Criminal Justice Joint Inspection

Report on an unannounced inspection visit to police custody suites in Lincolnshire

23–29 September 2015

by HM Inspectorate of Prisons and HM Inspectorate of Constabulary

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Inspecting policing in the public interest

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Lincolnshire

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This inspection was carried out in partnership with the Care Quality Commission.

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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 Lincolnshire police custody. The first inspection, conducted in January 2011, was described as disappointing. This inspection found the situation had not improved and that progress had been insufficient. Many of the recommendations we had made previously had not been achieved.

The strategic leadership for custody required improvement. The collection of performance data in some key areas, particularly in relation to vulnerable detainees, was inadequate. We found no data on the allocation of local authority secure beds for children who had been charged and could not be bailed, and no mechanism for monitoring the overall provision of appropriate adult (AA) services for vulnerable groups. The number of individuals detained under section 136 of the Mental Health Act was still too high. Staff were not held sufficiently accountable for the practices they employed in the custody suites as there was no monitoring of use of force or strip-searching in police custody.

Some concerning cases were identified during the inspection. Some staff were, in our view, too ready to remove detainees' clothing in response to perceived risk, but with too little consideration for their dignity. In one case, a detainee had been left in his underwear, and in another a 16-year-old girl had been left naked for approximately 10 minutes; both cases were unacceptable and demeaning. We were not satisfied that the force's current quality assurance processes could identify some of the poor practices we found so that they could be eliminated; any opportunities for learning were being missed by the current system of dip-sampling.

There was insufficient oversight on the use of force in the custody suites. There was no monitoring or analysis of trends and some records were poorly completed, giving little insight into events leading up to the force being used.

Staff interacted well with detainees, but we found inconsistencies in the way detainees' risks were managed. This needed to be tackled to ensure that the treatment of detainees was appropriate for their assessed needs and risks.

It was concerning to find that that it was common practice for vulnerable adults and children to have their fingerprints, DNA and photograph taken without the support of an appropriate adult (AA) and, in some cases, without understanding what was taking place. The lack of a 24-hour AA service prolonged the detention of children.

We found an inadequate complaints system which did not facilitate complaints being taken at the earliest opportunity, and custody staff who did not share the same understanding of the process. Furthermore, there was no guidance from the force outlining this process. We found, for example, two cases where children had asked to make complaints; these had not been not recorded or investigated.

Detainees sometimes experienced long delays in receiving the appropriate care by health care professionals. Further difficulties arose in accessing timely mental health assessments, including access to an appropriate bed. Organisations providing substance misuse services were good.

Overall, Lincolnshire police had made insufficient progress since the previous inspection. Better strategic oversight and working with partners to ensure safe and appropriate detention for the most

vulnerable detainees was needed. Systems for checking the practice of custody staff and officers across the custody suites were insufficient to provide reassurance that detainees were held safely, and staff were supervised or monitored. The report is critical of police custody being used too often as a place of safety, although the street-based mental health triage service and diversion schemes were good starts to reversing this trend.

In our inspection, we noted that, of the 24 recommendations made in our previous report after our inspection in January 2011, four recommendations had been achieved, nine had been partially achieved, 10 had not been achieved and one was no longer relevant.

This report provides recommendations to the force and the Police and Crime Commissioner to improve provision further. We expect our findings to be considered and for an action plan to be provided in due course.

Sir Thomas P Winsor
HM Chief Inspector of Constabulary

Martin Lomas
HM Deputy Chief Inspector of Prisons

November 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 College of Policing's *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 A documentary analysis of custody records is conducted as part of all police custody inspections. The analysis provides case examples illustrating the level of care that detainees receive, the quality of risk assessments and care arrangements, and access to services such as health care and legal advice.

2.4 Records are randomly selected from approximately four weeks before the inspection and the sample contains a minimum of five young people (aged 17 years and under). The number of records sampled from each custody suite is proportional to throughput at those suites – that is, more records are sampled at suites with a higher throughput and fewer from suites with a lower throughput. Where this information is unavailable, proportional sampling is based on the number of cells in each suite. Due to the small sample size, samples are not representative of the wider detention throughput. As part of this inspection, a total of 30 records were sampled.

2.5 This was the second inspection of Lincolnshire police, following up on our inspection of January 2011. The designated custody suites and cell capacity of each were as follows:

Custody suites	**Cells**
Lincoln	22
Grantham	14
Boston	14
Skegness	15

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

Strategy

2.6 The force was part of an East Midlands Criminal Justice Service collaboration with three other forces. There was a clear management structure up to deputy chief constable (ACC). A custody manager, at chief inspector level, was responsible for custody issues in Lincolnshire and Nottinghamshire. Custody sergeants were part of the local policing response teams. Short-term cover for sergeants was provided by patrol sergeants who, although custody trained, performed this role infrequently, which led to some inconsistent practices.

2.7 There was sufficient capacity across the four custody suites for the throughput of detainees. Custody detention officers (CDOs) were provided through a contract with G4S and received appropriate support and supervision from senior CDOs. A pool of trained temporary CDOs provided cover if required.

2.8 The policy and procedure for custody was contained in a single document, which was available for staff to view on the force intranet. However, some important information was missing – notably, concerning the purpose of appropriate adults (AAs) and the reporting procedures for complaints made against police staff by people in custody.

2.9 The collection of performance and management data was weak and did not provide opportunity to hold partners to account, especially local authorities and mental health trusts.

2.10 There was only one section 136 bed available in the county, resulting in too many people being brought into police detention under section 136 of the Mental Health Act. The ACC had recently convened a 'Gold'group to address this problem. A practical outcome from partnership meetings was the introduction of a street-based mental health triage service, which was a good initiative.

2.11 There was a good working relationship with, and support for, the independent custody visitor scheme.

2.12 The initial and refresher training for custody staff was appropriate and relevant. The force dip-sampled insufficient custody records and did not include cross-referencing to closed-circuit television (CCTV) or other paper records. There were good learning opportunities from regular communications to custody staff, with Independent Police Complaints Commission (IPCC) and other relevant updates, including learning from force audits.

Treatment and conditions

2.13 Custody staff engaged politely with detainees but did not explore their diverse needs sufficiently. Staff did not always ask detainees if they had, or were, carers, and women were not given the option to speak to a female member of staff. The removal of detainees' clothing and leaving them in a state of undress was unacceptable and demeaning.

2.14 Although it was positive that the number of children entering custody was reducing, some remained in custody longer than necessary owing to, in part, the inadequate AA provision. We had concerns about the force's safeguarding arrangements for children.

2.15 Detainees were not asked about their religious needs, despite all of the custody suites being well equipped with religious materials and books.

2.16 Staff interacted well with detainees during risk assessments, which were appropriately focused and enhanced by relevant probing questions. However, the subsequent care plans

were not always appropriate. The automatic use of 30-minute observations by some custody sergeants was potentially unsafe as it could obscure real individual risks.

2.17 There was disproportionate use of anti-rip clothing for some detainees who refused to participate in the risk assessment. The automatic removal of their corded clothing and footwear without assessment was also excessive.

2.18 Staff shift handovers did not involve all custody staff, with CDOs having a separate handover from sergeants. However, the content of the handovers was relevant and generally focused on risk and case progression.

2.19 The quality of pre-release risk assessments was variable; some custody staff focused appropriately on detainees' risks and vulnerabilities to ensure that they were released safely. However, several custody records we reviewed did not record all identified risks and vulnerabilities before release.

2.20 Oversight and governance of the use of force were inadequate. There was evidence that officers did not always complete use of force forms when force was used. There was no monitoring or analysis of use of force trends and data for training and to ensure staff accountability. Handcuffing of detainees in custody was mostly proportionate but those we saw brought into custody handcuffed generally remained in them until they were called to the booking-in desk. The force was unable to provide any data on the number of strip-searches conducted across the custody suites.

