Report on an unannounced inspection visit to police custody suites in

Kent

by HM Inspectorate of Prisons
and HM Inspectorate of Constabulary

2–11 June 2014

Glossary of terms

We try to make our reports as clear as possible, but if you find terms that you do not know, please see the glossary in our 'Guide for writing inspection reports' on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

Any enquiries regarding this publication should be sent to HM Inspectorate of Prisons at Victory House, 6th floor, 30–34 Kingsway, London, WC2B 6EX, or hmiprisons.enquiries@hmiprisons.gsi.gov.uk, or HM Inspectorate of Constabulary at 6th Floor, Globe House, 89 Eccleston Square, London SW1V 1PN, or haveyoursay@hmic.gsi.gov.uk

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

Printed and published by:
Her Majesty's Inspectorate of Prisons
Her Majesty's Inspectorate of Constabulary

Contents

Section 1. Introduction

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

This was the second inspection of Kent Police, the first being in 2010. We were disappointed to find, other than in health care, standards had not improved. There was insufficient focus on the care of children in custody and almost half the recommendations, from the previous inspection, remained unachieved.

Although data from Kent Police showed that the proportion of children arrested in Kent compared favourably with the rest of England and Wales, we were concerned that we saw more children in Kent custody suites than we have seen recently in other police custody inspections. However, this was not an indicator that more children were being arrested. We saw a child in every suite we visited during the inspection. Staff told us for children who were charged and refused bail, there was no local authority accommodation but there was no evidence that attempts were made to explore alternatives to custody. Custody staff could offer nothing suitable to help occupy children held in police cells, some of whom were subject to long delays. We saw compliant children routinely handcuffed on arrest or for the journey to court which was, in some instances disproportionate.

Most custody staff took a professional approach to their work, providing a good standard of care to detainees. However staffing levels required attention and we were told that the force would be moving to a new staffing model. The quality assurance process was weak and insubstantial, with too few custody records at too few suites reviewed to make a sustainable evaluation about outcomes for detainees.

Performance management information about custody was patchy and several key issues, including the provision of alternative accommodation for young people, were not recorded or analysed.

Interactions between staff and detainees were polite and courteous but risk assessment and subsequent management of risk was poor. Police national computer systems were not always checked before completing an assessment, many of which were rushed and mechanistic. Some vulnerable detainees had excessively long stays in custody exacerbating their distress. We were disturbed to find police officers undertaking close proximity checks being allowed to read books or use mobile telephones.

Pre-release risk assessments were often completed without any interaction with the detainee, and in some cases several hours after the detainee had been released. In one case we saw a 14-year-old child being released without any conversation with the sergeant undertaking the pre-release risk assessment.

Investigation into offences progressed too slowly and sometimes was handed over to the next shift rather than being progressed promptly. In some instances even basic tasks were not done. This caused delays in contacting and acquiring appropriate adults for vulnerable detainees and, ironically, the most vulnerable experienced the longest delays, because of their extra needs.

Virtual courts were not used efficiently and this sometimes resulted in detainees staying longer in custody than necessary.

Health care provision was good and mental health provision excellent. There was strong and robust strategic leadership on mental health issues, evidenced in the positive outcomes for detainees with mental ill health, and we identified two good practice points in the inspection.

Significant progress had been made in reducing the number of vulnerable detainees held in police custody under the provision of section 136 of the Mental Health Act.

We noted that, of the 15 recommendations made in our previous report after our inspection of 29 November to 3 December 2010, four recommendations had been achieved, five had been partially achieved, four had not been achieved and two were no longer applicable. It was particularly disappointing as some of the previous recommendations and housekeeping points could easily have been achieved.

It was clear from the progress made in health care that with appropriate strategic oversight at a senior officer level, championing a cause can have major benefits for detainees and the police service.

This report provides a number of recommendations for the force and Police and Crime Commissioner. We expect an action plan to be provided.

Sir Thomas P Winsor
HM Chief Inspector of Constabulary

Nick Hardwick
HM Chief Inspector of Prisons

February 2015

Section 2. Background and key findings

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

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

2.3 Kent Police had seven designated, full time, custody suites, comprising 163 cells in total. There was a designated TACT (terrorist) suite at Longport and a non-designated suite at Bluewater Shopping Centre.

Medway	40 cells
Northfleet	40 cells
Canterbury	15 cells
Folkestone	15 cells
Maidstone	19 cells
Margate	15 cells
Tonbridge	19 cells

2.4 This unannounced inspection was conducted across the whole force area. We examined the custody strategy, as well as treatment and conditions, individual rights and health care in the designated custody suites. In the year 1 June 2013 to 31 May 2014, a total of 37,323 detainees had been held, 4,405 of whom had been under the age of 18.

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

Strategy

2.5 An assistant chief constable provided strategic leadership on custody issues. Custody inspectors managed custody staff at the suites for which they had responsibility. Practices varied widely between the suites. There was insufficient leadership and oversight, and the management structure had not ensured consistent detainee care. Kent Police were in the process of establishing a new management structure that was expected to improve the position. Data collection was inconsistent and several key issues, including, for example, the number of young people in custody for whom there was alternative, secure and non secure, accommodation was not monitored.

2.6 We were told that the force would shortly be moving to a new staffing model, with staff being the responsibility of divisions. At the time of the inspection, custody staff were moved to other suites when demand required and limited staffing levels were stretched further by the need to staff virtual courts (see paragraph 5.19).

2.7 The active independent custody visitors' scheme was well supported by Police and Crime Commissioner's staff. Senior police officers chaired strategic partnership boards, which had produced some positive results, including reducing the number of section 136[2] detainees being brought into police custody.

2.8 All custody staff had undergone custody-specific training but some had not had refresher training within the previous year. Learning from adverse incidents was captured well and made readily available to staff.

2.9 Quality assurance processes were weak. Too few custody records, at too few suites, for example, were dip-sampled. There was no cross-referencing of custody records to closed-circuit television (CCTV) recordings, and insufficient auditing of these records.

Treatment and conditions

2.10 Custody staff were friendly and courteous to detainees but there was insufficient privacy in the booking-in areas. Custody staff made no specific provision for the many children and young people we saw in custody. Provision for detainees had been addressed but while the force had followed established cell design guidance when improving facilities for disabled detainees, it was still very limited; one suite had good adapted shower and toilet facilities but low bed plinths, making it unsuitable for such detainees. Items for religious observance were kept but not all staff knew where they were and in some suites they were stored disrespectfully.

2.11 Risk assessment and risk management were sometimes poor. The police national computer was not always checked before the risk assessment was completed. Many assessments were rushed and mechanistic. We found instances where rousing checks had been required but not performed, and saw officers using mobile telephones when undertaking close proximity observations. Some vulnerable detainees had excessively long stays in custody, exacerbating their distress. Most shift handovers were inadequate and did not involve all custody staff. Pre-release risk planning varied unacceptably, and in many instances was done post-release.

---

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

2.12 Not all detainees arrived in the suites handcuffed but we saw some disproportionate handcuffing of compliant children. There were inconsistencies in the circumstances in which staff would complete a use of force form for an incident in custody; this would have resulted in inaccuracies in the recording of use of force. We found a response plan concerning a detainee who was frequently arrested that highlighted the probable need for strip-searching and the use of a Taser when he was brought into custody. This was an extreme and unusual case, but we were nevertheless concerned that the advice given could lead officers to not give sufficient attention to the requirement to carry out an individually accountable dynamic risk assessment each time.

