person, with few conducted by telephone, and PACE inspectors showed a clear focus on detainee welfare. There were some areas that required improvement, including the need consistently to advise detainees that their further detention had been authorised and remind them of their rights if reviews had taken place while they were asleep.

S24 Detainees who were released under investigation or on bail were issued with relevant documentation, and were routinely advised of the consequences if they tried to interfere with the investigation. Arrangements for progressing cases for detainees released on bail were managed well but detainees released under investigation often experienced delays in concluding their cases.

S25 The complaints procedure was not well promoted, but staff were aware of how to take and deal with complaints.

In the custody cell, safeguarding and health

S26 The conditions and cleanliness in the custody suites were good overall. All cells had access to natural light and the temperature was mostly suitable. There were potential ligature points across the estate. At the end of the inspection, we provided the force with a comprehensive illustrative report detailing these, which they responded positively to.

S27 There was a caring culture among custody staff, and detainees told us that they had been well treated during their time in custody. A wide range of food, drinks, replacement clothing and toiletries were available and readily offered. There was limited access to showers, exercise and a range of reading materials but the introduction of distraction activities (quizzes and puzzle books) had been a positive initiative.

S28 Officers had a good understanding of safeguarding but information detailing any issues or concerns was not always recorded on custody records. Custody officers generally requested appropriate adults (AAs) promptly and most arrived without delay, especially those from the contracted scheme, so that early support was available to children and vulnerable adults.

Adult detainees who needed an AA because they were vulnerable were appropriately identified and received this support.

S29 Custody staff interacted well with children and provided them with good care. Children were only brought into custody as a last resort and custody officers were well focused on minimising the time that they spent there, and avoided overnight detention where possible. There was some good monitoring with partner agencies for children held in custody. Few were charged and refused bail but, despite close working with partners, they were not moved to alternative accommodation as they should have been.

S30 There was good oversight and governance of the health care provision. Staffing levels were proportionate to need, and detainees generally had good access to a timely, needs-led service. Health care professionals were experienced and competent, and delivered good care to detainees. Treatment rooms were clean and mostly complied with infection prevention standards.

S31 Medicines management arrangements were thorough. Access to prescription medication, including opiate substitution, was facilitated, and symptomatic relief for detainees experiencing withdrawal was also appropriately used. However, there was no access to any nicotine replacement products. Detainees received broadly good and responsive access to community-based drug and alcohol services.

S32 The mental health criminal justice liaison and diversion service delivered good support to detainees. Working arrangements between this team and custody staff were effective. The street triage service was an effective and valued asset in diverting mentally vulnerable individuals away from custody. When those with mental ill health presented in custody, Mental Health Act assessments were generally carried out promptly. We were told that access to inpatient beds and subsequent transfers to hospital were sometimes problematic but detainees did not routinely spend too long in custody waiting to be transferred. However, some detainees were transferred under section 136 to a health-based place of safety because their mental health needs had not been met in custody and their detention time under PACE had nearly run out. The force did not have enough details about these cases to understand why this was happening.

Release and transfer from custody

S33 Detainees were released safely. Particular attention was given to managing the safe release of children and vulnerable adults, and there was a clear focus on safeguarding and, where necessary, involving relevant agencies to support detainees. There were enhanced safeguarding arrangements for individuals arrested under suspicion of committing some higher-risk offences, which investigating officers had responsibility for implementing, but not all custody officers knew whether, or satisfied themselves that, these were put in place before release. The recording of release arrangements on custody records was not good enough and did not reflect the good practice we observed.

S34 Person escort records were well completed and contained accurate and relevant information. However, additional loose-leaf documentation was included and medical information was not secured, to ensure confidentiality.

S35 Detainees who were required, and ready, to appear in court after being held overnight were processed effectively. However, those who were arrested on warrant during the day were not accepted directly by the courts. Moreover, the courts would not always accept additional detainees after the initial collection, which resulted in some not being presented

before the first available court, and therefore remaining in police custody for longer than necessary.

Causes of concern and recommendations

S36 Cause of concern: The force did not consistently meet the requirements of PACE codes C and G for the detention, treatment and questioning of persons.

Recommendation: The force should take immediate action to ensure that all custody procedures comply with legislation and guidance.

S37 Cause of concern: The governance and oversight of the use of force were limited. Not all incidents involving the use of force in custody had been recorded, making the data unreliable and preventing effective scrutiny. Although the force reviewed some cases to assess how incidents were dealt with, the effectiveness of this was also limited by the unreliable data. Not all staff followed National Police Chiefs Council guidance in completing individual use of force forms.

Recommendation: The force should assure itself and others that when force is used in custody, it is safe and proportionate. It should:

- **ensure that all use of force incidents are properly recorded on the custody record, so that there is comprehensive, reliable and accurate data to inform the governance arrangements;**
- **strengthen the review of individual incidents by ensuring that there is an accurate pool of cases from which to draw these, and that closed-circuit television is readily available for viewing them;**
- **ensure that all officers complete use of force forms for any incident they are involved in.**

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

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

Our assessments are made against the criteria set out in the *Expectations for Police Custody* (available on our website at: https://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/police-custody-expectations-2/). 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* (available online at: https://www.app.college.police.uk/app-content/detention-and-custody-2/).

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 Leicestershire Police we analysed a sample of 111 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

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 Leicestershire Police delivered its custody services as part of the formal and well-established regional collaboration with Northamptonshire, Lincolnshire and Nottinghamshire Police Forces under section 22 of the Police Act 1996 – the East Midlands Criminal Justice Service (EMCJS). There was regional governance and oversight of custody services through the Head of the East Midlands Criminal Justice Service and a regional strategic custody board, chaired by an assistant chief constable (ACC; at the time of the inspection, this was a Leicestershire ACC), and above this through the regional strategic management board, chaired by a chief constable (at the time of the inspection, this was the Lincolnshire chief constable).

1.2 Within these collaboration arrangements, Leicestershire Police had its own local governance structure for custody. Under the direction of an ACC, there was a chief inspector, supported by six inspectors with overall responsibility for day-to-day custody operations. There were monthly local custody meetings, chaired by the chief inspector, which oversaw the delivery of custody services. This structure provided clear accountability for the safe delivery of custody.

1.3 Progress in improving outcomes for detainees had been made in some areas, but in others this had been limited. Several of our previous recommendations had not been met, and some of the concerns identified during the 2014 inspection remained. However, the force responded positively to our findings during the inspection, which gave us confidence that improvements would be made.

1.4 The force had 25 custody officers and 25 custody detention officers (CDOs) covering its three custody suites. There was little oversight by senior managers of the arrangements to manage demand in custody. Demand for custody services in the suites was managed by custody officers, who controlled the number of detainees being cared for – taking account of any who were high risk – and diverted them to other suites if needed. However, there was no assessment of whether demand was being managed in the right way and in the best interests of the detainee. Custody staff were not always deployed in the most effective way, and non-custody staff often covered duties informally to meet detainees' needs. Staff were sometimes overstretched, which had an impact on detainee care. For example, detainees were not always offered a shower, and some remained in custody for longer than necessary, waiting for custody processes to be carried out, particularly at the smaller suites, where there was only one custody officer on duty. The Custody Management Team had recognised the need to develop their understanding around workload demand and the capacity and capability assigned to deal with the fluctuating demand.

1.5 The initial training for custody officers was good; they received a three-week training course, facilitated regionally, and this was followed by a two-week period of shadowing more experienced staff before undertaking their duties. An additional two days of continuing professional development training were provided each year. Custody officers were mostly

positive about the training they received. CDOs were employed by G4S, which the force contracted to provide the service. The training course syllabus for custody officers was shared with G4S, which was responsible for training its own staff, to ensure that training provision was consistent. However, CDOs were less positive than custody officers about their ongoing training, and felt that it was too reliant on e-learning.

1.6 There was a clear process for the recording and reporting of adverse incidents. These were discussed in some detail at a regional health and safety meeting, and learning was identified and shared. There had been no deaths in custody since the previous inspection.

1.7 The force followed *Authorised Professional Practice – Detention and Custody* (APP) for custody, as set by the College of Policing. The EMCJS had also developed custody policies and procedures for all four forces to follow. However, not all practices we observed followed either APP guidance or the joint policies.

1.8 The force was open to feedback and encouraged external scrutiny. There was an effective independent custody visitor (ICV) scheme, and visitors told us that the force was receptive to the issues they raised. In addition, the force had commissioned an external audit of its custody services and was implementing its recommendations.