2.21 Overall, the physical conditions, cleanliness and general maintenance of the custody suites were good and there was a clear process for cleaning and checking cells. Access to showers and exercise was generally facilitated only on request.

Individual rights

2.22 There was evidence that most arresting officers did not comply with the relevant PACE code as they did not routinely advise custody sergeants of the reason for arrest. In some suites, voluntary attendees were booked in at the custody suite, which undermined the purpose of diversion from custody.

2.23 Staff understood the different requirements for safe and secure accommodation for detained children. Custody staff reported that safe accommodation had been made available on a limited number of occasions but data were not available to support this. Lincolnshire County Council provided a 24-hour AA service for vulnerable adults but the service was not responsive during the early hours of the morning. The AA service for children did not operate over 24 hours. Therefore, children and vulnerable adults alike were sometimes held in custody for longer than necessary.

2.24 Custody staff were not sufficiently aware of their responsibilities in relation to AAs when dealing with vulnerable adults or children. Children and vulnerable adults were regularly photographed and had their fingerprints and DNA taken without an AA being present, which was a breach of PACE.

2.25 Detainees were not always offered a copy of their rights and entitlements. Although they were asked if they wished to consult the PACE codes of practice, they were not provided with an explanation as to what these were, in order to make an informed decision. They had access to private telephone consultations with solicitors at all the custody suites, and solicitors reported good relationships with custody staff.

2.26 Most PACE reviews took place face-to-face and were thorough. However, when they were carried out while the detainee was asleep, they were not always reminded of their rights when they awoke.

2.27 Custody staff reported difficulties in getting detainees accepted by the remand court after 1pm on weekdays, resulting in them remaining in police custody for longer than necessary.

2.28 There was no consistent approach across the suites to dealing with detainees' requests to make a complaint. Some custody staff said that they would advise the detainee to go to the police station front desk on release, whereas others said that they would, appropriately, contact the duty inspector immediately. We were aware of two cases where detainees had asked to make a complaint but it had not been recorded and therefore not been investigated.

Health care

2.29 Lincolnshire Constabulary contracted G4S Forensic and Medical Services (UK) Ltd (G4SFMS) to provide health care professionals (HCPs) and forensic medical examiner (FME) services. Health services were operating with staff vacancies, which meant that detainees sometimes experienced long delays in receiving the appropriate care. However, when a practitioner was available, the quality of patient care was generally good. There was evidence that there were sometimes few or no HCPs available.

2.30 There was a lack of robust governance surrounding medicine management, including out-of-date patient group directions (which enable HCPs to supply and administer prescription-only medicine).

2.31 Substance misuse services were effective and offered good support to detainees with drug or alcohol problems. Team members were available in the suites and responded to need when alerted by custody staff or other HCPs.

2.32 Police custody suites were used too often as a place of safety under section 136 of the Mental Health Act. Diversion schemes were in place and had started to be used more effectively since April 2015.

2.33 Detainees spent too long in custody waiting for an appropriate bed following assessment for detention under the Mental Health Act. We came across one detainee who had remained in custody for four days waiting for an appropriate secure hospital bed.

Main recommendations

2.34 **Lincolnshire Police should collate and use data more meaningfully, including for use of force (in accordance with the National College of Policing, Authorised Professional Practice – Detention and Custody), to allow them to manage and improve detainee care and welfare.**

2.35 **Lincolnshire Police should develop more effective partnerships to ensure that police custody is not used as a place of safety for detainees under section 136 of the Mental health Act, except in exceptional circumstances.**

2.36 **When force is used against detainees, it should be proportionate and used as a last resort. It should be properly justified in the custody record, and use of force forms should be fully completed by all staff involved.**

2.37 **The force should engage with their counterparts in the local authority, instigate an immediate review for the provision of local authority accommodation under section 38(6) PACE 1984 for children, and monitor performance data to ensure that children are not unnecessarily detained in police cells.**

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 The force was part of an East Midlands Criminal Justice Service collaboration with three other forces on criminal justice business, including custody. There was a clear line management structure up to Deputy Chief Constable. The Assistant Chief Constable (ACC) provided the strategic lead for custody in Lincolnshire. The lead officer for the collaboration was a chief superintendent from Leicestershire police. There was a custody manager at chief inspector level who was responsible for custody issues in Lincolnshire and Nottinghamshire, but was able to allocate an appropriate amount of time to managing Lincolnshire custody matters.

3.2 There was sufficient capacity across the four custody suites for the throughput of detainees, which had totalled 14,307 in the previous 12 months. Spalding custody suite had been closed since the previous inspection. Each of the suites had a custody inspector. Custody managers were not responsible for the line management of the staff who worked in custody. Custody sergeants were part of the local policing response teams and were supervised by inspectors who managed other areas of business, including patrol. Short-term cover for sergeants was provided by patrol sergeants, who, although custody trained, performed this role infrequently (see paragraph 3.10). Custody detention officers (CDOs) were provided through a contract with G4S and received appropriate support and supervision from custody managers. There was a pool of trained CDOs who could provide cover in the event of a staff shortage among this group.

3.3 There was a standard operating procedure document for the force, The East Midlands Criminal Justice Service Custody Procedure, and this was available for staff to view on the force intranet. However, the document had some gaps, notably concerning the purpose of appropriate adults (AAs) and the reporting procedures for complaints made against police staff by people in custody (see also section on rights relating to treatment).

Recommendation

3.4 **Lincolnshire Police should update the East Midlands Criminal Justice Manual to ensure that it covers all relevant topics comprehensively, including the procedure for recording complaints made by those in custody and the purpose of the appropriate adult (AA) scheme.**

Partnerships

3.5 Chief and senior officers were involved in partnership work but this was often ineffective or too slow at improving outcomes for detainees – particularly the most vulnerable, such as children requiring accommodation after they have been charged and refused bail and for people detained under section 136 of the Mental Health Act (see main recommendation 2.35). The collection of performance and management data was weak and did not provide the opportunity to hold partners to account. There was poor analysis of trends in relation to

some key areas of custody and insufficient attention given to addressing shortfalls (see main recommendation 2.34).

3.6 There was only one section 136 bed available in the county, resulting in too many people being brought into police detention under section 136 of the Mental Health Act. [2] The ACC had convened a multi-agency 'Gold' group at the beginning of 2015 to reduce the number of section 136 detainees coming into custody (see also paragraph 6.26). Partnership work had resulted in the introduction of a street-based mental health triage service, which was a good initiative (see paragraph 6.25). This had resulted in a slow reduction in the number of section 136 detainees brought into police custody but this was still high at the time of the inspection (see main recommendation 2.35).

3.7 There was no management information available to indicate whether children who had been refused bail and needed to be kept in alternative safe or secure accommodation were provided with such accommodation by the local authority (see paragraph 5.9).

3.8 The independent custody visitor scheme was well regarded and supported by the force. Each of the custody suites received regular visits. The plan for the scheme was to recruit volunteers from more diverse backgrounds and ages.

Learning and development

3.9 There was a relevant and detailed initial and refresher training programme for all custody staff. The force disseminated learning from dip-sampling and other management processes but significant improvement was needed (see below).

3.10 Custody officers were trained over a three-week period. The training included relevant legislation, policy and procedure, computer skills and personal safety. Custody staff also had first-aid emergency training. Patrol sergeants who provided cover for custody officers received the same level of training but some worked infrequently in custody so had limited opportunity to practise their skills, which sometimes resulted in inconsistent, and occasionally poor, practice.