2.13 Most suites were clean but there was much graffiti on the backs of cell doors. Some exercise yards and van docks were dirty. Arrangements for maintenance checks were variable and haphazard. In almost every suite, staff failed to remove used cups and meal containers from cells.

2.14 All suites had good stocks of replacement clothing but not all detainees were able to shower or shave before going to court. Toilet paper was only provided on request. Catering was adequate and most staff provided extra meals on request. The provision of reading materials for detainees was limited but we saw staff allowing detainees to use the exercise yards.

Individual rights

2.15 Custody sergeants told us that, while they would be willing to refuse detention, they rarely needed to as officers generally made the appropriate decision. The extent to which alternatives to arrest were used was unclear because it was not monitored. Some investigations were progressed too slowly; it was common for investigative work to be handed over to the next team's shift while the detainee waited in custody. Some immediate tasks, such as organising appropriate adults (AAs), were deferred, prolonging detention for some vulnerable detainees. Overall, detainees spent too long in custody and the force's own data showed that average stays in custody had lengthened during the previous three years. In some instances, delays were exacerbated by long waits for AAs to attend.

2.16 We had concerns about the number of children and young people we saw being brought into custody, which was more than we usually observe. There was no monitoring of how many were then sent to alternative secure and non-secure local authority accommodation.

2.17 Rights and entitlements information for detainees was well explained and all received a helpful leaflet. Custody staff contacted legal advisers and relatives promptly. Most PACE reviews were undertaken in person but many were completed unacceptably early, not allowing appropriate time between detention and review to reconsider earlier answers and requests, and to review risk assessments and detention.

2.18 Virtual courts were in widespread use throughout the county. While the virtual court system has many benefits, particularly in reducing the need for detainees to experience lengthy journeys to court, we found problems with its implementation in Kent. The virtual courts system gave rise to unreasonable delays either because the virtual courts would not hear the case on the day, or because there were delays in transferring remanded detainees to prison. This had clear adverse effects on some detainees owing to the additional burdens on staff and custody provision generally. While many of the problems were not the sole responsibility of Kent Police, such adverse outcomes should be the focus of inter-agency cooperation in resolving them.

2.19 Staff gave us conflicting information about how detainees could make a complaint and one detainee we spoke to said that he did not know how to do so.

Health care

2.20 Some detainees had to wait too long to be seen by health services staff. In other respects, good health care was provided. Forensic nurse practitioners (FNPs) were managed by an experienced nurse manager, and clinical support and governance were generally satisfactory. Forensic medical examiners (FMEs) worked 24-hour shifts, and one was regularly on duty for several consecutive days, which could raise questions about fitness to practice when tired.

2.21 Commissioning responsibilities were due to pass to NHS England and working relationships were well developed.

2.22 Interactions between clinical staff and detainees were mostly respectful, with access to telephone interpreting services and private consulting rooms. All custody staff were trained in emergency first aid and had access to automated external defibrillators.

2.23 Clinical record keeping was good. As employees of Kent Police, FNPs could share information about detainees; however, we had concerns that this could discourage detainee disclosure and result in the inappropriate sharing of health information with custody staff.

2.24 Custody staff referred detainees with substance misuse issues for assessment, and substance misuse workers also went to the cells to offer a service. Local partnership working arrangements were effective and in some places they worked very well. There was a limited service in two suites, owing to staff shortages.

2.25 There was an excellent force-wide focus on mental health issues, with some very good outcomes for detainees. There were good partnerships between police and mental health services staff. These resulted in vulnerable people being identified early in custody or, at best, being diverted from custody altogether. Custody staff spoke positively about the service and we also identified areas of good practice.

Main recommendations

2.26 There should be sufficient staff in custody at all times to ensure the safety and well-being of detainees.

2.27 Quality assurance should be improved. Staff should monitor trends, identify areas for improvement and learning should be communicated to staff, to understand and improve outcomes for detainees.

2.28 The quality of risk assessments should be improved and risk management should be consistent, dynamic and proportionate with correct notes in the custody records.

2.29 Kent Police should monitor the number of children in custody for whom accommodation is required, looking at both secure and non-secure accommodation, and when it is not available. Kent Police should then work with partners to ensure appropriate accommodation is provided to children in custody.

2.30 Kent Police should engage with HM Courts and Tribunals Service, the National Offender Management Service and Prison Escort and Custody Service to ensure that the virtual court, court administration processes and the practices of escort contractors do not result in unnecessarily long stays in police custody.

Section 3. Strategy

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

Strategic management

3.1 An assistant chief constable (ACC) provided strategic leadership on custody issues. There was a centralised custody function under the head of strategic criminal justice, a superintendent, delivered through a chief inspector head of custody. However, there was insufficient supervision of custody provision in some areas, for example, relating to staffing levels, some partnerships and learning and development. There was evidence that this adversely affected outcomes for detainees.

3.2 The custody estate comprised a mix of modern and older suites. There had been some investment in the custody suites to improve safety.

3.3 Staffing levels required attention (see main recommendation 2.26), and the problem was exacerbated when staff were diverted to deal with virtual courts (see section on individual rights). This issue contributed to relatively long waits for detainees being booked in; police data indicated that the average length of time that detainees waited from arrival at the custody suite to authorisation of detention was around 30 minutes (see also section on treatment and conditions).

3.4 Custody staff included permanent custody sergeants and designated detention officers (DDOs), employed by Kent Police. They had a professional and positive approach to their work, providing a mostly good standard of care to detainees. It was good that the staffing model ensured that it was usually unnecessary to bring in police officers to act as gaolers because custody staff were moved temporarily to other suites when needed to fill gaps. Structures were under review and were due to change imminently to a more devolved custody model, with custody staffing being the responsibility of divisions.

3.5 There was a dedicated custody manager, who was an inspector, on each of the five shifts. They had responsibility for the custody suites and line management of the staff on their respective shifts. There were inconsistencies in the way they performed the role – for example, in the way that reviews of detention were carried out. The amount of time that each spent at their suite also varied.

3.6 Governance meetings in which custody was discussed included a monthly tasking and coordination meeting, chaired by the head of custody and attended by custody managers. Issues discussed included the custody estate, training, virtual courts, health and safety, partnerships and performance. The action logs from these meetings showed that they were active and well attended. Custody inspectors met their staff locally.

3.7 There was a structured process for the collection and analysis of some basic data relating to the treatment of detainees, including detention and waiting times and levels of use of force. However, there were significant gaps: data was not available on the number of young people placed in secure and non-secure local authority accommodation or on the use of strip-search. Such data is important – in the first instance to inform discussions on required service provision with local authority partners and, in the case of strip-searching, to provide assurance on proportionate use.

3.8 Procedures for custody were regularly reviewed against the College of Policing's Authorised Professional Practice on detention and custody.

Recommendation

3.9 The collection and evaluation of custody performance information should include the use of strip-searches.

Partnerships

3.10 There was an active independent custody visitor (ICV) scheme, comprising three panels, coordinated by the Police and Crime Commissioner's (PCC) office. This arrangement generally worked well and the PCC coordinator reported a good relationship. Issues identified by ICVs were usually resolved promptly, with some exceptions; for example, some repair work, especially at the older suites, took too long to complete. ICVs expressed concerns about staffing levels at some of the suites. The checks that they carried out included many of the recommendations from our 2010 inspection report. There was regular police representation at ICV panel meetings.