Areas for improvement

1.9 The force should ensure that custody staff are deployed in the most effective way, to improve outcomes for detainees and prevent them from remaining in custody for longer than necessary. There should be sufficient oversight of staffing levels by senior officers, to ensure that the suites are managed effectively.

1.10 The force should ensure that all custody staff consistently follow the College of Policing *Authorised Professional Practice – Detention and Custody*, and the East Midlands Criminal Justice Services' own guidance, so that detainees receive the appropriate treatment and care.

Accountability

1.11 The force collated comprehensive data in relation to its custody services. This included waiting and detention times, information on children and immigration detainees, levels of strip-searching, and the use of bail and release under investigation. However, there were some gaps – for example, in mental health assessments. Some data were unreliable – mainly in relation to the use of force and restraint in custody (see paragraphs 4.11 and 4.12). This made it difficult for the force to monitor performance effectively in some areas of its custody services.

1.12 The quality of recording on detention logs required improvement. While the records were easier to follow than we often find in other forces we inspect, some information was not captured well enough, and sometimes not recorded at all. For example, this included any safeguarding information for a detainee or action taken as a result (see paragraph 4.27), and the use of force or restraint, together with the justification and rationale for it (see paragraph 4.11).

1.13 The EMCJS regional team conducted a comprehensive quarterly audit of custody records, which identified trends and was used to drive improvement. However, beyond this there was little local quality assurance, and no structured dip-sampling of records was carried out

on a more regular basis to help the force identify where it needed to improve, which could have identified some of the gaps we found.

1.14 Not all practices we observed met the requirements of codes C and G of the Police and Criminal Evidence Act (PACE) codes of practice, notably in relation to the process of booking detainees into custody, and some aspects of inspectors' PACE reviews (see paragraphs 3.37 and 3.48, and cause of concern and recommendation S36). In one case, a detainee had been released without a review of detention taking place, which was a breach of PACE section 40(5).

1.15 The force had insufficient mechanisms to assure itself, the Police and Crime Commissioner and the public that the use of force in relation to detention and custody was always safe and proportionate. The governance and oversight of the use of force were limited, and did not include all use of force incidents that occurred in custody. While some data were available, we found cases where force or restraint had been used in custody but not recorded on the custody record. This meant that the data were not comprehensive, reliable or accurate enough to allow effective scrutiny. Although there was some assessment of incidents by inspectors reviewing a sample of cases, including cross-referencing them on closed-circuit television (CCTV), the under-recording of incidents on custody records resulted in some being missed; moreover, CCTV footage was kept for only up to 30 days, which restricted any review to incidents taking place in the previous month (see also paragraph 4.14). In addition, not all staff completed individual use of force forms, as required by the National Police Chiefs Council (see cause of concern and recommendation S37). The force was aware of these concerns and had already taken steps to improve the recording of use of force.

1.16 The force demonstrated a good commitment to meeting the public-sector equality duty. There were three specific custody-related objectives in its strategic equality action plan, concerning the identification and monitoring of any disproportionality for detainees and the management of transgender detainees. Staff received comprehensive training on their responsibilities under the Equality Act 2010, and senior officers acted as champions for each of the protected characteristics. However, not all detainees were asked to self-define their ethnicity; instead, the custody officer assigned them an ethnicity and added this to the custody record, which could have been inaccurate and limited the force's ability to assess whether outcomes for detainees from different ethnic groups were fair and equitable (see also paragraph 3.14 and area for improvement 3.23).

1.17 Staff had received training in unconscious bias, and this had been extended to ICVs and external partners. The force invited external quality assurance of incidents involving the use of force and strip-searching in custody from members of its community, to provide some external scrutiny over whether it was applying these coercive powers in a fair and transparent way to all detainees.

Areas for improvement

1.18 The force should strengthen its approach to performance management by addressing the gaps in its performance information and ensuring that all its data is reliable.

1.19 The force should improve the quality of its custody records by ensuring that all necessary information is fully recorded, including the rationale and justification for any decisions made.

1.20 The force should strengthen its approach to the quality assurance of custody services by having its own structured dip-sampling arrangements, to help identify where improvements are needed.

Partnerships

1.21 The force had a clear priority to divert vulnerable detainees away from custody, and staff understood this.

1.22 The force worked well with partners to support individuals with complex needs, and to provide interventions to prevent and reduce offending. There were diversion initiatives that children could be referred to, and a recently established community resolution and prevention team supported and diverted children in the early stages of their contact with the police, to try to prevent them from entering the criminal justice system.

1.23 Children were only taken into custody as a last resort, and mostly when all other diversion options had been explored. There was some good joint working with partners in relation to children in custody, and the number charged and remanded was low. However, none of these children were moved out of custody to local authority arranged accommodation.

1.24 The force was committed to improving services for those with mental ill health, worked well with its mental health partners and was delivering some good outcomes for detainees. This included good support for frontline and custody staff, which was resulting in people with mental ill health being diverted from custody, or being dealt with appropriately there.

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 vulnerability. They cited a range of factors that influenced this, such as age and mental ill health, along with the situation that an individual might find themselves in. The force had provided some good training to help officers recognise and understand some of the vulnerabilities that they might come across, including mental ill health, autism and adverse childhood experiences. Officers spoke positively about the training they had received, especially where this had involved external trainers and speakers. It was clear that they recognised and took account of an individual's vulnerability when deciding whether to arrest them or find a more appropriate alternative to custody.

2.2 Frontline officers told us that they generally had enough information about an incident, and those involved in it, to help them decide what action to take. Although they said that the quality of information from the call centre was sometimes variable, they could obtain good information from their own hand-held devices to inform their decision making and, if necessary, could ask the call handlers for further details.

2.3 There was a good focus on diverting children away from custody, in line with the force's strategic approach. Frontline officers considered and explored all other options first, such as voluntary interviews (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), taking children to another location until the incident was addressed or using community resolutions (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). When custody seemed to be the only option, frontline officers often discussed the circumstances and nature of the incident with the custody officer before deciding whether custody was appropriate. This meant that children were only taken into custody when this was necessary and the only course of action.

2.4 There was good support for frontline officers when dealing with detainees with mental ill health. These officers especially valued the service provided by the mental health triage car, and they told us that this often avoided detaining a person under section 136 of the Mental Health Act 1983 (see Glossary of terms) by finding other, more appropriate health-based options. If an individual was detained under section 136, the triage car service arranged a bed space for them at the place of safety. At the time of the inspection, the triage car service was being piloted as a 24-hour service (it had previously been available 8am to 2am), but when it was busy dealing with an incident (or, prior to the pilot study, when not on duty), officers contacted the mental health crisis teams to obtain information and advice.

2.5 Frontline officers reported good working relationships with mental health services. A police officer was based at the both the local hospital and the health-based place of safety, which helped in ensuring that section 136 detainees were handed over to health care staff as soon as possible. Officers told us that they generally did not have long waits with section 136

detainees at health facilities, which we rarely find in our inspections and was a good outcome for these detainees.

2.6 Individuals who had committed an offence but were showing signs of mental ill health were taken into custody so that any mental health concerns could be addressed there. The investigation into the offence continued unless a mental health assessment resulted in the detainee being sectioned and moved to a health-based place of safety.

2.7 Detainees were transported to custody in police vans or cars, depending on the risks posed. However, although the force was working with the ambulance service to improve the position, ambulances did not always arrive promptly to transport section 136 detainees, which resulted in officers using police vehicles or the triage car to take them to hospital or the health-based place of safety, which was not appropriate. However, decisions were taken in the best interests of the detainee, to avoid them waiting in an unsuitable environment until an ambulance could attend.

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 We saw custody staff engaging with detainees respectfully and with empathy, with some good practices to help improve rapport and positive interactions. For example, during booking-in, they took time to listen to detainees' issues, such as health or family concerns. Detainees we spoke to said that they had been treated well during their interactions with custody staff.

3.2 There were facilities in the custody suites to connect telephone calls to the cells intercom system, which meant that detainees could receive telephone calls, including with their legal representatives, in private (see paragraph 3.43).

3.3 Toilet paper was routinely provided to detainees, which meant that they did not have to request this from custody staff, which helped to maintain their dignity.

3.4 There was limited privacy for detainees at the booking-in desks, mainly because of the structure and design of the custody suites. Conversations between custody officers and detainees during booking-in and at other stages of custody processing could easily be overheard by other people in the suites, and during busy periods it was noisy, which made it hard for detainees and officers to hear each other. This meant that detainees could be reluctant to disclose personal or confidential information. Some detainees, but not all, as required by the recent changes to PACE, were asked if they wished to speak to an officer in private, to help mitigate this.