3.11 Custody inspectors dip-sampled 10 cases per month each, which was insufficient as it equated to less than 2% of cases per year. The process was also limited to custody records; there was no cross-checking of custody records against CCTV footage or person escort records, and no dip-sampling of shift handovers for further validation. The outcome of the dip-sampling was generally good and we saw detailed feedback to staff members which was redacted and sent more broadly when a common theme such as searching issues had been identified. Learning from IPCC bulletins was also circulated among staff, mainly by email. Areas for improvement identified in the dip-sampling process and force audits were also included in the refresher training days attended by custody staff.

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[2] Section 136 of the Mental Health Act 1983 enables a police officer to remove, from a public place, someone they believe to be suffering from a mental disorder and in need of immediate care and control, and take them to a place of safety – for example, a health or social care facility, or the home of a relative or friend. In exceptional circumstances (for example if the person's behaviour would pose an unmanageably high risk to others), the place of safety may be police custody. Section 136 also states that the purpose of detention is to enable the person to be assessed by a doctor and an approved mental health professional (for example a specialist social worker or nurse), and for the making of any necessary arrangements for treatment or care.

Recommendations

3.12 **Staff deployed in custody suites should have knowledge and skills required to work in custody.** (Repeated recommendation 2.26)

3.13 **Quality assurance measures, including the dip-sampling of custody records and reviewing of closed-circuit television footage, should be broadened to include 10% of cases.**

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 Detainees we spoke to, and our observations, confirmed that custody staff engaged politely and courteously with detainees. However, the individual needs of detainees were not always met. For example, the few women we saw being booked in were not given the option to speak to a female member of staff or offered hygiene products routinely. Of particular concern was that custody staff did not routinely ask detainees about caring responsibilities so that arrangements could be made, even though there was a specific question about this on the risk assessment.

4.2 We saw few children detained in custody and the data supplied by the force highlighted that the number was decreasing year on year, from 1,164 in 2012/13 to 944 in 2014/15. Custody staff told us that they made efforts to avoid holding children in custody for longer than necessary, although the records we reviewed showed that this was often hindered by the inadequate AA provision (see section on rights relating to detention).

4.3 There was little acknowledgement of the vulnerability of children; they were offered no specific support or care, and girls under 18 were not routinely assigned a named officer. We were particularly concerned about the force's safeguarding arrangements in relation to children. We reviewed the custody record and some associated CCTV footage relating to a 16-year-old girl detained at Skegness. She threatened self-harm and firstly had her bra removed by two female staff, who returned shortly afterwards with an anti-rip suit. Staff appeared to spend some time negotiating with the girl before she was restrained; staff then left the cell, inexplicably, taking the anti-rip suit with them, leaving the girl naked in her cell for a period of around 10 minutes. At this point, the top half of the anti-rip suit was posted through the cell hatch, followed by the lower half about 10 minutes later. Her behaviour was challenging and resulted in a male officer pushing her twice while she was naked. The vulnerability of this girl in police custody was compounded by her being left naked in a cell. Not enough was done to maintain her dignity. The next day, the girl complained to the sergeant that she had been 'violated'. The force did not refer this matter to the local authority to scrutinise the overall care and treatment of this girl independently as they did not regard this as necessary, and her complaint was not taken (see also paragraph 5.36). Following the inspection, we made a safeguarding referral.

4.4 We reviewed a further incident in which a detainee had his clothing removed and was left in a state of undress for a prolonged period. We referred both incidents to senior managers to review and take any necessary steps to end this practice.

4.5 Detainees were not routinely asked if they had any religious needs as part of the booking-in process, although all custody suites were well equipped with religious books and prayer mats, and the direction of Mecca was indicated on cell ceilings.

4.6 The provision for detainees with disabilities was limited to adapted toilet facilities in all suites. There were a few other adaptations for older detainees and those with physical disabilities, such as lowered cell call bells, wheelchairs and thick mattresses.

4.7 CDOs understood the importance of offering transgender detainees a choice about being searched by a male or female officer.

Recommendations

4.8 **Custody staff should ask all detainees if they have any obligations as carers or are being cared for by others, and whether they need help to address these.**

4.9 **Girls under 18 should be allocated a named female officer who is responsible for their care while in custody.**

4.10 **Custody staff should be more aware of the individual needs of vulnerable detainees, including women and children, and how to meet them.**

4.11 **Detainees who have had their clothing removed should be placed immediately in alternative suitable clothing.**

4.12 **Custody staff and managers should be fully aware of procedures for safeguarding children and of referral mechanisms to the local authority.**

4.13 **All suites should have facilities for detainees with physical disabilities.**

Safety

4.14 Custody staff interacted well with detainees to complete the risk assessments, and these were appropriately focused. Custody staff paid particular attention to detainees' mental and physical health needs and asked probing supplementary questions to enhance the assessment. At Lincoln, where the CDOs booked in detainees, they were supervised appropriately and were skilled at reassuring detainees throughout the booking-in process, particularly when exploring sensitive questions about their mental health. Staff took account of other sources of information during the risk assessment process, including warning markers on the police national computer and local intelligence systems.

4.15 In the sample of cases we analysed, the levels of observations that detainees were placed on were generally appropriate, reviewed regularly and changed appropriately, and mostly complied with. However, during the inspection we had concerns about some care plans devised for the management of the assessed risk. Custody staff at Lincoln and Grantham told us that it was common practice for CDOs to visit all detainees at 30-minute intervals, and that 60-minute observations were rarely used, regardless of the outcome of the risk assessment. An example of this occurred during the inspection at Lincoln, when a detainee who was assessed as having no mental health, self-harm or well-being concerns and described as 'calm and compliant' was placed on 30-minute observations, which was unnecessary in light of his assessed low risk. This lack of differentiation in observation levels between low- and high-risk detainees was unsafe as it could potentially obscure real individual risks, and undermined the risk assessment process. At Boston, a woman who had cut her wrists on the day she was detained and who had been assessed as 'high risk' was placed on 30-minute observations.

4.16 We saw some use of anti-rip clothing, mostly for detainees who refused or, in one case, could not (owing to their mental vulnerability) participate in the risk assessment, which was excessive. In one case, we observed the removal of a detainee's clothing for not complying with the risk assessment, escalating an already volatile situation and resulting in the detainee becoming more agitated and upset. This practice was not common across the custody suites,

and we were assured by some custody sergeants and the records we reviewed that a detainee's non-compliance did not always result in them having their clothing removed.

4.17 The routine removal of corded clothing and footwear was also disproportionate, particularly where detainees were assessed as low risk.

4.18 CDOs were aware of the importance of rousing detainees who were intoxicated, and communicated the outcome of any rousing checks to sergeants, particularly when they deemed that rousing was no longer necessary. In our custody record sample, there were no constant observations at close proximity and we did not observe any during the inspection.

4.19 All CDOs had personal-issue anti-ligature knives; although not all staff wore them, these knives were attached to the cells keys which all CDOs carried when visiting detainees in their cells.

4.20 The staff shift handovers across the custody suites were mostly conducted well; the content was generally relevant and focused appropriately on risk and case progression. They were not conducted with the whole team, however, with CDOs having a separate handover. The process would have been further enhanced if all incoming custody staff spoke to the detainees as part of the handover.

4.21 The quality of pre-release risk assessments was variable; some involved the detainee but in a few cases we observed the assessment being completed after the detainee had left the custody suite, without any interaction about their imminent release. In those that were well completed, custody staff focused appropriately on detainees' risks and vulnerabilities to ensure that they were being released safely. However, the subsequent completion of the record on the computer system (Niche) was not detailed and in some cases did not sufficiently reflect the good assessment that had taken place. Several of the custody records we reviewed did not record all identified risks and vulnerabilities before release. For example, although a detainee had substance misuse problems, depression and paranoia recorded on the risk assessment, these issues were not discussed or included in the pre-release risk assessment, and there was no mention of how he was getting home. Transport was offered to some detainees and fares were provided in exceptional circumstances. Despite a range of support leaflets being available at all suites, we saw few being offered to detainees on release.