3.11 There were links with partners at a strategic level, with the ACC attending the Kent Criminal Justice Board and Safeguarding Children's Board. The ACC chaired a 'mental health gold group' - a senior management meeting convened by the police consisting of senior managers from the health service; and there was police representation at the mental health partnership group. Partnership working produced positive results in reducing the number of section 136 patients being brought into police custody (see section on health care). However, there was insufficient strategic focus on alternatives to custody for children and on outcomes for children in custody.

Learning and development

3.12 All custody staff had undergone custody-specific training before taking on custody duties. The custody sergeant's course was linked to the national custody officer learning programme (NCOLP), produced by the College of Policing. Staff also received mental health awareness training. Many custody sergeants received annual refresher training, including learning from adverse incidents. However, some we spoke to had not received it within the previous 12 months. Refresher training for DDOs was limited to first aid and personal safety training.

3.13 A sergeant based at force headquarters was responsible for dip-sampling 20 randomly selected custody records each month from one of the seven suites. Although it covered a number of key custody processes, it did not adequately assess quality and did not easily identify individuals or provide an audit trail about actions taken. With only one suite being audited per month, too few records and sites were checked to make the quality assurance process effective, and it did not include any cross-referencing to CCTV recordings (see main recommendation 2.27).

3.14 There was an easily accessible and useful custody intranet site, which included information from the Independent Police Complaints Commission (IPCC) on deaths in custody.

3.15 Recording of near-misses (known as 'successful interventions') was overseen by the head of custody and the professional standards department. Information and learning from incidents was collated onto a database, which was accessible to all staff via the force intranet, and was discussed each month at the custody tasking and coordination meeting. The information was

also disseminated to custody staff via a criminal justice newsletter and briefings by custody inspectors. Learning from successful interventions was appropriately used in devising and updating training. Lessons learned from IPCC investigations were regularly emailed to all custody staff and it was recorded when staff had read them.

Recommendation

3.16 All staff required to work in custody should receive refresher training.

Section 4. Treatment and conditions

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

Respect

4.1 Custody staff interacted with detainees in a friendly and courteous manner but there was insufficient privacy in the booking-in areas. At Northfleet, detainees at the booking-in desk were able to read the names of other detainees on the whiteboard. The desk was so high that it impeded communication. At Margate, the holding cell was next to the desk and had no door, so detainees waiting in it could listen to others being booked in. At all suites, we saw detainees being asked questions about health and self-harm without staff taking basic steps to ensure privacy, such as closing doors. Some custody sergeants cleared the booking-in area of other detainees and staff when booking in a sensitive case. The control of cell keys was sometimes unsatisfactory, with investigating officers allowed to pick up keys and go to the cells. A set of keys at Tonbridge could not be found for 10 minutes; efforts to locate them lacked urgency and organisation.

4.2 CCTV images of cell toilets were obscured but few detainees were told this.

4.3 Female detainees were not routinely told that they could speak to a female officer if they wished, and were not asked if they might be pregnant. There was no specific provision for children and young people, and we saw many held in cells for long periods with nothing to do.

4.4 All suites had some provision for detainees with disabilities, including crutches and wheelchairs at some. Despite the force having improved facilities in accordance with Home Office cell design specifications, adaptations were too limited. No cells were fully accessible and not all cell call bells could be activated from the floor, for example, at Northfleet. Here there was a good adapted toilet and shower but all the bed plinths were low, thick mattresses were not kept, so the height of the bed could not be increased to an appropriate level, for those detainees who needed help to get up from the bed plinths. Hence, the suite was unsuitable for detainees with disabilities. At some suites, rights and entitlements information was available in Braille. There was no hearing loop at Northfleet, and at Margate, although a sign indicated that a hearing loop was fitted, staff did not know if it existed.

4.5 Prayer mats and a good selection of holy books were available at all suites, but at Northfleet staff struggled to find them and the Qur'an was not stored respectfully. At Margate, holy books and prayer mats were stored haphazardly with other items. Compasses were available for indicating the direction of Mecca.

4.6 Except at Medway, some custody staff were confused about how to care for transgender detainees. In one suite, a member of staff told us that a woman would search a male to female transgender person above the waist, and a man would search below. Nevertheless, a transgender detainee at Canterbury told us that she was being cared for well.

Recommendations

4.7 **Booking-in areas should have sufficient privacy for effective communication between staff and detainees.** (Repeated recommendation 4.9)

4.8 **Staff in custody suites should have a clearer focus on the needs of all detainees, particularly children, women, people who are transgender, and those with disabilities.**

Housekeeping points

4.9 Detainees should be routinely told that CCTV images of toilet areas are obscured.

4.10 Hearing loops should be available in every suite and staff told how to operate them.

4.11 Detainees should be made aware of the availability of religious books and artefacts, which should be accessible and stored respectfully.

Safety

4.12 Staff followed the risk assessment prompts on Genesis - the electronic custody records system. We saw a custody sergeant interact skilfully with a potentially vulnerable young person at Tonbridge, checking that the detainee could read and providing helpful explanations about the process. However, this was an exception and many risk assessments were completed in a mechanistic manner. There was little exploration of potential concerns about health and self-harm, and some assessments were rushed. Custody sergeants asked detainees if they had any dependants. Custody staff usually checked the police national computer (PNC) for warning markers before completing the risk assessment, but at Northfleet we were told that there had been occasions when no staff on duty had been trained in using this system, which meant that PNC information was sometimes excluded from the risk assessment (see main recommendation 2.28).

4.13 Our analysis of 30 custody records showed that, for the most part, risk was recorded. However, we did identify poor recording of risk in some custody records. In one, the risk assessment did not reflect the level of information contained in the custody record. The detainee had been a drug user who was taking medication to reduce withdrawal symptoms, but the risk assessment did not refer to her drug and alcohol dependency. In another case, warning makers for self-harm were recorded on the PNC. The detainee was intoxicated on arrival in custody and no reference was made to the PNC marker when the risk assessment was completed the next morning. The detainee was placed on 30 minute rousing checks due to intoxication, but the issue of self-harm did not appear to have been considered. The copy of the PER form was too faint to read, so it was unclear whether self-harm had been taken into account when the detainee was transferred to court.

4.14 Risk management was sometimes poor, with some areas of major concern. At Northfleet, we found that the information on the whiteboard was different to that on the Genesis system and it did not accurately record who was in each cell. Shoes and jewellery were removed from detainees but they were allowed to keep spectacles, which was good.

4.15 All custody suites had CCTV in every cell, although in some cases the images were unclear.

4.16 At Northfleet, Margate and Medway, we saw officers undertaking constant watch being distracted by reading or using their mobile telephones. We found some records of incorrect checks being undertaken; for example, at Folkestone, a detention log noted numerous observations that the intoxicated detainee was asleep and breathing, whereas rousing checks had been specified. When we brought this to the attention of custody staff, they appeared unconcerned. At some suites, when asked about rousing checks, not all DDOs were completely clear about the importance of obtaining a response that demonstrated consciousness. At Medway, a constant watch using CCTV was carried out using a monitor that displayed only a small image because staff did not know how to switch it to full-screen.

4.17 In our custody record analysis (CRA), we came across vulnerable detainees who had been subject to prolonged stays in custody (see also section on individual rights). These included a woman arrested in the early hours of the morning who had been diagnosed with depression and panic attacks, had previously self-harmed, and cared for an autistic son. At about 9.30am she had had a panic attack, after which a nurse had recommended that she be dealt with quickly and released. Despite this, she had waited a further two hours to be interviewed and had not been released until 2.50pm, after receiving a caution.