3.5 The booking-in desks at Euston Street were high, which could be off-putting, particularly for children or other vulnerable detainees. However, at Keyham Lane and Beaumont Leys they were at a suitable height, making interactions for detainees less intimidating.

3.6 There were no separate booking-in rooms, or any other arrangements, at any of the custody suites, to allow enough privacy for detainees to disclose private or sensitive information, or for conversations to take place between custody officers and detainees confidentially. We saw numerous instances during the booking-in process where this would have been beneficial.

3.7 Personal information about detainees – particularly detention summaries, some with photographs – was kept in such a way that it could easily be seen by others in the custody suites. CCTV monitors showing detainees either in the exercise yards or waiting in the holding rooms could easily be viewed by people in the custody suites. This did not provide enough privacy for detainees' identities to remain confidential, or sufficient dignity for them while in custody.

3.8 There were notices in the booking-in and holding areas, informing detainees and others that CCTV recording was taking place in the suites, but none in any of the cells or corridors. Most detainees were told that CCTV cameras were monitoring them, and that toilets were appropriately obscured on CCTV screens, to protect their privacy and dignity when using them. However, some were not given this information, especially if they were taken to their cells by police officers rather than CDOs.

3.9 The design of the shower doors at Keyham Lane and Beaumont Leys custody suites did not provide sufficient privacy, particularly for female detainees.

3.10 Footwear was routinely removed from detainees but, despite sufficient stocks of plimsolls and slippers being available, we saw that detainees were often without footwear in their cells, with cold concrete floors, which was detrimental to their dignity, warmth and comfort. However, we saw no detainees walking around the custody suite without footwear.

3.11 Items of clothing and footwear removed from detainees were sometimes left on the floor in cell corridors, which was disrespectful and potentially a health and safety hazard.

Area for improvement

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

- **having arrangements to allow private or sensitive information to be disclosed in a confidential environment;**
- **ensuring that all detainees are routinely asked if they wish to speak to a member of staff in confidence, to discuss any personal or confidential issues, as required by PACE code C3.5(c);**
- **ensuring that personal information (detention summary sheets) is appropriately stored, to maintain detainee confidentiality;**
- **ensuring that all detainees are told that closed-circuit television (CCTV) recording and monitoring are taking place, with toilets obscured from view, and clearly displaying notices in all the cells and corridors;**
- **ensuring that detainees can shower in sufficient privacy at all custody suites;**
- **providing replacement footwear for detainees to use in cells;**
- **ensuring that clothing and footwear removed from detainees is stored appropriately.**

Meeting diverse and individual needs

3.13 Custody officers had a good understanding of how to meet the broad range of detainees' diverse needs. Some good individualised care was provided but the provision of some care was limited.

3.14 Custody officers did not routinely ask detainees to self-define their ethnicity, and in many instances we observed, this was presumed by the custody officer. This meant that the

information held was potentially inaccurate, which would have had an impact on how well it could be used to assess fair treatment for all detainees (see also paragraph 1.16).

3.15 Custody officers had received specific training and were well prepared to understand and manage the various individual and diverse needs of those coming into custody. This included understanding the impact of adverse childhood experiences, mental ill health, autism, dyslexia, attention-deficit hyperactivity, different religious requirements and diverse cultures, and recognising the needs of transgender detainees. Custody officers told us that some of the training had been classroom based, which had been beneficial in developing their awareness and preventing misconceptions. However, CDOs had received little training on these issues, and felt that they were not provided with the same opportunities as custody officers.

3.16 The facilities for detainees with poor mobility or sight impairments were limited and varied across the suites. Euston Street was the designated site for detainees with disabilities with wheelchair access, hearing loops and toilet facilities. However, none of the suites had cells with specific adaptations for detainees with mobility impairments, such as lowered call bells, or contrasting colour bands to help visually impaired detainees. There were no wheelchairs or walking aids at Keyham Lane, and no toilets for detainees with disabilities, or showers that could easily be accessed at Keyham Lane or Beaumont Leys. Extra thick mattresses were available at Euston Street but not at the other two suites – although the force told us they would double up mattresses. The exercise yard at Euston Street was the only one that could be used by those in wheelchairs, as Keyham Lane and Beaumont Leys both had a step leading to the yard. However, we observed custody staff meeting the needs of a child with mobility difficulties by buying a blow-up bed for use in his cell.

3.17 There was some emphasis on meeting the needs of female detainees. Leaflets were available, informing them that they could speak to a female member of staff about any gender-specific issues, and they were routinely offered menstrual care products, of which there was a well-stocked range, including disposal bags. However, not all custody officers offered these detainees the opportunity to speak to a female member of staff. In practice, this was difficult to achieve, as when there were no female custody staff working, and a female officer was assigned from elsewhere in the force, they were not always readily available to attend the suite if needed.

3.18 The force recognised the requirements of a wide range of faiths. This included religious observance materials for those following Christianity, Islam, Hinduism, Judaism, Buddhism and Sikhism – although not all of these were available at Keyham Lane. The religious books and other artefacts were all appropriately stored. In most of the cells, there were signs depicting the direction for prayers for those following Islam. During booking-in, we saw custody officers asking detainees if they had any religious observance and/or dietary requirements.

3.19 At all of the suites, there were support arrangements for detainees with sight or hearing impairments, including rights and entitlements in Braille, hearing loops to help detainees with limited hearing, and printed versions of rights and entitlements documents to assist those with dyslexia. There were a few versions of the easy-read format of rights and entitlements information but these were only available at Keyham Lane, and there were no sign language DVDs at any of the custody suites. However, we saw a sign language interpreter attending a custody suite for one detainee.

3.20 Custody officers were able to access up-to-date rights and entitlements documents in numerous languages, through the relevant website.

3.21 The force had contracted interpreting services through two separate providers – a telephone and an in-person service. At Euston Street, two-way handsets were used for

telephone interpreting but at the other two suites we saw speakerphones being used, which sometimes compromised the privacy of detainees. The in-person interpreters attended when detainees were interviewed. Custody officers told us that both of the services were easy to use and generally worked well, with no notable or recurring issues.

3.22 Custody staff had a good understanding of their responsibility to inform foreign national detainees' home nation embassy or consulate of the detainee's arrest, where required or requested, and could contact them without difficulty.

Area for improvement

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

- **ensuring that there is suitable provision for detainees with disabilities, including extra thick mattresses and access to an adapted toilet, at all suites;**
- **ensuring that wheelchairs and other walking aids are available at all the custody suites;**
- **ensuring that detainees are asked to self-define their ethnicity when being booked into custody, and that it is accurately recorded;**
- **ensuring that a female member of staff is readily available when allocated as a single point of contact for female detainees, and carries out the role effectively;**
- **ensuring that there is a consistent supply of religious books at all custody suites;**
- **ensuring that individual rights and entitlements information is available in DVD format (sign language), with suitable playback equipment, to help those with hearing impairments, and in easy-read format for children or those who find reading difficult, at all the custody suites;**
- **ensuring that two-way handsets are available, to enable interpreting services to provide confidentiality, for detainees at Keyham Lane and Beaumont Leys custody suites.**

Risk assessments

3.24 The approach to identifying risks was generally good but there were some weaknesses in their ongoing management.

3.25 On arrival, most detainees were booked in quickly. They did not wait in vehicles outside the custody site but some experienced long waits in holding rooms, sometimes because of local booking-in practices (see paragraph 3.35). There was little management of queues to manage risks or to prioritise children or vulnerable detainees for booking-in.

3.26 Custody officers focused appropriately on the welfare of detainees, and identifying risks and vulnerability factors. They interacted positively with detainees to complete the risk assessment template, responded patiently to individual need, and asked relevant

supplementary and probing questions. There was routine cross-referencing to police national computer warning markers and historical information, held on both the custody record and force computer systems, to inform risk assessments further. However, custody officers did not always ask arresting and escorting officers if they had any relevant information to inform risk assessments further.

3.27 Initial care plans mostly reflected observations at a level that was commensurate with the presenting risk. However, it was of particular concern that the observation levels set for detainees who were under the influence of alcohol and/or drugs did not always include rousing checks (level 2, according to APP), which posed potential risks and had been a concern at the previous inspection. In general, observation levels were reviewed regularly but there was not always sufficient justification recorded on custody records as to why these had been changed.

3.28 The frequency of checks conducted on detainees was mostly adhered to but, in our case audits, records reflected a few late visits. These checks were not always carried out by the same member of staff (which did not follow APP guidance), which meant that changes in a detainee's behaviour or condition might not always have been readily identified. When rousing checks were identified as needed for detainees under the influence of alcohol and/or drugs, staff conducted and recorded them in accordance with annex H of PACE code C.