Recommendations

4.22 **Restrictions on detainees' footwear and clothing should be subject to individual risk assessment.**

4.23 **Observations of detainees should be set at levels appropriate to the risk posed and should always be adhered to.**

4.24 **Anti-rip clothing should only be used in exceptional circumstances and as a last resort to protect the detainee from harm, with a recorded rationale, based on a risk assessment.**

4.25 **All custody staff should be involved in the same shift handover.**

4.26 **Pre-release risk planning should take into account the risks arising during custody as well as any consequences of release, and detainees should be offered information about relevant support organisations at the point of release.**

Use of force

4.27 Oversight and governance of the use of force were inadequate. There was evidence that officers did not always complete use of force forms when force was used, and those we were able to review contained tick-boxes and scant information about the justification for its use. There was no monitoring or analysis of use of force trends and data for training and to ensure staff accountability (see main recommendation 2.34). All of the custody staff we spoke to had undergone personal safety training.

4.28 The CCTV footage we reviewed of one case reflected insufficient efforts to de-escalate, poor technique and some heavy-handedness by staff. It showed a 68-year-old man offering little physical resistance but not complying with the booking-in process being taken directly to a cell, where, without any reasonable justification, he was restrained and taken to the floor by two officers. A third, female, officer entered the cell and, with the detainee appearing to offer little or no resistance, the officers proceeded to remove his clothing and then left him in the cell dressed just in his underpants. There was no justification in the custody record for either the use of force or the removal of his clothing (see main recommendation 2.36, and also paragraph 4.3 for a further such example). We referred both matters to senior managers to review and take any necessary action. As CCTV footage was not reviewed as part of the dip-sampling process (see paragraph 3.11), opportunities for learning lessons were missed.

4.29 We reviewed the custody record and associated CCTV footage of a case in which a Taser had been drawn in Grantham. There were a number of concerns. For example, the officer who was conducting a constant watch in the custody suite had not removed the Taser from his belt, which was not in accordance with the force standard operating procedures. The subsequent paperwork filed by the officer was poorly completed and did not provide sufficient information about what had ensued before the Taser had been drawn and the detainee 'red dotted' (that is, aiming the Taser or placing the laser sight red dot onto a subject). From the CCTV, it was clear that the detainee had posed a threat to staff but use of the Taser should not have been an immediate option. This incident was being reviewed by the force.

4.30 The force was unable to provide any data on the number of strip-searches conducted across the custody suites. In our custody record analysis (CRA), a strip-search had been conducted in two out of the 30 cases, all of which had been authorised appropriately, although the gender of the searching officers had not been recorded. We viewed two incidents on CCTV footage in which staff of the opposite gender to the detainee had been present when the detainee was having their clothing forcibly removed.

4.31 Few detainees arrived at the custody suites in handcuffs. However, the small number who did, generally remained in them in the holding room until they were called to the booking-in desk, which was excessive, particularly as they were compliant.

Recommendations

4.32 **Detainees should only have their clothing removed by staff of the same gender.**

4.33 **Handcuffs should be removed from detainees after arrival, unless a risk assessment indicates otherwise.**

Physical conditions

4.34 Overall, the physical condition of the custody suites was good. Although deep cleaning was required in some of the cells at Skegness, the custody estate was clean and well maintained, with few signs of graffiti. All custody suites were cleaned daily and there was an agreed cleaning schedule outlining areas to be cleaned daily, weekly and monthly, which was complied with. There was a clear process for checking cells and for reporting maintenance issues. The records we reviewed showed that reported maintenance problems were generally responded to and resolved within 48 hours.

4.35 Daily, weekly and monthly checks were conducted at each of the custody suites but were not always effective at identifying ligature points. We found several ligature points in all of the custody suites.

4.36 CCTV operated in all custody suites and there were signs to inform detainees of this. All toilet areas were pixellated on the CCTV monitor. However, at Lincoln the CCTV monitors showing footage of cells and their occupants in the booking-in area could be seen by detainees, which was inappropriate.

4.37 After booking in, in most cases detainees were escorted to their cell by a CDO, who explained in-cell equipment such as the cell call bell and toilet flush. There was a poster in all the custody suites reminding CDOs to inform detainees of how to use the call bell. When CDOs were busy, this task was sometimes handed to arresting officers, who were not always as thorough in providing an explanation. Cell call bells were responded to promptly.

4.38 Each suite had a fire evacuation policy and plans, and an evacuation kit containing sets of handcuffs, handcuff keys, evacuation instructions and paperwork. Few of the staff could recollect undertaking fire evacuation exercises, however, and there were no records of any such exercises taking place.

Recommendations

4.39 **Lincolnshire police should address the safety issues around ligature points and, where resources do not allow them to be dealt with immediately, the risks should be managed.** (Repeated recommendation 2.28)

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

Housekeeping point

4.41 The closed-circuit television monitors should not be viewable by detainees or non-custody staff in the booking-in area.

Detainee care

4.42 Mattresses and pillows were provided but were not always cleaned between uses. Clean blankets were offered routinely at all suites. There were sufficient stocks of replacement clothing, which was routinely offered to detainees whose clothing was seized for evidential purposes or otherwise soiled. Family members were also able to bring in items of clothing for detainees appearing in court. Replacement footwear was not always provided, even though most detainees had their footwear removed.

4.43 Toilets and showers were clean but none of the shower cubicles, at any of the custody suites, offered sufficient privacy. Detainees were routinely given toilet paper. There were adequate supplies of hygiene products, including combs and toothbrushes. Women were not routinely told about the availability of sanitary products but at Lincoln and Skegness there were notices on the wall informing them of their availability.

4.44 Access to showers and exercise was generally facilitated only on request by detainees, requiring them to have prior knowledge of their availability. During a night visit, we saw three detainees asking to take a shower and this was facilitated in each case. In our CRA, only two detainees in the sample had received outside exercise (one at Lincoln and one at Boston), both of whom had been held for over 40 hours. We saw a few detainees in the outside but CDOs told us that exercise could only be facilitated if they were not busy.

4.45 Microwave meals and porridge were available, and food and drink were provided at mealtimes and on request. Food preparation areas were clean and well equipped. In our CRA, most detainees in the sample had been offered at least one meal while in custody.

4.46 All of the custody suites had reading material, mainly brought in by staff, but it was only provided at the request of detainees. There were no books for children but at Boston there was reading material in the main languages of the local community.

4.47 All the suites had rooms to facilitate visits, and these had been used to support some vulnerable detainees.

Recommendations

4.48 **Replacement footwear should be provided for all detainees if their own footwear is removed or stored outside their cell.**

4.49 **Women detainees should be offered sanitary products routinely.**

4.50 **All detainees held overnight, or those who require one, should be offered a shower.** (Repeated recommendation 4.35)

4.51 **All suites should hold a stock of reading material suitable for children.**

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 and CDOs under supervision at Lincoln booked detainees into custody. We saw custody sergeants asking arresting officers to provide a full explanation of the circumstances of the arrest but we saw few exchanges in which the reason(s) for the arrest under PACE code G[3] were asked for or provided by officers. In most cases, the custody sergeant asked arresting officers if the reason for the arrest was for a 'prompt and effective' investigation, which did not satisfy us that the requirements of PACE code G were complied with or fully understood. Sergeants told us that they were confident in refusing detention when the circumstances did not merit it, and they were able to provide us with details of such cases.