4.18 Handover methods varied from one suite to another and few were of a good standard. In most cases, handovers for DDOs and for custody sergeants were conducted separately; we were told that this was because they concerned different aspects of detainees' detention but we found that similar information was given to all staff. There was no overlap between the night and early shifts; some suites used written handover briefings for all handovers but others used these for only some handovers. At Tonbridge, custody sergeants and DDOs handed over separately but simultaneously in the same location, interrupting each other. At Folkestone, two handovers we saw were of a much better quality, involving all custody staff, with a comprehensive briefing sheet.

4.19 We observed a constant watch handover among police officers at Medway which had no input from the custody sergeants. We were told that the officers were managed by their own response sergeant and therefore were responsible for briefing incoming colleagues.

4.20 Cell call bells were answered promptly and their use was explained to detainees. DDOs at all suites told us that they checked the cell call bells daily. At Canterbury and Margate, there was no audible signal that call bells had been activated. At Folkestone, the CCTV images of cells were poor and the cell intercoms were not working. Anti-ligature knives were attached to cell keys at all suites, and some staff carried their own as well.

4.21 At Tonbridge, we found that a young person had been conveyed to court by police officers without custody staff having completed a person escort record form.

4.22 Pre-release risk planning varied unacceptably, and in many instances was done post-release. In our CRA, we found many retrospective entries concerning pre-release risk assessments (PRRAs), one being completed six hours after the person had left the custody suite. Custody sergeants claimed that because they completed the Genesis PRRA from the information in the detention log, it was not always necessary to go through the questions with the detainee. Most PRRAs were simplistic and limited in scope, typically consisting of: "Are you fit and well? How are you feeling? Have you any thoughts of self-harm?" One custody sergeant at Folkestone went to considerable effort, informing an ex-serviceman about sources of help with battle-induced post-traumatic stress disorder on release. Yet, the same custody sergeant merely asked a sex offender being released: "Now, you're not going to do anything stupid are you?" At Medway, we saw a 14-year-old-girl, in custody for the first time, being released without any interaction with the sergeant who had conducted the PRRA. Custody staff arranged lifts home for several detainees and sometimes detainees were provided with bus or train fares.

4.23 There were few leaflets containing details of support organisations and we did not see detainees being offered the 'advice for detained persons' leaflet that was available in some suites.

Recommendations

4.24 Custody sergeants should take part in any handover of a constant watch, remain responsible for the continued safety and well-being of vulnerable detainees in their care, and ensure that officers undertaking close proximity watches are not distracted.

4.25 All custody staff should receive their handovers together, in an area cleared of other staff and detainees.

4.26 Custody staff should always complete a current version of the person escort record when detainees are transferred from police custody. This document should contain relevant information about risk assessment and management, to ensure the welfare and safe transport of the detainee and officers.

4.27 All cell call bell panels should emit an audible signal when the bell is activated.

4.28 Pre-release risk assessment questions should inform both the custody sergeant and detainee about risks and available sources of advice and information, leading to a safe release from custody.

Housekeeping point

4.29 The CCTV system should display clear images, especially those located in cells, and staff should be trained in how to use it. Intercom systems should function correctly.

Use of force

4.30 Although not all detainees arrived at custody suites in handcuffs, we saw some examples of handcuffing that seemed disproportionate. We also saw a 13-year-old boy handcuffed by escort staff when being taken from the custody suite to a cellular vehicle for transfer to court. He was compliant and had been tearful at the suite the previous evening. While handcuffing by escort contractors was not under the control of Kent Police, it was unreasonable and disproportionate for a child to be treated in this way.

4.31 There was no consistency, and therefore a lack of clarity, about the circumstances in which a use of force form would be completed following an incident in custody; this could have resulted in inaccuracies when recording the use of force. At Folkestone, we were concerned to hear that an aggressive detainee was subject to a baton strike to gain his compliance in the cell, although there was no record that this incident had occurred. Custody sergeants said that it was not necessary to separately record uses of force that took place in custody, other than noting them in the detention log. Custody staff told us they were not aware of any monitoring of trends in use of force in custody.

4.32 At Tonbridge, there was a response plan in use concerning the restraint of a particularly difficult man who was often detained there. This plan advised custody staff to consider strip-searching him on every occasion he came into custody and required the provision of a constant watch by two officers in full protective clothing, one of whom to be armed with a

Taser. The plan took no account of the absolute requirement to consider an individually accountable dynamic risk assessment each time such measures were used, and this plan had been written without consultation with health services staff.

4.33 We saw few detainees being strip-searched. We were concerned that our CRA found a record of a strip-search that suggested the search might have been an intimate search which should have been conducted by a medical practitioner and not police officers. We brought this to the attention of Kent Police who investigated the matter and were satisfied that the conduct of the search was lawful.

Recommendations

4.34 Children and young people should not be handcuffed unless indicated by an individual risk assessment.

4.35 The police should monitor the use of force at each custody suite by ethnicity, age, location and officers involved. (Repeated recommendation 2.26)

Physical conditions

4.36 Most suites were clean, although there was widespread graffiti on the backs of cells doors. Conditions at Tonbridge were less good. Two cells had brown stains around the toilets that had been reported but not addressed. During the inspection, three cells were taken out of use because of the poor conditions. Five new cells at this suite were stark, with no windows and narrow bed plinths, and the van dock area and the holding cell were dirty. The exercise yards were generally adequate, except at Folkestone.

4.37 There were inadequate arrangements for cell checks at most suites. At Tonbridge, there was no record of systematic cell checks being undertaken there since April 2014. At Canterbury, we saw staff checking cells carefully and there were records of regular weekly checks. There were good stocks of handcuffs at every suite, and they all had a fire evacuation plan, although there were no records of practice evacuations taking place.

Recommendations

4.38 Conditions in the van dock, holding area and cells at Tonbridge should be improved.

4.39 Health and safety walk-through arrangements should be thorough, consistently applied at all custody suites and be subject to effective quality assurance.

Housekeeping point

4.40 Regular emergency evacuation drills should take place at every suite and be recorded.

Detainee care

4.41 At all suites, there was a good stock of bedding, although at Tonbridge some of the pillows were in poor condition. Mattresses and pillows were wiped down with an anti-bacterial cloth between uses.

4.42 Detainees who had their clothing removed, or were unwilling to have the waist cord cut in tracksuit trousers, were provided with replacement clothing. There were good stocks of tracksuits, plimsolls, foam slippers and replacement underwear at all suites. Stocks of paper suits were available but staff told us that they only issued these for forensic purposes. Disposable razors were available at some suites. All suites had feminine hygiene packs but not all custody staff routinely offered them to women.

4.43 Showers at every suite provided a reasonable level of privacy. We saw some detainees going to court being offered a shower but at Margate a detainee who had been in custody all weekend was not woken in time on the Monday morning to be offered a shower or breakfast before court. Toilet paper was provided only on request.

4.44 At Northfleet, breakfast and lunch on weekdays were provided by the police station canteen, and detainees told us that the food was good. At other times, and at all other suites, microwave meals were provided. These were of low calorific value but we saw detainees given additional meals on request. Cereal bars and orange squash were provided, and hot drinks offered regularly. At several suites, staff failed to remove used cups and meal containers from occupied cells regularly, and in some cells the build-up of empty containers was inconsiderate and unacceptable, especially if detainees were not given an option to dispose of the waste themselves. Food preparation areas were mostly satisfactory, with some individual attention required in cleaning some areas.