3.29 Footwear and clothing with cords continued to be routinely removed, in the absence of an individualised risk assessment, which did not follow APP guidance. Positively, there was no use of anti-rip clothing. When a detainee's risk assessment indicated a heightened level of risk, they were appropriately placed on level 3 constant observation via CCTV, or on level 4 physical supervision in close proximity at the cell door. In these cases, we expect that the officers conducting these roles are fully briefed by the custody officer but this was not always the case.

3.30 All custody staff carried anti-ligature knives. Cell call bells were responded to promptly. When call bells were muted on the authority of a custody officer, there was an efficient mechanism for this to be automatically reinstated within a reasonable time frame.

3.31 The management and control of cell keys was poor, and had not improved since the previous inspection. Non-custody staff accessed cell keys routinely, which diminished the control that custody staff maintained in the suite.

3.32 Handovers were properly focused on risk, detainee welfare and case progression. However, as we found at the previous inspection, custody officers and CDOs handed over separately to their incoming peers, with no involvement of health care practitioners (HCPs), even when they were available. This approach to handovers potentially diminished the quality and accuracy of information shared between individual staff, particularly when some shifts were staggered, with several individual handovers taking place throughout the day. Not all custody officers visited detainees after receiving their handover, and those who did, did not always engage or interact with them.

Area for improvement

3.33 The approach to managing some elements of risk should be improved. In particular:

- **All detainees should be placed on appropriate observation levels, including those under the influence of alcohol and/or drugs, who should be placed on observation levels that include rousals;**

- **Detainees' clothing and footwear should only be removed on the basis of an individual risk assessment;**
- **Officers conducting CCTV or close proximity observations of detainees should be appropriately briefed;**
- **There should be effective control over the management of custody keys;**
- **All custody staff should be involved collectively in shift handovers.**

Individual legal rights

3.34 The approach to ensuring that detainees received their legal rights in custody was not always good enough and some practices did not meet the requirements of the PACE codes of practice.

3.35 On arrival at the custody suite, detainees were generally lodged in holding rooms, where they waited while officers exchanged the details of the circumstances of the arrest with the custody officer. This was routinely done without the detainee being present, and delayed the booking-in process. Officers also sometimes had to create occurrence records, required by the custody computer system before the booking-in process could begin, which further delayed it.

3.36 Data supplied by the force showed that, in the previous year (1 February 2019 to 31 January 2020), the average waiting time between detainees arriving at the custody suites and their detention being authorised had been 30 minutes. This was higher than the average in other forces inspected recently.

3.37 Custody officers did not always ask for details of the necessity for arrest, and, when offered, these were not always sufficient. In most cases, custody officers authorised detention when they opened the custody record, before discussing this with the detainee. When detainees approached the booking-in desk, custody officers did not always ensure that they were informed of the grounds and necessity for their detention before it was authorised. These practices did not meet the requirements of paragraph 2.2 of PACE code G (see Glossary of terms) and paragraphs 2.1A and 3.4(a) of PACE code C (see Glossary of terms) (see also paragraph 1.14, and cause of concern and recommendation S36).

3.38 Custody officers told us that they were confident in refusing detention when the circumstances did not merit it, and provided details of such cases.

3.39 Alternatives to custody included restorative justice processes (restorative justice is the collective resolution between victim and offender as to how to deal with the consequences of an offence), conditional cautions (a conditional caution can be issued if the offender admits the offence and accepts the conditions being imposed: if the offender subsequently fails to comply with the conditions, they can be subsequently be prosecuted) and voluntary attendance (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). Facilities for interviewing voluntary attendees were available at many police stations, and these individuals were also interviewed in the custody suites, where they could access interview rooms without entering the main booking-in areas. Data supplied by the force showed that, in the previous year, there had been 5,621 voluntary attendees.

3.40 The force had seen a 5% increase (11 cases) in the number of immigration cases brought into custody over the previous three years. Data provided by the force showed that the average

length of detention for immigration detainees following service of an IS91 warrant of detention (see Glossary of terms) in the previous year had been 12 hours three minutes, which was an improvement on the previous inspection.

3.41 Detainees should be kept in custody for the minimum time necessary to progress their cases. Custody officers had a clear focus on ensuring that detainees were released or transferred at the earliest opportunity, and in most cases this happened. In our custody record analysis (CRA), detention times overall were not excessive or vastly different from those in other forces we have inspected recently. However, we were told, and observed, that investigations for detainees arrested during the evening were not always progressed in a timely way. Delays were attributed to the non-availability of an investigating officer and waits for Crown Prosecution Service decisions to prosecute. We also observed delays due to the lack of custody officers and staff to deal with investigating officers' updates and queries, and to process and release detainees promptly.

3.42 Custody officers treated detainees with dignity and respect, and fully explained their three main rights while in custody (to have someone informed of their arrest, to consult a solicitor and access free independent legal advice, and to consult the PACE codes of practice). A written notice setting out detainees' full rights and entitlements was readily available in all custody suites but custody officers did not always offer or issue it to detainees (see also paragraph 3.56).

3.43 All detainees were offered free legal representation; if they declined, their reasons were recorded. Posters informing detainees of their right to free legal advice were not displayed in all the suites at the start of the inspection but were supplied within a few days. There were sufficient interview/consultation rooms for detainees to consult their legal representatives in private. Detainees wishing to speak to their legal representatives on the telephone could do so privately, as calls were transferred to their cells (see also paragraph 3.2). Legal representatives were routinely allowed to view a summary printout of the front sheet of their client's custody record, on request.

3.44 Detainees were told that they could read the PACE codes of practice during booking-in, and up-to-date versions were readily available. However, these were not always explained or proactively offered to detainees.

3.45 It was positive and unusual for us to find that all custody officers were aware of the requirements of annex M of PACE code C, to provide translated documents to non-English-speaking detainees. These were available through the custody computer system, and were readily issued to these detainees – in particular, when their initial detention was authorised.

3.46 When authorising the taking of biometric samples from a detainee, custody officers clearly explained why these samples were required and how they were to be used, but did not inform the detainee of the force retention and disposal policy for the samples. There was a good process for managing and transporting DNA samples. Freezers in the custody suites had locks but these were not used, which compromised the integrity of stored samples.

PACE reviews

3.47 The overall approach to PACE reviews of detention was good, and better than we often see. However, there were some areas that required more focus (see cause of concern and recommendation S36).

3.48 PACE reviews were undertaken by dedicated PACE inspectors or, when they were not available, by operational duty inspectors across the force area. Inspectors treated detainees

courteously and with respect when conducting reviews. These reviews had an appropriate focus on welfare and the best interests of the detainee. However, due process was not always followed; some detainees were not advised that their continued detention had been further authorised, and not all were offered an opportunity to make representations concerning their continued detention. This did not meet the requirements of paragraph 15.3 of PACE code C (see also paragraph 1.14 and cause of concern and recommendation S36).

3.49 Most reviews were conducted on time, and we were told by custody officers that, wherever possible, reviewing officers would seek to conduct a review with the detainee in person. This was evident from our CRA and observations. Relatively few reviews were conducted by telephone. While reviews were rarely late, some were conducted too early, without appropriate justification.

3.50 In our case audits and observations, when reviews had taken place while detainees were asleep, most of these had been overnight, during the detainee's period of rest. In most cases, the detainee had not been informed as soon as possible after they woke up that a review had taken place; this did not meet the requirements of paragraph 15.7 of PACE code C (see also paragraph 1.14 and cause of concern and recommendation S36).

3.51 In our CRA, we identified one case in which a review of a detainee's detention had been required but not carried out. There was nothing recorded as to why this had not taken place when it was due, or why it was still outstanding when the detainee had been released on bail over an hour later. This was a breach of PACE section 40(5) (see also paragraph 1.14 and cause of concern and recommendation S36).

Access to swift justice

3.52 When custody officers identified that there was insufficient evidence to charge detainees, decisions were made either to seek authorisation, through the appropriate channels, to bail them or release them under investigation (RUI). We saw RUI detainees being appropriately advised by the custody officers of the consequences if they tried to compromise the investigation. To ensure that detainees fully understood this, a document was given to them that explained the types of offences that they would be committing if they approached witnesses or interfered with the course of justice.