5.2 Alternatives to custody were available in the form of voluntary attendance,[4] fixed penalty notices and restorative justice (RJ).[5] Facilities for interviewing voluntary attendees outside custody were available at all the police stations where the custody suites were based. At Boston and Grantham, when these facilities were busy, officers brought their voluntary attendees into the custody suite for interview, which was contrary to the ethos of the process, which was to divert individuals from police custody. Custody staff were unsure about how often voluntary attendance was used and no data were available on the deployment of this alternative.

5.3 At Skegness we saw a 19-year-old male detainee, who had never been arrested previously, brought into custody for stealing two sandwiches from a local bakery, with no consideration given to dealing with the matter through RJ. The custody sergeant authorised his detention but then instructed the arresting officer to return to the bakery to seek an RJ resolution. This was successful and after the detainee agreed to pay for the sandwiches, he was released from custody, having spent just over one hour in a cell. Although this arrest was lawful, it would not have been necessary if the officer had sought an RJ resolution on initial attendance.

5.4 Most detainees were booked in promptly after arrival at the custody suites; however, we saw some waits of up to 35 minutes at Skegness, due primarily to the volume of demand. These waits were comparable to the average waiting time across the four suites supplied by the force for July 2015, which, at 26.67 minutes, was unacceptable and prevented the early identification of risk.

5.5 All custody staff were aware of the need to keep detention periods to a minimum and custody sergeants were clear about their obligations to ensure that cases were progressed

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[3] PACE code G refers to the Police and Criminal Evidence Act 1984, code G, which is the code of practice for the statutory power of arrest by police officers.
[4] Usually for lesser offences, where suspects attend by appointment at a police station to be interviewed about alleged offences. This avoids the need for arrest and subsequent detention in police custody.
[5] Restorative justice is a process whereby some lesser criminal cases can be resolved at the time of the offence through an agreement between the offender and victim.

quickly, and we observed this. In our CRA, the average length of detention was 11 hours 58 minutes, with seven out of 30 detainees being held for less than six hours. The force was unable to supply data to show the average length of detention, which was poor as this area of business was not being monitored (see main recommendation 2.34).

5.6 Custody staff reported a good relationship with Home Office immigration enforcement officers, a number of whom were based at Boston police station. We were told that large numbers of immigration detainees were regularly held and that those who were to be transferred to immigration removal centres were usually moved on within 24–48 hours; however, longer delays had sometimes been experienced. The force was unable to supply any data on the number of immigration detainees held or their overall average time in police custody (see main recommendation 2.34).

5.7 Professional telephone interpreting services were available to assist when dealing with non-English-speaking detainees. At Lincoln, these were accessed through the use of two portable handsets linked in to the same telephone call. Elsewhere, the service was accessed through the use of loudspeaker telephones, which lacked privacy and could be noisy when the suites were busy. Staff told us, and records we reviewed highlighted, that there was a good face-to-face interpreter service available for interviews.

5.8 Staff assured us that the custody suites were never used as a place of safety for children under section 46 of the Children Act 1989.[6]

5.9 Custody staff told us that they had not known the local authority to provide secure accommodation when a child had been charged and could not be bailed. Some staff were aware of a few occasions when safe[7] accommodation had been provided on request but data were not available to support this. The force was able to supply data which showed that 977 children had been detained in custody in the previous 12 months. However, they were unable to disaggregate the data to show how many children had been charged and not bailed or how many requests had been made to the local authority for alternative accommodation as these were not routinely collected (see main recommendation 2.34).

5.10 Custody staff were not always aware of their responsibilities in relation to AAs when dealing with vulnerable adults or children. In our CRA, we found evidence of a 17-year-old girl held at Lincoln who had her photograph, fingerprints and a DNA sample taken without her AA being present, which was inappropriate and a breach of PACE (code D, 2.15). Custody staff at all the suites told us that this was common practice when dealing with children and vulnerable adults, particularly if the individual had been in custody previously.

5.11 Family or friends were contacted in the first instance to act as an AA but not all staff were aware that guidance documents were available on the custody computer system (Niche) for issue to such parties, detailing their role and responsibilities when acting as an AA.

5.12 In the absence of family members, AAs for children were available through The Appropriate Adult Service (TAAS), which was contracted to provide a service between 7am and midnight; however, custody staff told us that in their experience this service only operated between 9am and 9pm. Lincolnshire County Council operated a 24-hour AA service for

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

[7] Under PACE code C Note 16D, the availability of secure accommodation is only a factor in relation to a child aged 12 or over when other local authority accommodation would not be adequate to protect the public from serious harm from them.

vulnerable adults, which was provided through trained social workers and staff; however, custody staff told us that they regularly experienced long delays when these services were required in the early hours of the morning. Positively, they said that, where possible, they would bail a detainee waiting for the services of an AA if one was not readily available, although this was not always possible. Therefore, children and vulnerable adults alike were sometimes held in custody for longer than necessary.

5.13 In our CRA, there were five children in the sample aged between 15 and 17 years. One of these, a 16-year-old girl held at Grantham, did not appear to have received the support of an AA. In her rights documentation it was recorded that an AA had been called and attended but these were both noted as occurring at the same time. There was no address or contact number given for the AA and no AA signature on either the rights documentation or the youth caution that the child was given. The force did not collect data on the standard of the AA service or seek to work with the providers to improve the situation (see main recommendation 2.34).

Recommendations

5.14 **Lincolnshire Police should ensure that arresting officers and custody sergeants are fully aware of and comply with the requirements of the necessity criteria for arrest as detailed in PACE code G.**

5.15 **Lincolnshire Police should remind operational staff to seek restorative justice resolutions when dealing with applicable lesser criminal offences.**

5.16 **Lincolnshire Police should monitor the average waiting times from time of arrival in custody to detention being authorised, to ensure that detainees are booked in promptly.**

5.17 **Suitable telephone equipment should be provided in all suites to facilitate private telephone interpreting.**

5.18 **Lincolnshire Police should ensure that the taking of photographs, fingerprints and DNA samples in cases involving children and vulnerable adults takes place in the presence of an AA.**

5.19 **AAs should be readily available 24 hours a day for children and vulnerable adults.**

Housekeeping point

5.20 Custody staff should be made aware of the availability of a guidance document to assist family or friends acting as AAs, and this should be routinely issued where relevant.

Rights relating to PACE

5.21 During booking-in, custody sergeants and CDOs advised detainees of their three main rights[8] but they were not routinely given a written notice setting out their rights and

[8] Three main rights – the right to have someone informed of their arrest; the right to consult a solicitor and access free independent legal advice; and the right to consult the PACE codes of practice.

entitlements. In some instances, custody staff asked the detainee if they wanted a copy of their rights and entitlements 'printed off', which was not helpful to the detainee as they may not have been fully aware of what they were being asked or the implications of refusing. Custody staff were able to access these notices in foreign languages for non-English-speaking detainees but despite this we saw a Slovakian detainee at Lincoln who was not issued with a copy in his own language. None of the custody staff we spoke to was aware that an easy-read pictorial version of detainees' rights and entitlements, for those needing help with understanding or reading, was available on the Home Office website.

5.22 We saw detainees being told during the booking-in process that they could read the PACE codes of practice but these were not routinely explained by custody staff. There were sufficient copies at all suites. Posters informing detainees of their right to free legal advice, in a range of languages, were available in all the suites.

5.23 All detainees were offered free legal representation; if a detainee declined, staff asked and recorded the reason why they did not wish to use this service, and detainees were told that they could change their mind at any time. Those wishing to speak to legal advisers were able to do so in the privacy of either their cells or consultation rooms, through the use of portable handset telephones. We saw legal advisers being given copies of their client's custody record, and solicitors reported good relationships with custody staff. Records demonstrated that solicitors had been contacted promptly after being requested.