4.45 All suites had exercise yards and we saw them in use. There was a poor selection of books and magazines for detainees at most suites, although there was a better selection at Canterbury. However, there was nothing in languages other than English and they were not offered routinely. Staff at Margate could offer nothing except use of the exercise yard to a 13-year-old held in custody overnight who could not read. Even though most suites had closed visits booths, visits were not normally facilitated.

Recommendations

4.46 Staff should regularly remove rubbish from cells.

4.47 There should be a suitable range of reading material for detainees, including young people, non-English speakers and those with limited literacy, and these should be offered routinely.

Housekeeping points

4.48 Staff should offer hygiene packs to female detainees.

4.49 A small supply of toilet paper should be placed in each cell, subject to a risk assessment.

4.50 Food preparation areas and equipment should be kept clean.

Section 5. Individual rights

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

Rights relating to detention

5.1 Custody sergeants told us that, while they would be willing to refuse detention if they were not convinced that arrest was warranted, it was rarely necessary to do so because officers complied with the provisions of code G of the Police and Criminal Evidence Act (PACE), as alternatives to custody were available, such as street bail and voluntary attendance,[3] but custody staff were unclear about the extent to which they were used. The management of voluntary attendees coming into the custody suite for interviews varied widely. Some custody sergeants insisted on seeing the person to complete a risk assessment with them. This was contrary to force policy and could result in unnecessary delays while the attendee waited to be booked in. The 'CHIP and PIN' mnemonic card, designed to encourage police officers to consider the necessity of arrest, was a good initiative, but we did not see or hear staff refer to it.

5.2 Some investigations were progressed unreasonably slowly. During the inspection, at Canterbury, two young people were arrested at 6am and immediately made subject to a rest period until 2pm. PACE Code C states that a detainee must have a period of eight hours in any 24 hours which are free from questioning, this rest period appeared unnecessary as the young people had only just arrived in custody. The investigation was allocated to an officer at 3pm and it was only then that appropriate adults (AAs) were arranged and interviews scheduled. We found many similar examples of such delays, and they were exacerbated by difficulties in securing the attendance of AAs for young people and vulnerable adults, and sometimes, we were told, long waits for decisions from the Crown Prosecution Service. Our CRA showed that the average detention time in Kent was 12.2 hours, which was longer than in many other forces, and Kent Police data showed that the average time in detention had increased in the previous three years.

5.3 We found that officers regularly handed investigations on to the next team's shift to follow up instead of progressing them immediately, often resulting in detainees remaining in custody for longer than necessary. This was confirmed by two legal advisers we spoke to, who attended several custody suites in Kent regularly.

5.4 Custody staff described good relationships with Home Office Immigration Enforcement officers, who attended promptly. Kent Police data showed that over the previous 12 months, 398 immigration detainees had been held for, on average, just under 13 hours; which compared favourably with other forces. Professional telephone interpreting services were used; however, this was via speaker telephones at the booking-in desks, which compromised confidentiality. There was a good database of interpreters for face-to-face work and custody staff told us that they provided a good service.

---

[3] Usually for lesser offences, where suspects attend by appointment at a police station to be interviewed about alleged offences. This avoids the need for an arrest and subsequent detention in police custody.

5.5 In this inspection we saw a number of children and young people brought into custody and subjected to unnecessarily long stays. During the inspection, at Margate, a 13-year-old boy was arrested on a Sunday afternoon (see also paragraph 4.30). Distressed and tearful, he was held overnight to attend court the next day, rather than being returned to the children's home where he lived. Similarly, at Medway, a 14-year-old girl was arrested at 11pm and held overnight (see also paragraph 4.22). An AA attended at 10.30am and she was released at 12.30pm without charge, having spent 13 hours in custody (see main recommendation 2.29).

5.6 Custody staff told us that, when necessary, they requested secure accommodation from the local authority but it was never available. Kent Police were unable to identify how many such requests had been made, and if any had resulted in young people being moved to either secure or non-secure accommodation. Custody sergeants told us that they never considered the suitability of non-secure accommodation, and had never requested it.

5.7 Custody sergeants told us that they always tried to contact a family member to act as an AA. They had a useful agreement about the AA role that they asked family members to sign, but this was filed in the custody record rather than being left with the AA for their guidance. A Kent organisation, Young Lives, provided volunteer AAs for young people and vulnerable adults up until about 10pm every day, including weekends. Volunteer AAs told us that they were appropriately trained and supervised. While the force told us the AA scheme mostly met the requirements specified in its service level agreement, there were delays in arranging an AA (see paragraph 5.2), and sometimes they did not attend for several hours. At Maidstone, on a Saturday evening, we were told that there were no volunteer AAs available that night. Generally, custody staff tried to coordinate the attendance of the AA with that of the investigating officer and legal adviser, to minimise the amount of time that AAs were kept waiting at the suite. In our CRA we came across an instance in which there had been a delay of six hours before the AA reached the suite. Local youth offending services (YOS) did not normally provide AAs for young people and we saw no YOS staff visiting the suites, despite many children and young people being detained. Custody staff told us that the suites were never used as a place of safety under Section 46 of the Children Act 1989.

Recommendations

5.8 Kent Police should collect and analyse data on people who are dealt with through voluntary attendance at police stations.

5.9 Two-handset telephones should be provided in all suites to facilitate telephone interpretation.

5.10 Kent Police should work with local social services departments and youth offending services to ensure the provision of appropriate adults for young people who are facing a stay in police custody.

5.11 Appropriate adults should be available without undue delay to support vulnerable adults in custody.

Housekeeping point

5.12 To eliminate unnecessary delays, risk management processes for voluntary attendees should be reviewed and custody sergeants briefed about them.

Rights relating to PACE

5.13 Custody sergeants explained detainees' rights and entitlements to them during booking-in and told them that these could be exercised at any time. They also provided a good information sheet to all detainees, although this was not the most up-to-date version available as the updated version was being rolled out at the time of the inspection. Not all custody staff were aware of the easy-read version of rights and entitlements information, even though it was on the force intranet. Information on rights and entitlements was available, and there was useful translated information that explained processes such as charge and bail. Custody records did not note whether or not foreign national rights were given to immigration detainees or whether, if necessary, their embassy had been informed of their arrest.

5.14 All suites displayed copies of the Criminal Defence Service 'You Need a Solicitor' poster, and some had the version in languages other than English. We saw custody staff allowing detainees to telephone relatives and legal advisers promptly, and routinely advising those who had initially refused legal advice that they could change their mind at any time and that a solicitor would be contacted on their behalf.

5.15 Every suite had copies of the PACE code C book. Detainees were told about it, but custody sergeants did not always offer the most up-to-date version and not all showed it to detainees.

5.16 Our CRA showed that custody staff contacted legal advisers promptly. Of the nine detainees (30%) who had wanted to have someone informed of their detention, in seven cases the nominated person had been contacted, one detainee was being held incommunicado and for one the record did not show whether or not their nominated person had been contacted. Telephone calls from legal advisers could be transferred to cells through intercoms, allowing enhanced privacy, although this facility was not available at Folkestone, where a portable handset telephone was used instead. We saw legal advisers, as required, being given their clients' custody records.

5.17 Every suite had plenty of consultation rooms, although a legal adviser told us that consultations could be overheard at Margate. Custody staff there were unaware of the problem.