3.53 However, at the time of the inspection, there were 490 active bail cases dating from April 2017 and 1,904 RUI detainees; of the latter, 1,653 cases were over 28 days old, and 1,243 over three months old, which appeared high. Our CRA identified that only 49% of detainees' cases were concluded during their first period in custody – avoiding the need for bail or RUI – which was lower than we have found in other forces inspected recently.

3.54 The progress of bail cases was monitored by two bail managers, who sent timely reminders to officers responsible for the case, to ensure that outstanding enquiries were pursued, and applicable bail periods adhered to. The force also had a procedure to monitor and oversee RUI detainees, to ensure that cases were progressed in a timely manner. However, frontline officers and supervisors we spoke to said that they were not always given the time to complete outstanding enquiries, which often led to delays in the investigation.

Area for improvement

3.55 The force should ensure that detainees have access to swift justice by monitoring cases effectively and giving officers enough time to complete outstanding enquiries.

Complaints

3.56 Information on the complaints process was not displayed in any of the custody suites. There were no posters or other visible promotional information about making a complaint. The information was contained in the last page of the rights and entitlements documentation, but this was not always given to detainees (see also paragraph 3.42). However, there were Independent Office for Police Conduct leaflets at all the suites, setting out the procedures to make complaints against the police.

3.57 Our expectation is that a detainee should be able to make a complaint before leaving custody. However, the force's complaints policy did not specifically state this. Custody staff told us that, if a detainee wanted to make a complaint, they would contact the duty PACE inspector to see if they were available to take it; if they were not, staff said that they would tell the detainee to make their complaint after being released. The PACE inspectors confirmed that this was the procedure.

Area for improvement

3.58 The force should strengthen its approach to dealing with complaints from detainees by promoting the complaints procedure, so that detainees know how to make complaints while in 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 The Leicestershire Police custody estate had reduced slightly since the previous inspection, with the closure of a contingency suite at Wigston Police Station. There remained three full-time designated suites at Beaumont Leys, Euston Street and Keyham Lane, with a total capacity of 67 cells. The King Power Football Stadium in Leicester had additional capacity to hold detainees for short periods. We inspected the four facilities, and found potential ligature points in all of them, mainly due to the design of toilets, location of ceiling air vents and fit of cell hatches. At the end of the inspection, we provided the force with a comprehensive illustrative report detailing these, to which they responded positively.

4.2 Overall, conditions and cleanliness across the suites were good. There was natural light in all cells, and little evidence of graffiti. The temperature in suites was controlled from a central location; while temperatures were mostly suitable, some detainees told us that their cells were cold (see also paragraph 4.21).

4.3 A high-quality CCTV system had been installed across the custody estate, including in all cells. All suites had notices advising detainees that CCTV was operating, but these were not always prominently displayed in relevant areas, such as in cells and corridors (see also paragraph 3.8 and area for improvement 3.12).

4.4 The height of the cell benches at Beaumont Leys was lower than in standard cells, and there were no extra-thick mattresses available to raise the height, if required (see also paragraph 3.16 and area for improvement 3.23). Most cells had toilets, which were obscured from view on CCTV monitors, and most also had in-cell handwashing basins with drinking water, and appropriate signage to identify this.

4.5 The cell call bells that we tested were functioning.

4.6 Daily checks of the physical environment, including cells and communal areas, were conducted by CDOs against a pre-determined checklist. However, they were carried out inconsistently, and had failed to find defects that we found – for example, holes in mattresses. Any damage or faults found were reported in an email to a central custody address. Minor faults were, in most cases, responded to promptly but staff told us that some repairs could take a considerable time to be completed.

4.7 Custody staff awareness of fire evacuation procedures was reasonable. However, fire evacuation plans were not displayed prominently. There were sufficient sets of handcuffs available to evacuate safely if required, but most staff told us that they had not been involved in a fire drill for several years, and some had never been involved in one. Information provided showed that a fire evacuation drill had taken place at all three suites, but only at

Keyham Lane had one been held in the previous 12 months. These records did not always identify who had been present for the drill, or the actions taken when learning points had been identified.

Areas for improvement

4.8 The temperature in the suites and cells should be regulated appropriately.

4.9 All cell benches should be of an adequate height.

4.10 The force should ensure that all legal requirements concerning fire safety are adhered to.

Safety: use of force

4.11 The information collated on the use of force in custody was not reliable. Poor recording on custody records of when force was used on detainees made it difficult to identify when incidents had occurred and whether the force used had been appropriate and proportionate. In two cases, we found that the only record of force being used had been made by health care professionals dealing with the detainee. Use of force forms were usually completed comprehensively and with sufficient detail, but not all officers involved in the incident itself submitted the required form, as required by the National Police Chiefs Council. This had not improved since the previous inspection (see cause of concern and recommendation S37).

4.12 Data provided by the force for 1 February 2019 to 31 January 2020 on the use of restraint equipment in custody showed 91 instances of its use, including 57 uses of restraint straps and five uses of incapacitant spray. We were not confident that the information we were provided with was accurate, and when we queried some of it, it was found to be incorrect. This meant that the force could not show that restraint equipment was being used appropriately (see area for improvement 1.18).

4.13 However, during the inspection we saw good examples of staff de-escalating challenging situations with detainees, avoiding or minimising the use of force.

4.14 We reviewed the custody records of 12 cases in which force had been used against detainees in custody. CCTV recordings were kept for only 30 days, so we were able to view the footage of only eight of these cases. Our review showed that the force used had generally been proportionate and necessary. However, we referred one case back to the force, for them to review and learn from; we were concerned that the incident had lacked effective and appropriate supervisory oversight, resulting in the poor application of control and restraint techniques and the detainee being handcuffed to the rear for a considerable period.

4.15 CDOs and all but one of the custody officers were up to date with their personal safety training. There were arrangements for the remaining officer to attend the relevant training courses.

4.16 Not all detainees who arrived in custody were handcuffed; those who were, usually had these removed promptly after arrival. However, the time that handcuffs were removed was not recorded, to enable the force to show that it was not holding detainees in handcuffs for longer than necessary.

4.17 The force had a comprehensive policy and procedures document for the authorisation and conducting of strip-searches of detainees in custody, which followed APP guidance. Data provided by the force showed that 4.7% of adult detainees and 3% of children had been strip-searched in the previous year, and our CRA showed that the force had a lower percentage of strip-searches than many other police forces we have inspected since March 2016. In the custody records we looked at, we found that the rationale and authorisation for strip-searches had been well recorded and documented.

4.18 Custody inspectors conducted a monthly review of CCTV footage of a small number of use of force incidents, to quality assure them. Findings from this review were used to identify learning opportunities and provide feedback to those involved. However, these findings were not shared more widely across the force, and the review included only incidents that that the force knew about – and not all incidents were recorded (see above). There were no mechanisms to identify incidents that had taken place in custody but not been captured on the custody record (see cause of concern and recommendation S37).

Detainee care

4.19 Custody staff showed a strong caring culture in looking after detainees. The detainees we spoke to said that they had been well cared for during their time in custody, with regular offers, and provision, of meals and drinks, and that custody staff had been helpful and considerate towards them.

4.20 There were sufficient stocks of food and drinks, consisting of various microwaveable meals (including vegetarian, gluten-free and halal options), instant noodles, cornflakes and porridge, and all food products were within their use-by dates. Custody staff told us that there were provisions for other meals to meet specific individual requirements, or to give variation for detainees who were kept in custody for long periods, by buying food or allowing it to be brought in by friends or relatives, at the discretion of the custody officer. Drinking water was available in all the cells.

4.21 The only blankets available for issue to detainees were made of anti-rip material, offering little comfort. We observed that many detainees had to be provided with two blankets, but some detainees we spoke to told us that they still felt cold in their cells (see also paragraph 4.2 and area for improvement 4.8).

4.22 The limited reading material available consisted mainly of out-of-date newspapers and magazines, with nothing for children or in languages other than English, and this was not routinely offered or provided. In our CRA, only 9% of detainees had been offered reading material, which was contrary to APP guidance to offer this routinely. However, we saw some detainees with reading material in their cells. Distraction packs were now available – arranged through the charity RECOOP (Resettlement and Care of Older ex-Offenders and Prisoners) – containing various quizzes and puzzles to help detainees pass the time. We did not see these being used routinely, but saw one being used well with a disruptive detainee.

4.23 There were sufficient supplies of toiletries, towels and replacement clothing, including paper underwear, and footwear for detainees of both genders.

4.24 Although we saw detainees receiving exercise and showers, these were not regularly offered, as required by APP guidance, even to those held overnight or for extended periods in custody. Access to these often relied on the availability of staff. Some detainees were provided with wash kits to use in their cells, but only cold water was available there.