5.24 Detainees were told that they could inform someone of their arrest, which staff facilitated. In our CRA, 10 detainees had asked for someone to be informed, and in all cases the chosen person had been contacted or an attempt made to contact them.

5.25 PACE reviews were undertaken by dedicated custody and operational duty inspectors across the force area, and most were conducted face-to-face. Those we observed were good, timely and appropriate. In our CRA, 19 detainees had required a PACE review; however, in the case of two detainees at Boston there was no record that a review had been conducted, in spite of the detainees being held in custody for over six hours without being charged at that time. In one case, the detainee had been held in custody for over 13 hours without any review being recorded. In the other case, the detainee had been held for just over eight hours, after which he had been charged and bailed. It was not clear why neither of these detainees had received a review.

5.26 In our CRA, seven reviews had taken place while the detainee was asleep and it was not recorded in any of these cases that the detainee had been told that the review had taken place or reminded of their rights and entitlements. Custody sergeants confirmed that information relating to 'sleeping reviews' was not exchanged during handovers and therefore could be overlooked. In one case we looked at in Skegness, it was recorded that a 16-year-old girl had been reviewed remotely over the telephone.

5.27 The management of DNA samples taken in custody was prompt and effective.

5.28 Custody staff at all the suites told us that Lincoln Magistrates' Court, which was the only remand court for the force area, would not normally accept detainees after 1pm on weekdays and 9am on Saturdays, which was too early. Custody staff said that there could be a limited amount of flexibility on a daily basis, depending on how busy the court was. The court not accepting detainees after 1pm meant that people were often held in police detention for too long when they were refused bail by the police.

Recommendations

5.29 **All detainees should be given a copy of their written rights and entitlements.**

5.30 **Reviews of detention should be conducted as required in PACE code C, and PACE reviews for children should be carried out face-to-face.**

5.31 **Senior police managers should engage with HM Courts and Tribunals Service to ensure that early court cut-off times do not result in unnecessarily long stays in police custody.** (Repeated recommendation 5.15)

Housekeeping points

5.32 Staff should be made aware of the availability of the easy-read pictorial version of the rights and entitlements information.

5.33 PACE codes of practice should be routinely explained and offered by custody staff.

Rights relating to treatment

5.34 There was no consistent approach across the suites to responding to a detainee's request to make a complaint. Some custody staff said that they would advise the detainee to go to the police station front desk on release, whereas others said that they would contact the duty inspector immediately and it would be the inspector's decision as to whether or not they logged the complaint while the detainee was still in custody. Notices were displayed at Lincoln advising detainees to ask to speak to the duty inspector if they were dissatisfied with their treatment but these were not displayed in any of the other custody suites. Details of how to make a complaint were included in the rights and entitlements documentation but this was not routinely given or offered to detainees (see paragraph 5.21) and no trend analysis was conducted in relation to complaints in custody (see main recommendation 2.34).

5.35 We observed a 16-year-old boy being booked in at Lincoln who indicated that he wished to make a complaint as he had marks and a small cut to one of his wrists, which he said had resulted from his handcuffs being too tight. The custody sergeant told us that he would tell the duty inspector, who was in the suite at the time, of the child's intention to complain. However, this did not occur and when we later checked the custody record we found no evidence that the inspector had been made aware of the complaint.

5.36 Similarly, a 16-year-old girl who wanted to make a complaint about her treatment in custody informed the sergeant, who in turn informed the duty inspector but told her that she would have to pursue her complaint once she had left custody. There was no evidence to suggest that the girl's complaint was followed up (see also paragraph 4.3). These examples did not satisfy us that there were processes to facilitate complaints being taken at the earliest practicable time.

Recommendations

5.37 **Detainees should be able to make a complaint while they are still in custody.**

5.38 **All complaints made by children about restraints should be referred to the local authority-designated officer for investigation.**

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 Lincolnshire Constabulary contracted G4SFMS to provide HCPs and FME services. Mental health services were provided by Lincolnshire Partnership NHS Foundation Trust and drug and alcohol recovery services were provided by the community-based drug and alcohol recovery service, Addaction.

6.2 Two HCPs and an FME were contracted to provide 24-hour on-call cover throughout the county, although there were gaps in this provision due to staff vacancies which sometimes caused a delay in response times; this was verified by the detailed contract data that G4SFMS provided to the force. There were three agreed response time bands for G4SFMS staff attending custody suites of 60, 90 and 120 minutes for specific conditions. The 90% target rate had been achieved from April to August 2015, apart from in July 2015, when it had been 88%. Exception reports for May to July 2015 for late responses showed that on 17 occasions, detainees had waited between three and four hours to be seen, and the longest wait had been 12 hours, which was too long. We were told that FMEs had occasionally declined to attend, giving telephone advice only, which staff felt was not in the best interest of the detainee. These incidents were investigated by G4SFMS if they were informed about them.

6.3 HCPs were either paramedics or nurses with at least three years' experience. One newly recruited staff member had just started and three were undergoing the vetting process; this would help to alleviate some of the staffing difficulties. There were four full-time FME posts; two were covered by eight FMEs on a flexible rota basis and the other two were vacant.

6.4 Clinical governance arrangements were in place, with good uptake of mandatory training and professional development opportunities, although there was no evidence of infection control audits and some staff had not had an annual appraisal. There was a comprehensive induction programme for new staff, and HCPs had access to telephone support at all times.

6.5 Medical and nursing professional credentials and revalidation were monitored and staff had access to a range of corporate and clinical policies. Staff knew how to report an incident, and feedback was given to drive service improvement. The process for detainees to make a health care-related complaint was not well advertised.

6.6 The treatment rooms had been refurbished and were clean, and met most infection control standards; however, sharps bins were stored on the floor and were not signed or dated at the start of use. In the medical room at Boston, we found five full sharps bins which had not been disposed of and we were unsure of how long they had been there. Only the medical room at Skegness had suitable storage for medical equipment and appropriate clinical surfaces for forensic sampling; the others used filing cabinets for storage, which was inappropriate.

6.7 Custody staff received mandatory annual basic life support training and had access to an automated external defibrillator (AED) and oxygen, and there was a clear audit trail to verify that they were checked and maintained routinely.

Recommendations

6.8 **There should be adequate staffing to ensure that clinical services are safe, and detainees should be seen within the agreed response times.**

6.9 **All medical rooms should have appropriate storage for medical equipment and clinical surfaces for forensic sampling, and fully comply with infection control guidance identified through regular infection control audits.**

Housekeeping points

6.10 All staff should have access to an annual appraisal which identifies individual professional development.

6.11 Detainees should be able to complain about health services through a well-advertised and confidential health care complaints system.

Patient care

6.12 The clinical interactions we observed were professionally delivered and clinically appropriate, and there was access to professional telephone interpreting services if needed. Contemporaneous handwritten clinical assessment records were legible and those we assessed were of a high standard, with consent to treatment and information sharing recorded, and all had the detainee's signature.

6.13 All paper-based clinical records were kept appropriately in a locked metal safe, which was accessible only to G4SMFS staff. The records were collected regularly by G4SMFS, scanned and stored at another location, and there were systems for prompt retrieval if required. Appropriate entries were also placed on the custody computer system (Niche), to ensure safety and maintain confidentiality.

6.14 Medicines were stored in locked cupboards in each medical room and records were accurate. Stock levels were well managed, medication counts were correct and cupboards were well organised. Medication was in date and disposed of appropriately. There were no refrigerators in any of the medical rooms for storing heat-sensitive medications.