5.18 Most reviews took place in person, and inspectors read custody records before undertaking them. We observed one review at Canterbury in which the inspector failed to ask the detainee if he or she wished to make representations. At Tonbridge, we observed a daytime review by telephone which did not involve the inspector speaking to the detainee. The sergeant was asked to advise the detainee that a review had taken place and authority had been given to extend their time in detention. In our CRA, 11 of the 30 detainees in the sample had been reviewed unacceptably early, some only two hours after detention had been authorised, this did not allow appropriate time between detention and review to reconsider earlier answers and requests, review risk assessments and detention. A laminated card was attached to the detention log of any detainee who had been reviewed while they were asleep, to remind staff to tell the detainee about it on waking, and we saw this being done. However, ICVs were critical of the failure to inform detainees about reviews carried out while they were asleep, so the system may not have been completely effective.

5.19 Virtual courts, by which court appearances take place via remote CCTV link, were in widespread use throughout the county. They dealt with all first magistrates' court hearings, except for those involving children and young people, vulnerable detainees and those subject to warrants from courts outside the county. We found instances where the virtual court system resulted in long stays in police custody because the detainee's case could not be

heard on the day of charge or because there were delays in transferring remanded detainees to prison.[4] We spoke to one detainee who could not be dealt with by the virtual court until the day after being charged; he was then not collected until the day after the virtual court had remanded him in custody, which meant that he spent two nights in police custody unnecessarily. Another detainee spent two days in custody before his virtual court hearing owing to the lack of an interpreter. We observed, and staff told us, that these instances placed additional burdens on police custody provision and had a direct impact on detainee care and custody capacity.

5.20 In East Kent, the Saturday court would not deal with detainees arrested on warrants because their administration centre was at another court, meaning that such detainees were held in police cells all weekend, unnecessarily. Staff were critical of the impact on staff morale and their ability to respond to detainees' needs (see main recommendation 2.30). Kent Police told us they were concerned about the issue and were working with the Metropolitan Police to set up a pilot where a court could be available every day of the week.

5.21 The management of DNA samples was good.

Recommendations

5.22 Up-to-date copies of the relevant PACE codes of practice should be available at all suites and shown to detainees during booking-in.

5.23 PACE reviews of detention should be completed in a timely and consistent manner, in person whenever possible, with detainees invited to make representations.

Housekeeping points

5.24 The most recent version of rights and entitlements information should be in use at every suite and staff should be briefed about the availability of the information in other formats.

5.25 Custody records should include fields to record if foreign national rights have been administered and whether detainees wish their High Commission, Embassy or Consulate to be informed. Ethnicity should be recorded on custody records in all cases.

Rights relating to treatment

5.26 We were given conflicting information about how detainees could make complaints. Some custody sergeants told us that they would inform the custody inspector if a detainee wanted to complain, and that the complaint would be taken while the detainee was in custody. Others said that inspectors refused to take complaints while the detainee was in custody, and that the complaint would be noted in the detention log and the detainee told to contact the police on release. It was only at Folkestone that staff told us that they would provide a copy of the IPCC leaflet to detainees who were considering complaining. One detainee, remanded in custody by the virtual court, was held for two nights because the escort

[4] When a detainee is remanded in custody at a hearing taking place in a court house, he or she must be transferred to prison at the end of the day because detainees cannot be held in court custody overnight. When a detainee is remanded in custody by the virtual court, the escort company can decide not to make the transfer on the day of the appearance, resulting in the detainee staying on in police custody.

contractor failed to collect him for transfer to prison (see paragraph 5.19). He told us that he did not know how to submit a complaint about this.

Recommendation

5.27 Detainees should be told how to make a complaint and enabled to do so before they leave custody. (Repeated recommendation 5.18)

Section 6. Health care

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

Governance

6.1 Forensic nurse practitioners (FNPs), employed by Kent Police, provided primary health services, supported by contracted forensic medical examiners (FMEs). The service was nurse led, with FMEs primarily providing telephone advice. Kent and Medway NHS and Social Care Partnership Trust provided mental health services. Partnership working and communication between providers and custody staff were good.

6.2 FNPs were managed by an experienced nurse manager and two deputies. Clinical governance processes were generally satisfactory but some areas, including training, infection control, audits and clinical policies, were underdeveloped. The team had a wide knowledge base and staff retention was good. The team gender balance was reasonable and detainees could ask to be seen by an FNP of their gender, although this was not explained to them. FNPs received annual appraisals and monthly supervision. Initial induction training was good but subsequent training opportunities were too limited and most FNPs were out of date with mandatory training.

6.3 The local policies did not cover all essential areas such as infection control, safeguarding and clinical governance. Learning from complaints and significant incidents was shared with the team and informed service delivery.

6.4 FNP response times were monitored. However, referral times were not consistently recorded, so we were unable to analyse them accurately (see recommendation 6.20). FME response times were not monitored. They worked 24-hour shifts, and one FME was regularly on duty for several consecutive days, which could raise concerns about fitness to practice when tired. We were told that the low demand for FME services mitigated the impact of these shifts. There was no system to ensure that FMEs received appropriate appraisals or training. At the time of the inspection, the FME service was being re-tendered and the new contract included expected response times and governance requirements.

6.5 Commissioning responsibility was due to pass to NHS England in 2015 and working relationships were well developed. Key performance data were discussed at the well-attended quarterly partnership meeting. A health needs assessment informed service delivery.

6.6 We saw respectful interactions between clinical staff and detainees. There was good access to telephone interpreting services. Clinical consultations generally occurred in private, unless a risk assessment indicated otherwise, although we saw a consultation inappropriately conducted at the booking-in desk, in front of two arresting police officers and the custody sergeant.

6.7 All suites had dedicated clinical rooms, of varying size. None of the rooms fully met infection control standards owing to non-compliant fixtures and fittings, clutter and inadequate cleaning. Emergency alarms in the Folkestone and Maidstone clinical rooms were inaccessible. Overall stock management was good. Health promotion literature and

reference books were appropriate but we found out-of-date pharmacological reference books in some suites.

6.8 FNPs had access to oxygen, suction and emergency drugs but were not always on site. Custody staff received regular first-aid and resuscitation training and had easy access to automated external defibrillators, but not to oxygen and suction. First-aid kits varied across the suites and, despite weekly recorded checks, several contained expired items.

Recommendations

6.9 Health services staff should have timely access to mandatory training and continuing professional development opportunities.

6.10 Health services staff should have access to a full range of NHS-equivalent policies and procedures, including information governance, infection control, safeguarding and clinical governance.

6.11 Consultations should always occur in private unless a recorded risk assessment indicates that this is not appropriate.

6.12 All clinical rooms should be fit for purpose, including complying with NHS primary care environmental and infection control standards, and have alarm bells that are easily accessible.

6.13 Custody staff should have access to adequate stocks of in-date standardised emergency equipment in all suites, including oxygen and suction.

Housekeeping point

6.14 Out-of-date pharmacological reference books should be removed.

Patient care

6.15 Detainees were referred to FNPs based on need identified by the custody sergeant, or at detainee request. In our CRA, we found some cases where referral to the FNP seemed necessary but had not occurred. Four FNPs covered the seven suites, with one based permanently at Medway and the remainder covering two suites each between 7.30am and 5am the next day. One or two FMEs were always on call for custody and the sexual assault referral centre. They generally only attended for complex clinical situations and specific forensic testing. Custody sergeants told us, and we were able to confirm, that FNP response times were often excessive when FNPs covered two suites. Ambulance response times for emergencies were reported to be good.