Area for improvement

4.25 The force should improve its care for detainees by:

- **increasing the range of reading material available, especially for children and those whose first language is not English, and offering this routinely;**
- **increasing detainees' access to showers and exercise, particularly when they are held overnight or for extended periods.**

Safeguarding

4.26 The officers we spoke to had a good understanding of how to identify vulnerability and safeguarding concerns, and their responsibilities in addressing these. They received training on safeguarding children and vulnerable adults; this included training in the role of the custody officer in identifying concerns and raising these with investigating officers so that they could be dealt with.

4.27 Arresting and investigating officers were responsible for making safeguarding referrals to the force's specialist team and telling custody officers of any risks or concerns that might affect the detainee's care in custody or on release. We saw some good examples of officers providing this type of information, with custody officers directing any necessary further action. Custody officers could also find more details by looking at the referral forms and other information held on the custody computer system. However, safeguarding information, and any action taken, was not always recorded on custody records – including how vulnerable adults and children would get home when released from custody (see paragraph 1.12 and area for concern 1.19).

4.28 In general, children and vulnerable adults received prompt support from appropriate adults (AAs). Custody officers requested AAs early on in detention, although would delay requests if a detainee was under the influence of alcohol or drugs, or it was in their best interests to have a period of sleep. AAs were expected to attend as early as practicable, to help detainees understand their rights and entitlements while in custody, and then to remain or return for all other aspects of custody processing when their presence was required.

4.29 Family members or carers were sought as AAs in the first instance, and arresting officers sometimes asked them to attend at the time of the arrest. When they were not able to attend, or it was not appropriate for them to act as AA – for example, if they had been a witness to the incident – AAs for vulnerable adults were obtained through The Appropriate Adult Service (TAAS), and for children through the Youth Offending Service (YOS) during the day and TAAS at night. AAs from TAAS arrived promptly, in line with contractual arrangements, but custody officers told us that the service from YOS was less responsive and not as reliable, sometimes leading to children having long waits before receiving support from an AA.

4.30 The force did not monitor how long children or vulnerable adults waited before receiving support from an AA, and request times were not always recorded on the custody record. AA provision was included in discussions with partners about children in custody, and was also considered as part of the quarterly audits (see paragraph 1.13) carried out on a sample of cases, which provided some insight into how the AA arrangements worked in practice. In most of the cases we looked at and observed, children and vulnerable adults had both received early support.

4.31 Custody officers were confident in deciding whether an adult was vulnerable and needed support from an AA. They used a range of factors to help them make this decision, such as the detainee's presentation, previous history and whether they themselves felt that they needed this support. At all of the suites, we observed vulnerable adults appropriately receiving support from an AA.

4.32 There was AA guidance available at Keyham Lane and Beaumont Leys but not at Euston Street. Custody officers said that they would hand this to family members who were not familiar with the role, and would also explain verbally what was expected of them.

4.33 Custody officers and CDOs interacted well with children, responding to their needs and providing good care. Children coming into custody during the day were seen by a member of the mental health criminal justice liaison and diversion service (CJLDS) team (see section on mental health), who tried to engage with them, assess any concerns and liaise with other agencies if the child was known to them; this process was carried out by a nurse for children brought into custody during the night. Girls were assigned a female officer to look after their welfare needs, in line with legislative requirements, although it was not always clear if they had visited or spoken to the child. Children were able to speak to their parents or family members by telephone throughout their stay in custody. We were told that they might be able to wait in interview rooms with their AA rather than in their cell, but we did not see, or find records of, this happening. There was a requirement that inspector reviews of detention for children were always carried out in person, to make sure that the children were not kept in custody unnecessarily, and although we saw some exceptions, this was mainly achieved (see also paragraph 3.49).

4.34 There were few arrangements or facilities to keep children away from adult detainees. The design of the suites made this difficult to achieve, and we observed children placed in cell blocks with adult detainees, with little consideration of whether other cells might have been quieter or more appropriate. Easy-read versions of the rights and entitlement notice was available at only one suite and was not routinely given out to children (see also paragraph 3.19).

4.35 Children were only brought into custody as a last resort. The force had a children and young person's action plan, which included diverting children away from custody. For example, the force had worked with care homes to agree their responsibilities and when to involve the police. Seconded police officers based in the YOS teams reviewed children entering custody, to assess whether any prevention work could be put in place to minimise reoffending.

4.36 Custody officers were well focused on minimising the time that children spent in custody. Investigations were generally progressed promptly, including overnight. When it seemed unlikely that the case would be completed within a reasonable time, custody officers avoided overnight detention, if possible, by bailing or releasing children under investigation.

4.37 There was some good monitoring with partner agencies of children held in custody. Quarterly remand strategy meetings with the police and representatives from various agencies, including local authority services and the AA provider, considered cases of children who had been charged and refused bail, or held on a warrant or for breach of bail. This included whether the concordat on children in custody had been followed, and whether the local authorities had met their statutory responsibility to move the children charged and refused bail out of custody into other accommodation. Safeguarding concerns, the effectiveness of AA provision and the child's wider involvement in the criminal justice system were also discussed. Minutes of these meetings showed a good level of scrutiny over these cases, as well as wider discussions around services for children in custody.

4.38 Few children were charged and refused bail. However, despite the close monitoring described above, little progress had been made in moving children out of custody. In the year

to 31 January 2020, 33 children had been charged and refused bail. Of these, three had been remanded for only a short time before being sent to court, so other accommodation had not been required. Of the remainder, 24 requests had been made to the local authority for alternative accommodation but none of the children had been moved, which was a poor outcome for them. There were escalation procedures but custody officers did not always follow these because it was regarded as a 'paper exercise', as there was no secure accommodation available in Leicestershire, and little prospect of any other appropriate accommodation being found. It was not clear why requests had not been made in the other six cases. We looked at a case where a child had spent a long time in custody without any request for alternative accommodation being made, with no explanation for this.

Area for improvement

4.39 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.

Governance of health care

4.40 Effective governance and challenge of all aspects of health care were achieved through operational scrutiny by senior officers, and regular planned meetings with the force and other stakeholders. Mitie (Forensic Medical Services) was commissioned by the police to provide physical health services for detainees through a health care professional (HCP)-led model. Nurses and paramedics provided continuous embedded input at Euston Street – 24 hours a day, seven days a week. Similar input was delivered at Beaumont Leys and Keyham Lane at weekends, with a single HCP working across these two suites from Monday to Friday. There were few vacancies, and any additional cover was provided through an established bank of experienced staff. The arrangements delivered effective cover, with detainees generally receiving a timely, needs-led service. No complaints had been received about the service in the previous 12 months. Clinical incidents were well captured and reviewed appropriately to distil any organisational learning.

4.41 Clinical performance data provided by Mitie were qualitative in nature and verified by the force, and used to inform future plans. Senior HCPs led small teams, providing supervision and ensuring local clinical oversight. Sound processes had been established, but line management arrangements were not yet fully embedded and senior HCPs were often expected to maintain these systems as well as constantly covering clinical shifts, which could be stretching.

4.42 Attendance at mandatory training was generally well facilitated. Some HCPs needed to refresh their Immediate Life Support skills but this training had been booked and was planned to take place within the next few weeks. Senior HCPs had good access to professional development but this was more limited for other staff, although there were plans to test key competencies annually, which would be a positive initiative once implemented. Treatment rooms were clean, spacious and complied with most infection prevention standards. In addition to HCPs, custody staff were also first-aid trained and had access to their own resuscitation equipment, including oxygen and an automated external defibrillator.

Patient care

4.43 There was good access to HCPs. Police custody staff identified detainees with health care needs promptly, and in our CRA the mean waiting time for detainees to see an HCP had been 24 minutes, which was impressive. Performance reports provided by the force supported this perspective, with a 95% compliance rate against agreed targets. The HCPs we met were experienced, and we observed skilled support and care being provided, which was confirmed by the detainees we spoke to. All children arriving in custody were seen by an HCP. Clinical records were held electronically on SystmOne, with key milestones appropriately noted on the custody record. With detainees' consent, HCPs could access their NHS records to verify prescribed medicine regimes.

4.44 Access to prescription medication was facilitated, and this included community-prescribed opiate substitution treatment. There was a wide range of patient group directions (which enable nurses to supply and administer prescription-only medicine), and symptomatic relief for detainees experiencing withdrawal was also properly utilised. However, there was no access to nicotine replacement products, which could have been detrimental to the well-being of some detainees. Detainees could take regular prescribed medicines with them to court, but there was no ongoing support for those experiencing withdrawal who were attending court, although symptomatic relief was usually facilitated before leaving custody. Medicine management arrangements, including storage and disposal, were thorough.