6.15 All the patient group directions (which enable HCPs to supply and administer prescription-only medicine) were out of date, with a review date of July 2012. HCPs wrote a label and placed this, along with medication that had been removed from its original packaging, into a clear bag for custody staff to administer at a later time. There was no patient information about the medication, as highlighted in the G4S standard operating procedure, and custody staff had not been trained in medicine management.

6.16 Detainees could continue to receive validated prescribed medication in custody, including opiate substitution therapy. HCPs had good links with local GP surgeries and pharmacies, and the police collected prescribed medications from detainees' homes or from local pharmacies if possible. There was a comprehensive assessment tool for opiate and alcohol withdrawal in use and symptomatic relief was available. Medication, including controlled drugs, diazepam and dihydrocodeine, was left for custody staff to give to the detainee, with only one custody officer administering it, without being witnessed routinely by another officer.

6.17 At each suite, custody staff had access to a small range of medications, supplied by G4SFMS, including prescription-only medication such as asthma inhalers and angina sprays, as well as mild pain killers and nicotine replacement patches. They were able to administer any of these, following only telephone advice from a G4S FME, without the detainee being examined by the FME or a formal prescription; this was unsafe for prescription-only medication.

Recommendations

6.18 **There should be robust governance of medication management, including a review of all patient group directions (PGDs) and local operating procedures, and appropriate medicine management training for custody staff.**

6.19 **A health care professional should review detainees requiring prescription-only medication face-to-face and prescribe using a valid PGD or prescription.**

Housekeeping point

6.20 There should be a refrigerator available in each treatment room; minimum and maximum drug refrigerator temperatures should be recorded daily and remedial action taken if they are outside of range, to ensure the correct storage of heat-sensitive medication.

Substance misuse

6.21 Addaction, a voluntary community organisation, provided a good drug and alcohol support service in police custody for adult detainees with drug or alcohol problems. They attended all four custody suites and local courts on set days throughout the week. Addaction workers spoke to all detainees and told them about the services and treatments available. If a detainee wanted to see a worker at times when they were not available, custody or G4SFMS staff completed a referral form and left it for the worker for when they next attended the custody suite; they then contacted the client in the community or passed the information on to prison drug workers if necessary.

6.22 Detainees were offered an initial assessment at a local team office in the community to identify an individualised recovery plan; this could include harm minimisation services, working towards abstaining or reducing substance/alcohol use, and links to local recovery groups and family support. There were no needle exchange schemes in the custody suites but there were several venues across the force area where it was possible for drug users to obtain clean needles.

6.23 Children with drug or alcohol problems were signposted to appropriate services or directly referred into age-appropriate services.

Mental health

6.24 Partnership working between mental health services and the force had been improved with the introduction of strategic meetings and a mental health and learning disability liaison officer, who had a good working relationship with health partners. Diversion schemes were in place and had started to be used more effectively since April 2015, following a mental health awareness-raising campaign. This had reminded custody officers to follow existing mental health processes, including accessing mental health advice about diversion before

detention, and to refresh knowledge about aspects of the Mental Health Act, particularly the use of section 136.

6.25 A street-based mental health triage service operated from 4pm to midnight every day and was a positive initiative, providing an emergency response to those in mental health crisis. There were four mental health crisis teams across the county and they aimed to respond to a request from custody suites within four hours. However, custody officers and HCPs told us that there were sometimes delays in the response from the crisis team and in expediting mental health assessments, including access to an appropriate bed. This meant that detainees spent too long in custody as there were often no beds available. We came across a detainee with mental health issues who had spent four days in custody waiting for an appropriate secure hospital bed, which was unacceptable. A range of circumstances had contributed to this, including a lack of agreement between the crisis team and the emergency duty team in deciding who should take responsibility. The emergency duty team provided two approved mental health professionals for Lincolnshire out of hours, and assessments were prioritised based on risk, but their travel time could also prolong response times.

6.26 In 2013/14, the custody suites had been used 342 times, and in 2014/15 343 times as a place of safety under section 136 of the Mental Health Act, which was far too high. There was only one hospital-based place of safety in the county, although we were told that there were firm plans to increase this to two in the near future (see also paragraph 3.6). Lincolnshire had an action plan under the Crisis Care Concordat, which had identified areas for improvement in relation to the use of section 136.

6.27 The use of section 136 for children had reduced from 13 in the eight months to April 2015 to one in the six months to August 2015. The local child and adolescent mental health service came to the custody sites as required.

6.28 Custody staff had received training in mental health awareness as part of their induction and some staff had received refresher training in mental health, learning disabilities and autism.

Recommendations

6.29 **Mental health assessments and Mental Health Act assessments should be expedited in a timely fashion to ensure that detainees do not remain in custody for too long.**

6.30 **Mental health awareness refresher training should be regular and enable all custody staff to identify and manage the care of detainees appropriately and safely.**

Section 7. Summary of recommendations

Main recommendations

7.1 Lincolnshire Police should collate and use data more meaningfully, including for use of force (in accordance with the National College of Policing, Authorised Professional Practice – Detention and Custody), to allow them to manage and improve detainee care and welfare. (2.34)

7.2 Lincolnshire Police should develop more effective partnerships to ensure that police custody is not used as a place of safety for detainees under section 136 of the Mental health Act, except in exceptional circumstances. (2.35)

7.3 When force is used against detainees, it should be proportionate and used as a last resort. It should be properly justified in the custody record, and use of force forms should be fully completed by all staff involved. (2.36)

7.4 The force should engage with their counterparts in the local authority, instigate an immediate review for the provision of local authority accommodation under section 38(6) PACE 1984 for children, and monitor performance data to ensure that children are not unnecessarily detained in police cells. (2.37)

Recommendations

Strategy

7.5 Lincolnshire Police should update the East Midlands Criminal Justice Manual to ensure that it covers all relevant topics comprehensively, including the procedure for recording complaints made by those in custody and the purpose of the appropriate adult scheme. (3.4)

7.6 Staff deployed in custody suites should have knowledge and skills required to work in custody. (3.12, repeated recommendation 2.26)

7.7 Quality assurance measures, including the dip-sampling of custody records and reviewing of closed-circuit television footage, should be broadened to include 10% of cases. (3.13)

Treatment and conditions

7.8 Custody staff should ask all detainees if they have any obligations as carers or are being cared for by others, and whether they need help to address these. (4.8)

7.9 Girls under 18 should be allocated a named female officer who is responsible for their care while in custody. (4.9)

7.10 Custody staff should be more aware of the individual needs of vulnerable detainees, including women and children, and how to meet them. (4.10)

7.11 Detainees who have had their clothing removed should be placed immediately in alternative suitable clothing. (4.11)

7.12 Custody staff and managers should be fully aware of procedures for safeguarding children and of referral mechanisms to the local authority. (4.12)

7.13 All suites should have facilities for detainees with physical disabilities. (4.13)

7.14 Restrictions on detainees' footwear and clothing should be subject to individual risk assessment. (4.22)

7.15 Observations of detainees should be set at levels appropriate to the risk posed and should always be adhered to. (4.23)

7.16 Anti-rip clothing should only be used in exceptional circumstances and as a last resort to protect the detainee from harm, with a recorded rationale, based on a risk assessment. (4.24)

7.17 All custody staff should be involved in the same shift handover. (4.25)

7.18 Pre-release risk planning should take into account the risks arising during custody as well as any consequences of release, and detainees should be offered information about relevant support organisations at the point of release. (4.26)

7.19 Detainees should only have their clothing removed by staff of the same gender. (4.32)

7.20 Handcuffs should be removed from detainees after arrival, unless a risk assessment indicates otherwise. (4.33)

7.21 Lincolnshire police should address the safety issues around ligature points and, where resources do not allow them to be dealt with immediately, the risks should be managed. (4.39, repeated recommendation 2.28)