6.16 Clinical record keeping was good. FNPs recorded consultations on local pro-formas, which were then attached to the custody record. FNPs advised detainees that, as employees of Kent Police, they could share all the information they received about detainees with them. However, we were concerned that this could discourage detainee disclosure and we saw some inappropriate sharing of confidential health information with custody staff.

6.17 Standardised stock medication was stored securely. Diazepam and dihydrocodeine were held behind the custody desk, in view of the CCTV camera. Custody staff tried to retrieve medications from detainees' homes where appropriate. Detainees started on antibiotics

were appropriately given the whole course to take away. FNPs ordered and managed medication stocks. Stock levels were generally appropriate, medication counts were correct and cupboards were well organised. However, we found several expired medicines on one site, although more robust processes to ensure that medicines were in date were introduced during the inspection. Drug refrigerator temperatures were not consistently recorded.

6.18 Most detainees on methadone prescriptions for opiate addiction could not continue their prescription in the suites, although those on buprenorphine could. Appropriate symptomatic relief for drug and alcohol withdrawal was available but nicotine replacement therapy was not available for smokers, which could have increased the stress of being detained.

6.19 FNPs administered most medication; if this was not possible, a dose was placed in a bag, with details of the drug and administration times alongside a written prescription. The custody sergeant then supervised the detainee taking the medication at the desk, in view of the CCTV camera. Any discarded or expired medication went into a drug safe and was periodically taken to a local pharmacy for destruction. There was no system to monitor medications left for administration by custody staff, so managers could not be assured that all medication that should have been discarded went into the discard cupboard, especially as medications deposited there were not consistently logged.

Recommendations

6.20 There should be robust systems to ensure that all detainees who require a health assessment are promptly referred and are then seen by a health care professional within agreed response times.

6.21 Clinical consultations should be conducted with adequate consideration of medical confidentiality, and only information required to ensure adequate care in custody should be shared.

6.22 Detainees who are prescribed opiate substitution medication in the community should be supported to continue this in custody if clinically appropriate.

6.23 Detainees who smoke should have timely access to nicotine replacement therapy.

Housekeeping points

6.24 Minimum and maximum drug refrigerator temperatures should be recorded daily and appropriate remedial action taken if outside of range.

6.25 There should be robust systems to identify which medicines should be discarded, ensure that these are recorded in the disposal register and achieve timely, safe disposal.

Substance misuse

6.26 A high proportion of detainees had substance misuse problems. In our CRA, five detainees (17%) had been identified as being drug dependent and one (3%) as alcohol dependent. There were two different substance misuse providers, with one providing services in four suites and the other providing services in three; both provided high levels of input six days a week, although the Folkestone and Canterbury services had been temporarily reduced owing to staff vacancies.

6.27 Custody staff referred detainees with substance misuse issues for assessment, and substance misuse workers also visited the cells to offer a service. Local partnership working arrangements were effective, and in Tonbridge the substance misuse worker and mental health practitioner worked well together. Margate had a drug testing on arrest scheme. At all suites, substance misuse workers made appropriate community referrals, with detainee consent. Substance misuse workers saw young people aged 16 or over, and the YOS saw those who were under 16; they were all then referred to local specialist services if required. Detainees were told about local needle exchange programmes if needed.

Mental health

6.28 Custody staff said that a large and increasing number of detainees had a current or previous mental illness. In our CRA, seven (23%) detainees had reported a history of mental health problems, mainly depression or anxiety. Mental health diversion services had extended since the previous inspection to include all suites, and Saturday provision. Custody staff spoke positively about the service.

6.29 Each suite had a dedicated registered mental health nurse (RMN) from Monday to Friday, 8am to 4pm, and on Saturdays three RMNs covered the seven suites. Detainees could self-refer or were referred by custody staff based on the risk assessment or on presentation. RMNs checked if referred detainees were known to mental health services and shared relevant risk information with custody staff. They liaised effectively with relevant services, including probation, prison and community mental health services as required. Detainees with significant mental health issues received additional input at court. RMNs saw young people if necessary and referred them to specialist services as required. A specialist child and adolescent mental health nurse was attached to each local YOS to provide timely emergency assessments and liaison.

6.30 The crisis team provided out-of-hours mental health support. Custody staff described frequent delays with crisis team and Mental Health Act assessments, and transfers to NHS mental health facilities. Kent Police and all the relevant mental health partners had developed effective systems to escalate problems within each organisation to achieve a prompt solution; these incidents were then reviewed in joint meetings to learn from them.

6.31 There were five beds available in four designated NHS section 136 suites, with a supporting multi-agency section 136 policy. In the 12 months to May 2014, 39 patients detained under section 136 had been brought into police custody, which was a large reduction from the time of the previous inspection. The extension of a mental health street triage pilot had contributed to this reduction.

6.32 Kent Police had an excellent force-wide focus on mental health issues, and partnerships between the police and mental health providers were productive. There were effective mechanisms for police and mental health providers to discuss strategic issues.

6.33 All custody staff received mental health awareness training during induction, and this was also included in their annual refresher training; an online training package was also available. Police staff had a single point of contact to call for mental health support (including advice on how to manage particular situations as they occurred), section 136 concerns and information on whether an individual was known to mental health services.

Good practices

6.34 *The local multi-agency escalation protocol for identified problems with mental health assessments contributed to positive detainee outcomes, and the shared learning informed service improvement.*

6.35 *The single point of contact for police staff to call for advice on mental health and section 136 issues gave prompt relevant information and support, which improved detainee care.*

Section 7. Summary of recommendations and housekeeping points

Main recommendations

7.1 There should be sufficient staff in custody at all times to ensure the safety and well-being of detainees. (2.26)

7.2 Quality assurance should be improved. Staff should monitor trends, identify areas for improvement and learning should be communicated to staff, to understand and improve outcomes for detainees. (2.27)

7.3 The quality of risk assessments should be improved and risk management should be consistent, dynamic and proportionate with correct notes in the custody records. (2.28)

7.4 Kent Police should monitor the number of children in custody for whom accommodation is required, looking at both secure and non-secure accommodation, and when it is not available. Kent Police should then work with partners to ensure appropriate accommodation is provided to children in custody. (2.29)

7.5 Kent Police should engage with HM Courts and Tribunals Service, the National Offender Management Service and Prison Escort and Custody Service to ensure that the virtual court, court administration processes and the practices of escort contractors do not result in unnecessarily long stays in police custody. (2.30)

Recommendations

Strategy

7.6 The collection and evaluation of custody performance information should include the use of strip-searches. (3.9)

7.7 All staff required to work in custody should receive refresher training. (3.16)

Treatment and conditions

7.8 Booking-in areas should have sufficient privacy for effective communication between staff and detainees. (4.7, repeated recommendation 4.9)

7.9 Staff in custody suites should have a clearer focus on the needs of all detainees, particularly children, women, people who are transgender, and those with disabilities. (4.8)

7.10 Custody sergeants should take part in any handover of a constant watch, remain responsible for the continued safety and well-being of vulnerable detainees in their care, and ensure that officers undertaking close proximity watches are not distracted. (4.24)

7.11 All custody staff should receive their handovers together, in an area cleared of other staff and detainees. (4.25)

7.12 Custody staff should always complete a current version of the person escort record when detainees are transferred from police custody. This document should contain relevant information about risk assessment and management, to ensure the welfare and safe transport of the detainee and officers. (4.26)