Area for improvement

4.45 **On an individual assessed basis, nicotine replacement should be offered to smokers.** (Repeated recommendation 6.16)

Substance misuse

4.46 Turning Point provided a direct link to community-based drug and alcohol services, and was available within the custody suites from Monday to Saturday. This input was mostly triggered through the 'test on arrest' schemes operating in custody but all detainees could access face-to-face support if needed. If ongoing community support was planned, the assessing practitioner would individually follow up the detainee on release. A single practitioner covered all three suites, so there was no continuous presence in every suite, but they were able to respond flexibly to detainee requests for support. Overall, the support provided was reasonable and proportionate to demand, and better than we often find in police custody.

Mental health

4.47 Leicester Partnership NHS Trust provided the mental health CJLDS in custody. A small, experienced team delivered good support to detainees through a seven-day-a-week service, working from 8am to 10pm. Practitioners were based at Euston Street but worked flexibly across all suites.

4.48 The team aimed to see all vulnerable detainees in custody. Referrals were screened and risk assessed, and although not all detainees were seen, because they chose not to be or were released, an experienced registered HCP saw all individuals needing a specialist assessment. Detainees were provided with advice and information, signposted to community and voluntary support services and were occasionally accompanied to appointments. The service was due to expand in April 2020, to adopt an all-vulnerabilities model, providing support to detainees who, because of age, gender, sexuality, illness, disability, alleged offence or social

circumstances, might be more vulnerable to the impact and stress associated with detention, and who therefore might require additional support in custody and pre-release. Plans were well advanced to implement this model, and we felt that it would enhance services further.

4.49 We observed effective working relationships between custody staff and CJLDS practitioners. There was clearly a strong mutual understanding of each other's role, and communication between partners was excellent. CJLDS staff who worked in custody also covered the street triage service. This was a jointly run initiative between the police and NHS, whereby specialist mental health practitioners and trained police officers attended incidents and provided immediate help and advice to officers at the scene of an incident, and ensured that potentially vulnerable members of the public received the help they needed as quickly as possible (see also paragraph 2.4). This service was a valued asset, which effectively diverted vulnerable individuals away from custody and further demonstrated the range of integrated support available to custody staff.

4.50 The pathway for detainees who became mentally unwell in custody was good. In these circumstances, Mental Health Act assessments were generally carried out promptly. Some custody officers told us that access to inpatient beds and subsequent transfers to hospital were sometimes problematic. The pathway was not routinely monitored, which was a data gap (see also paragraph 1.11 and area for improvement 1.18), but there was no indication that detainees were spending too long in custody as a result.

4.51 There had been only one case of a detainee being held in custody as a place of safety under section 136 (see Glossary of terms) in the previous 12 months, but the circumstances behind this case were unclear. In addition, some detainees had been transferred from custody under section 136 to a health place of safety because their mental health needs had not been met in custody and their detention time under PACE had nearly run out, but only limited details of these cases were available and they did not show how these decisions had been made (see also paragraph 1.11 and area for improvement 1.18).

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 Since the previous inspection, there had been an improved focus on ensuring that detainees were released safely. Custody officers engaged well with detainees to complete pre-release risk assessments (PRRAs), and made appropriate use of initial risk assessments and care plans to ensure that all identified risks had been addressed or managed before release. Particular attention was given to managing the safe release of children and vulnerable detainees. When necessary, relevant agencies, such as HCPs, were often involved to support the release of the detainee. However, in our observations, PRRA templates were generally completed after detainees had been released and often did not fully reflect what we had seen. In our case audits and review of PRRAs, we also found that records lacked detail. For example, release arrangements had not been recorded routinely and did not always demonstrate how a detainee planned to travel home after release (see also paragraph 4.27).

5.2 Detainees without the means to travel home following release could be given travel warrants for trains and petty cash for bus journeys, both of which were easily accessible to custody officers. When these options were not appropriate – for example, if detainees were deemed to be vulnerable, or during the night when public transport was not available – custody officers told us that they would ask police officers to take detainees home. However, officers were not always available, owing to other operational commitments, so this arrangement could not be relied on.

5.3 On release, most detainees were given a support leaflet with useful telephone numbers, but this was only available in English.

5.4 Enhanced safeguarding arrangements were in place for individuals arrested under suspicion of committing some higher-risk offences, and were the responsibility of the investigating officers dealing with them, but not all custody officers knew whether, or satisfied themselves that, this happened before release.

5.5 Person escort records (PERs) were well completed and contained accurate and relevant information. However, we saw PERs with medical information in unsealed envelopes, which did not ensure confidentiality. Moreover, additional loose-leaf documentation, such as charge sheets, continued to be inserted into some PERS, despite our previous recommendation against doing this.

Area for improvement

5.6 The force should ensure that medical information for person escort records is kept confidentially, and stop the practice of inserting loose-leaf documentation.

Courts

5.7 Detainees who were required and ready to appear in court after being held overnight were processed in a timely manner and were not held in police custody for longer than necessary. However, those arrested on warrant during the day had to be brought to the police custody suites as the local remand court, Leicester Magistrates' Court, would not accept them directly.

5.8 Custody staff told us that the court would not accept additional detainees, after the initial collection, after 2pm but they were often refused much earlier. While we saw some detainees being accepted by the court before 2pm, we saw several (and were told about more) who were refused, including sometimes very early in the day. This resulted in them not being presented before the first available court and therefore remaining in police custody for longer than necessary. This was a similar position to that found during the previous inspection.

Area for improvement

5.9 **Senior police managers should work with the HM Courts and Tribunals Service, so that detainees are presented to the first available court and do not spend longer than necessary in police custody.** (Repeated recommendation 5.23)

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

Causes of concern and recommendations

6.1 Cause of concern: The force did not consistently meet the requirements of PACE codes C and G for the detention, treatment and questioning of persons.

Recommendation: The force should take immediate action to ensure that all custody procedures comply with legislation and guidance. (S36)

6.2 Cause of concern: The governance and oversight of the use of force were limited. Not all incidents involving the use of force in custody had been recorded, making the data unreliable and preventing effective scrutiny. Although the force reviewed some cases to assess how incidents were dealt with, the effectiveness of this was also limited by the unreliable data. Not all staff followed National Police Chiefs Council guidance in completing individual use of force forms.

Recommendation: The force should assure itself and others that when force is used in custody, it is safe and proportionate. It should:

- **ensure that all use of force incidents are properly recorded on the custody record, so that there is comprehensive, reliable and accurate data to inform the governance arrangements;**
- **strengthen the review of individual incidents by ensuring that there is an accurate pool of cases from which to draw these, and that closed-circuit television is readily available for viewing them;**
- **ensure that all officers complete use of force forms for any incident they are involved in.** (S37)

Areas for improvement

Leadership, accountability and partnerships

6.3 The force should ensure that custody staff are deployed in the most effective way, to improve outcomes for detainees and prevent them from remaining in custody for longer than necessary. There should be sufficient oversight of staffing levels by senior officers, to ensure that the suites are managed effectively. (1.9)

6.4 The force should ensure that all custody staff consistently follow the College of Policing *Authorised Professional Practice – Detention and Custody*, and the East Midlands Criminal Justice Services' own guidance, so that detainees receive the appropriate treatment and care. (1.10)

6.5 The force should strengthen its approach to performance management by addressing the gaps in its performance information and ensuring that all its data is reliable. (1.18)

6.6 The force should improve the quality of its custody records by ensuring that all necessary information is fully recorded, including the rationale and justification for any decisions made. (1.19)

6.7 The force should strengthen its approach to the quality assurance of custody services by having its own structured dip-sampling arrangements, to help identify where improvements are needed. (1.20)

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

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

- having arrangements to allow private or sensitive information to be disclosed in a confidential environment;
- ensuring that all detainees are routinely asked if they wish to speak to a member of staff in confidence, to discuss any personal or confidential issues, as required by PACE code C3.5(c);
- ensuring that personal information (detention summary sheets) is appropriately stored, to maintain detainee confidentiality;
- ensuring that all detainees are told that closed-circuit television (CCTV) recording and monitoring are taking place, with toilets obscured from view, and clearly displaying notices in all the cells and corridors;
- ensuring that detainees can shower in sufficient privacy at all custody suites;
- providing replacement footwear for detainees to use in cells;
- ensuring that clothing and footwear removed from detainees is stored appropriately. (3.12)