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

7.23 Replacement footwear should be provided for all detainees if their own footwear is removed or stored outside their cell. (4.48)

7.24 Women detainees should be offered sanitary products routinely. (4.49)

7.25 All detainees held overnight, or those who require one, should be offered a shower. (4.50, repeated recommendation 4.35)

7.26 All suites should hold a stock of reading material suitable for children. (4.51)

Individual rights

7.27 Lincolnshire Police should ensure that arresting officers and custody sergeants are fully aware of and comply with the requirements of the necessity criteria for arrest as detailed in PACE code G. (5.14)

7.28 Lincolnshire Police should remind operational staff to seek restorative justice resolutions when dealing with applicable lesser criminal offences. (5.15)

7.29 Lincolnshire Police should monitor the average waiting times from time of arrival in custody to detention being authorised, to ensure that detainees are booked in promptly. (5.16)

7.30 Suitable telephone equipment should be provided in all suites to facilitate private telephone interpreting. (5.17)

7.31 Lincolnshire Police should ensure that the taking of photographs, fingerprints and DNA samples in cases involving children and vulnerable adults takes place in the presence of an AA. (5.18)

7.32 AAs should be readily available 24 hours a day for children and vulnerable adults. (5.19)

7.33 All detainees should be given a copy of their written rights and entitlements. (5.29)

7.34 Reviews of detention should be conducted as required in PACE code C, and PACE reviews for children should be carried out face-to-face. (5.30)

7.35 Senior police managers should engage with HM Courts and Tribunals Service to ensure that early court cut-off times do not result in unnecessarily long stays in police custody. (5.31, repeated recommendation 5.15)

7.36 Detainees should be able to make a complaint while they are still in custody. (5.37)

7.37 All complaints made by children about restraints should be referred to the local authority-designated officer for investigation. (5.38)

Health care

7.38 There should be adequate staffing to ensure that clinical services are safe, and detainees should be seen within the agreed response times. (6.8)

7.39 All medical rooms should have appropriate storage for medical equipment and clinical surfaces for forensic sampling, and fully comply with infection control guidance identified through regular infection control audits. (6.9)

7.40 There should be robust governance of medication management, including a review of all patient group directions (PGDs) and local operating procedures, and appropriate medicine management training for custody staff. (6.18)

7.41 A health care professional should review detainees requiring prescription-only medication face-to-face and prescribe using a valid PGD or prescription. (6.19)

7.42 Mental health assessments and Mental Health Act assessments should be expedited in a timely fashion to ensure that detainees do not remain in custody for too long. (6.29)

7.43 Mental health awareness refresher training should be regular and enable all custody staff to identify and manage the care of detainees appropriately and safely. (6.30)

Housekeeping points

Treatment and conditions

7.44 The closed-circuit television monitors should not be viewable by detainees or non-custody staff in the booking-in area. (4.41)

Individual rights

7.45 Custody staff should be made aware of the availability of a guidance document to assist family or friends acting as AAs, and this should be routinely issued where relevant. (5.20)

7.46 Staff should be made aware of the availability of the easy-read pictorial version of the rights and entitlements information. (5.32)

7.47 PACE codes of practice should be routinely explained and offered by custody staff. (5.33)

Health care

7.48 All staff should have access to an annual appraisal which identifies individual professional development. (6.10)

7.49 Detainees should be able to complain about health services through a well-advertised and confidential health care complaints system. (6.11)

7.50 There should be a refrigerator available in each treatment room; minimum and maximum drug refrigerator temperatures should be recorded daily and remedial action taken if they are outside of range, to ensure the correct storage of heat-sensitive medication. (6.20)

Section 8. Appendices

Appendix I: Inspection team

Clive Burgess	HMIC lead staff officer and team leader
Vinnett Pearcy	HMI Prisons inspector
Kellie Reeve	HMI Prisons inspector
Fiona Shearlaw	HMI Prisons inspector
Anthony Davies	HMIC staff officer
Maureen Jamieson	HMI Prisons health services inspector
Kathleen Byrne	Care Quality Commission inspector
Joe Simmonds	HMI Prisons researcher
Alissa Redmond	HMI Prisons researcher

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 deployed in custody suites should have knowledge and skills required to work in custody. (2.26)
Partially achieved (recommendation repeated 3.13)

Appropriate arrangements should be in place to divert people with mental health problems from police custody suites, including those being assessed under section 136 of the Mental Health Act. (2.29)
Not achieved

Recommendations

Custody managers should have time to carry out sufficient dip-sampling of custody records to quality assure standards of practice. (3.14)
Not 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.

Main recommendations

Risk assessment procedures should be revised to ensure greater consistency, regular reviews and better management oversight. (2.27)
Partially achieved

Lincolnshire police should address the safety issues around ligature points and, where resources do not allow them to be dealt with immediately, the risks should be managed. (2.28)
Partially achieved (recommendation repeated 4.39)

Recommendations

Diversity training should be improved, to enable more effective engagement with minority groups. (4.7)
Achieved

Some cells should be adapted for use by detainees with physical disabilities, and access to toilet facilities for such detainees should be improved. (4.8)
Partially achieved

Booking-in areas should allow for private communication between detainees and staff and confidentiality of personal information. (4.9)
Not achieved

The removal of detainees' clothing should cease to be the standard response to any concerns about self-harm; when clothing is taken away, assessments should be reviewed regularly. (4.17)
Not achieved

When appropriate, detainees should be roused to elicit a response. (4.18)
Achieved

Lincolnshire police should submit a use of force form in every appropriate instance, and should monitor the use of force at each custody suite by ethnicity, age, location and officers involved, in line with Association of Chief Police Officers (ACPO) guidance. (4.22)
Not achieved

Governance should be improved to ensure that custody staff employ consistent, approved methods when using force. (4.23)
Not achieved

Health and safety walk-through arrangements should be thorough and consistently applied at all custody suites. (4.27)
Not achieved

All detainees held overnight, or those who require one, should be offered a shower. (4.35)
Not achieved (recommendation repeated 4.50)

Suitable alternative clothing should always be provided to detainees when needed. (4.36)
Partially achieved

Individual rights

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

Recommendations

The force should engage with UK Border Agency to ensure that immigration detainees are held for the shortest possible time. (5.6)
Not achieved

Custody staff should ensure that any dependency issues of detainees are identified and, where possible, addressed. (5.7)
Partially achieved

Senior police officers should engage with the local authority to ensure that they meet their statutory obligation to provide place of safety beds for juveniles. (5.13)
Partially achieved

Appropriate adults should be available to support juveniles aged 17 and under and vulnerable adults in custody, including out of hours. (5.14)
Partially achieved

Senior police officers should engage with HM Court Service to ensure that early court cut-off times do not result in unnecessarily long stays in custody. (5.15)
Not achieved (recommendation repeated, 5.31)

Detainees should be told how to make a complaint and be able to do so before they leave custody. (5.17)
Partially achieved

Health care

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

Recommendations

The practice of secondary dispensing by health services professionals should cease. (6.7)
No longer relevant

In all cases, there should be documentary evidence that consent for a clinical examination has been obtained. (6.15)
Achieved

There should be an offender mental health strategy and information-sharing protocol in Lincolnshire, and regular strategic meetings between police officers and Lincolnshire Partnership NHS Trust. (6.27)
Achieved

HM Inspectorate of Prisons and HM Inspectorate of Constabulary are members of the UK's National Preventive Mechanism, a group of organisations which independently monitor all places of detention to meet the requirements of international human rights law.