7.13 All cell call bell panels should emit an audible signal when the bell is activated. (4.27)

7.14 Pre-release risk assessment questions should inform both the custody sergeant and detainee about risks and available sources of advice and information, leading to a safe release from custody. (4.28)

7.15 Children and young people should not be handcuffed unless indicated by an individual risk assessment. (4.34)

7.16 The police should monitor the use of force at each custody suite by ethnicity, age, location and officers involved. (4.35, repeated recommendation 2.26)

7.17 Conditions in the van dock, holding area and cells at Tonbridge should be improved. (4.38)

7.18 Health and safety walk-through arrangements should be thorough, consistently applied at all custody suites and be subject to effective quality assurance. (4.39)

7.19 Staff should regularly remove rubbish from cells. (4.46)

7.20 There should be a suitable range of reading material for detainees, including young people, non-English speakers and those with limited literacy, and these should be offered routinely. (4.47)

Individual rights

7.21 Kent Police should collect and analyse data on people who are dealt with through voluntary attendance at police stations. (5.8)

7.22 Two-handset telephones should be provided in all suites to facilitate telephone interpretation. (5.9)

7.23 Kent Police should work with local social services departments and youth offending services to ensure the provision of appropriate adults for young people who are facing a stay in police custody. (5.10)

7.24 Appropriate adults should be available without undue delay to support vulnerable adults in custody. (5.11, repeated recommendation 2.28)

7.25 Up-to-date copies of the relevant PACE codes of practice should be available at all suites and shown to detainees during booking-in. (5.22)

7.26 PACE reviews of detention should be completed in a timely and consistent manner, in person whenever possible, with detainees invited to make representations. (5.23)

7.27 Detainees should be told how to make a complaint and enabled to do so before they leave custody. (5.27, repeated recommendation 5.18)

Health care

7.28 Health services staff should have timely access to mandatory training and continuing professional development opportunities. (6.9)

7.29 Health services staff should have access to a full range of NHS-equivalent policies and procedures, including information governance, infection control, safeguarding and clinical governance. (6.10)

7.30 Consultations should always occur in private unless a recorded risk assessment indicates that this is not appropriate. (6.11)

7.31 All clinical rooms should be fit for purpose, including complying with NHS primary care environmental and infection control standards, and have alarm bells that are easily accessible. (6.12)

7.32 Custody staff should have access to adequate stocks of in-date standardised emergency equipment in all suites, including oxygen and suction. (6.13)

7.33 There should be robust systems to ensure that all detainees who require a health assessment are promptly referred and are then seen by a health care professional within agreed response times. (6.20)

7.34 Clinical consultations should be conducted with adequate consideration of medical confidentiality, and only information required to ensure adequate care in custody should be shared. (6.21)

7.35 Detainees who are prescribed opiate substitution medication in the community should be supported to continue this in custody if clinically appropriate. (6.22)

7.36 Detainees who smoke should have timely access to nicotine replacement therapy. (6.23)

Housekeeping points

Treatment and conditions

7.37 Detainees should be routinely told that CCTV images of toilet areas are obscured. (4.9)

7.38 Hearing loops should be available in every suite and staff told how to operate them. (4.10)

7.39 Detainees should be made aware of the availability of religious books and artefacts, which should be accessible and stored respectfully. (4.11)

7.40 The CCTV system should display clear images, especially those located in cells, and staff should be trained in how to use it. Intercom systems should function correctly. (4.29)

7.41 Regular emergency evacuation drills should take place at every suite and be recorded. (4.40)

7.42 Staff should offer hygiene packs to female detainees. (4.48)

7.43 A small supply of toilet paper should be placed in each cell, subject to a risk assessment. (4.49)

7.44 Food preparation areas and equipment should be kept clean. (4.50)

Individual rights

7.45 To eliminate unnecessary delays, risk management processes for voluntary attendees should be reviewed and custody sergeants briefed about them. (5.12)

7.46 The most recent version of rights and entitlements information should be in use at every suite and staff should be briefed about the availability of the information in other formats. (5.24)

7.47 Custody records should include fields to record if foreign national rights have been administered and whether detainees wish their High Commission, Embassy or Consulate to be informed. Ethnicity should be recorded on custody records in all cases. (5.25)

Health care

7.48 Out-of-date pharmacological reference books should be removed. (6.14)

7.49 Minimum and maximum drug refrigerator temperatures should be recorded daily and appropriate remedial action taken if outside of range. (6.24)

7.50 There should be robust systems to identify which medicines should be discarded, ensure that these are recorded in the disposal register and achieve timely, safe disposal. (6.25)

Good practice

Health care

7.51 The local multi-agency escalation protocol for identified problems with mental health assessments contributed to positive detainee outcomes, and the shared learning informed service improvement. (6.34)

7.52 The single point of contact for police staff to call for advice on mental health and section 136 issues gave prompt relevant information and support, which improved detainee care. (6.35)

Section 8. Appendices

Appendix I: Inspection team

Maneer Afsar	HMIP team leader
Sarah Cutler	HMIP inspector
Peter Dunn	HMIP inspector
Andy Lund	HMIP inspector
Fiona Shearlaw	HMIP inspector
Mark Ewan	HMIC inspector
Rob Bowles	HMIC inspector
Majella Pearce	HMIP health services inspector
Huw Jenkins	Care Quality Commission

Appendix II: Progress on recommendations from the last report

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

Strategy

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

Main recommendations

Staff should submit a use of force form in every appropriate instance, and the force should monitor the use of force at each custody suite by ethnicity, age, location and officers involved. (2.26)
Partially achieved (recommendation repeated, 4.37)

A representative sample of completed custody records should be dip-sampled locally on each BCU to ensure standards in custody are maintained. (2.27)
No longer applicable

Treatment and conditions

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

Recommendations

There should be cells adapted for detainees with disabilities at the four nominated custody suites. (4.8)
Not achieved

Booking-in areas should have sufficient privacy for effective communication between staff and detainees. (4.9)
Not achieved (recommendation repeated, 4.7)

Any changes to the risk assessment management plan should be recorded in the risk assessment section of the custody record. (4.14)
Not achieved

The force should address the safety issues around ligature points and, where resources do not allow them to be dealt with immediately, the risks should be managed. (4.24)
Partially achieved

Health and safety walk through arrangements should be thorough and consistently applied at all custody suites. (4.25)
Partially achieved

All detainees held overnight, or who require one, should be offered a shower. (4.30)
Achieved

Suitable alternative clothing should always be provided to detainees when needed. (4.31)
Achieved

Food offered to detainees should be of sufficient quality and calorific content to sustain them for the duration of their stay, and it should be offered at mealtimes. (4.34)
Achieved

Individual rights

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

Main recommendations

Appropriate adults should be available to support juveniles aged 17 and under and vulnerable adults in custody, including out of hours. (2.28)
Partially achieved (recommendation repeated, 5.11)

Recommendations

Senior police officers should engage with the local authority to ensure the provision of remand in custody beds for juveniles. (5.15)
Partially achieved

Police managers should liaise with court managers to ensure court cut off times at Tonbridge should be later to prevent unnecessarily long stays in custody. (5.16)
No longer applicable

Detainees should be told how to make a complaint and facilitated to do so before they leave custody. (5.18)
Not achieved (recommendation repeated, 5.29)

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.

Main recommendations

Police custody should only be used as a place of safety for Section 136 assessments in exceptional cases. (2.29)
Achieved