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

- ensuring that there is suitable provision for detainees with disabilities, including extra thick mattresses and access to an adapted toilet, at all suites;
- ensuring that wheelchairs and other walking aids are available at all the custody suites;
- ensuring that detainees are asked to self-define their ethnicity when being booked into custody, and that it is accurately recorded;
- ensuring that a female member of staff is readily available when allocated as a single point of contact for female detainees, and carries out the role effectively;
- ensuring that there is a consistent supply of religious books at all custody suites;
- ensuring that individual rights and entitlements information is available in DVD format (sign language), with suitable playback equipment, to help those with hearing impairments, and in easy-read format for children or those who find reading difficult, at all the custody suites;

- ensuring that two-way handsets are available, to enable interpreting services to provide confidentiality, for detainees at Keyham Lane and Beaumont Leys custody suites. (3.23)

6.10 The approach to managing some elements of risk should be improved. In particular:

- All detainees should be placed on appropriate observation levels, including those under the influence of alcohol and/or drugs, who should be placed on observation levels that include rousals;
- Detainees' clothing and footwear should only be removed on the basis of an individual risk assessment;
- Officers conducting CCTV or close proximity observations of detainees should be appropriately briefed;
- There should be effective control over the management of custody keys;
- All custody staff should be involved collectively in shift handovers. (3.33)

6.11 The force should ensure that detainees have access to swift justice by monitoring cases effectively and giving officers enough time to complete outstanding enquiries. (3.55)

6.12 The force should strengthen its approach to dealing with complaints from detainees by promoting the complaints procedure, so that detainees know how to make complaints while in custody. (3.58)

In the custody cell, safeguarding and health care

6.13 The temperature in the suites and cells should be regulated appropriately. (4.8)

6.14 All cell benches should be of an adequate height. (4.9)

6.15 The force should ensure that all legal requirements concerning fire safety are adhered to. (4.10)

6.16 The force should improve its care for detainees by:

- increasing the range of reading material available, especially for children and those whose first language is not English, and offering this routinely;
- increasing detainees' access to showers and exercise, particularly when they are held overnight or for extended periods. (4.25)

6.17 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. (4.39)

6.18 On an individual assessed basis, nicotine replacement should be offered to smokers. (4.45, repeated recommendation 6.16)

Release and transfer from custody

6.19 The force should ensure that medical information for person escort records is kept confidentially, and stop the practice of inserting loose-leaf documentation. (5.6)

6.20 Senior police managers should work with the HM Courts and Tribunals Service, so that detainees are presented to the first available court and do not spend longer than necessary in police custody. (5.9, repeated recommendation 5.23)

Section 7. Appendices

Appendix I: Progress on recommendations and areas for improvement since 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.

Areas of concern and recommendations

7.1 The force should implement quality assurance processes to assess the standards of custody provision, with a greater emphasis on qualitative performance, and ensure positive outcomes for detainees. (2.39) **Partially achieved**

7.2 The quality and consistency of initial risk assessments should be improved and regularly monitored as part of the quality assurance for training, staff development and safe outcomes for detainees. (2.40) **Achieved**

7.3 Custody sergeants should exercise appropriate supervision over the recording of use of force in custody. Leicestershire Police should collate use of force data from custody and examine them for trends, in accordance with the Association of Chief Police Officers' policy and College of Policing Guidance. (2.41) **Not achieved**

7.4 The Police and Crime Commissioner and the Chief Officer Group should engage with the local authorities to instigate an immediate review of the provision of local authority accommodation for children under section 38(6) of PACE (1984). They should monitor performance data to ensure that children are not unnecessarily detained in police cells. Custody staff should only fingerprint and photograph children, and take DNA samples from them, in the presence of an appropriate adult. (2.42) **Achieved**

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.

Areas for improvement

7.5 Leicestershire Police should assure itself that the current staffing model in custody suites allows for safe detention and reduces the time that detainees spend waiting to be booked in. (3.8) **Not achieved**

7.6 Custody refresher training should be provided to all staff who work within the custody environment as a matter of course, including topics such as safer custody and child protection. (3.18) **Achieved**

7.7 A process for adverse incidents, in line with the College of Policing Authorised Professional Practice (APP) guidance, should be implemented and staff should receive regular information about learning from incidents. (3.19) **Achieved**

7.8 7.8 Operating procedures for custody which align with the College of Policing APP guidance, should be developed, published and communicated to staff to ensure safe treatment of detainees. (3.20) **Achieved**

Treatment and conditions

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

Areas for improvement

7.9 Booking-in areas should afford privacy to detainees. (4.9) **Not achieved**

7.10 Cells adapted for use by detainees with disabilities should be provided. (4.10) **Partially achieved**

7.11 Girls aged 16 or under should be in the care of a named female officer at all times. (4.11) **Achieved**

7.12 Detainees' shoes and cords should not be routinely removed. (4.29) **Not achieved**

7.13 Intoxicated detainees should be subject to rousing checks, in compliance with the National College of Policing APP guidance, which should be recorded in the detention log. (4.30) **Not achieved**

7.14 All risk assessments, including pre-release risk assessments, should be undertaken with the detainee and be open to review if circumstances change. Observations should be clearly recorded in the detention log, including actions taken after release. (4.31) **Partially achieved**

7.15 All custody staff should be involved in the same shift handover and, wherever possible, this should be away from the booking-in area and recorded. (4.32) **Not achieved**

7.16 All cells should be clean, well maintained, and properly heated and ventilated. Recording of cell checks should be improved, with clear records showing checks undertaken and repairs completed. (4.44) **Partially achieved**

7.17 Emergency practice evacuations should take place regularly and be recorded. (4.45) **Not achieved**

7.18 Thicker mattresses should be provided. (4.54) **Partially achieved**

7.19 Pillows should be provided routinely to all detainees. (4.55) **Partially achieved**

7.20 Bed plinths should be at normal bed height, except in cells designated for detainees who are intoxicated, and should be wide enough to enable detainees to sleep comfortably. (4.56) **Not achieved**

7.21 Detainees held overnight and those who require one should be offered a shower and showers should afford sufficient privacy, particularly for female detainees. (4.57) **Not achieved**

7.22 All female detainees should be offered a hygiene pack. (4.58) **Achieved**

7.23 Detainees should be offered suitable reading material at all suites. (4.59) **Partially achieved**

Individual rights

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

Areas for improvement

7.24 Leicestershire Police should ensure that there are no unnecessary delays in progressing detainees' cases because of investigations being passed on to other officers. (5.11) **Partially achieved**

7.25 Senior police managers should work with the HM Courts and Tribunals Service to ensure that early closure times do not result in unnecessarily long stays in police custody. (5.23) **Not achieved** (recommendation repeated, 5.9)

7.26 Leicestershire Police should review the practice of adding extraneous paperwork to PERs. (5.24) **Partially achieved**

7.27 Custody staff should be reminded that detainees who want to make a complaint about their care and treatment should be able to do so before they leave custody. (5.29) **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.

Areas for improvement

7.28 Clinical rooms and practices should comply with relevant standards of infection control, and contemporary standards for preventing contamination and forensic sampling. (6.9) **Not achieved**

7.29 Medical room doors should be locked when not in use. (6.10) **Achieved**

7.30 On an individual assessed basis, nicotine replacement should be offered to smokers. (6.16) **Not achieved** (recommendation repeated, 4.45)

7.31 The system for transporting mental health reports should be robust, safe and secure to ensure privacy and confidentiality of patient records. (6.23) **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* (available on our website at: www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/police-custody-expectations-2/).

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 (95% confidence interval with a sampling error of 7%). The analysis focuses on the legal rights and treatment and conditions of the detainee. Where comparisons between groups or with other forces are included in the report, these differences are statistically significant. A statistically significant difference between the two samples is one that is unlikely to have arisen by chance alone, and can 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.

Case audits

We carry out in-depth audits of approximately 40 case records (the number may increase depending on the size and throughput of the force inspected) 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 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
Fiona Shearlaw	HMI Prisons inspector
Norma Collicott	HMI Constabulary and Fire & Rescue Services inspection lead
Patricia Nixon	HMI Constabulary and Fire & Rescue Services inspection officer
Marc Callaghan	HMI Constabulary and Fire & Rescue Services inspection officer
Vijay Singh	HMI Constabulary and Fire & Rescue Services inspection officer
Steve Eley	HMI Prisons health and social care inspector
Kathleen Byrne	Care Quality Commission inspector
Joe Simmonds	HMI Prisons researcher
Helen Ranns	HMI Prisons researcher