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

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

28 March–8 April

Contents

Fact page 1

Summary 2

Introduction 7

Section 1. Leadership, accountability and partnerships 9

Section 2. Pre-custody: first point of contact 14

Section 3. In the custody suite: booking in, individual needs and legal rights 17

Section 4. In the custody cell, safeguarding and health care 25

Section 5. Release and transfer from custody 36

Section 6. Summary of causes of concern, recommendations and areas for improvement 38

Section 7. Appendices 41

Appendix I: Methodology 41

Appendix II: Inspection team 44

Fact page

Note: Data supplied by the force.

Force

Hertfordshire Constabulary

Chief constable

Charlie Hall

Police and crime commissioner

David Lloyd

Geographical area

County of Hertfordshire

Date of last police custody inspection

2015

Custody suites

- Hatfield: 30 cells
- Stevenage: 24 cells

Annual custody throughput

1 March 2021 to 28 February 2022 – 12,196

Custody staffing

- 1 chief superintendent
- 1 superintendent
- 1 chief inspector
- 5 inspectors
- 30 custody sergeants
- 55 detention officers

Health service provider

CRG (Castle Rock Group Healthcare)

Summary

This report describes our findings following an inspection of Hertfordshire Constabulary custody facilities. The inspection was conducted jointly by HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) and HM Inspectorate of Prisons (HMIP) in April 2022. It is part of our programme of inspections covering every police custody suite in England and Wales.

The inspection assessed the effectiveness of custody services and outcomes for detained people throughout the different stages of detention. It examined the force's approach to custody provision in relation to detaining people safely and respectfully, with a particular focus on children and vulnerable adults.

This inspection took place during the COVID-19 pandemic. We continue to adapt our ways of working to manage the risks as the pandemic continues. We gave the force more notice of the inspection than usual. And we carried out our case audits, interviews and focus groups remotely. We made our observations over the two-week period, but we limited the number of our inspectors in the suite at any one time.

We last inspected custody facilities in Hertfordshire in 2015. We found that of the 43 recommendations made during the 2015 inspection, the force has fully or partially achieved 33.

To help the force improve, we have made two recommendations to it (and the police and crime commissioner). These address our main causes of concern. We have also highlighted a further 13 areas for improvement. These are set out in section 6 of this report.

Leadership, accountability and partnerships

Hertfordshire Constabulary has a clear governance structure for the safe and respectful provision of its custody services. Operational and strategic meetings appropriately oversee and manage custody services. The force's custody provision has improved since our last inspection, although two areas need urgent attention.

There are two custody suites, based at Hatfield and Stevenage. There are usually enough custody staff available, but they are over-stretched at times.

The force collects and monitors different information to show how well custody services perform. There are a few gaps and inaccuracies, but the range of information collected is more extensive than we usually see. The force makes good use of some of this performance information to improve services, but this isn't consistent. Some areas that need attention haven't been addressed.

The governance and oversight of the use of force in custody isn't good enough. Much of the information to allow effective oversight is either missing or inaccurate, and there is little quality assurance of incidents. This means the force can't assure itself, the police and crime commissioner, or the public that the use of force in custody is always necessary and proportionate.

In our review of incidents involving the use of force, we found that not all of them were well managed. We have significant concerns that when force is used, it isn't always justified and proportionate. This hasn't improved since our last inspection and is now a cause of concern.

There is generally good attention to meeting the requirements of the Police and Criminal Evidence Act (PACE) 1984 and its codes of practice. The force has adopted the College of Policing's Authorised Professional Practice for detention and has its own policies. But these aren't always followed.

Recording on custody records isn't always good enough. Important information is sometimes missing. Quality assurance of custody services takes place regularly but it focuses on completion of tasks, rather than the quality of the information and the reasons for decisions.

The force has a good understanding of, and commitment to, meeting the public sector equality duty. It monitors some custody outcomes to make sure they are fair.

There is a clear priority to divert children and vulnerable adults away from custody. The force works well with its partners to achieve this. There is a focus on prevention activities, and the force has diversion schemes to keep children and vulnerable people out of custody and prevent offending. There are effective arrangements with mental health partners to meet the needs of those with mental ill health.

Pre-custody: first point of contact

Frontline officers have a good understanding of what makes a person vulnerable. They take account of this when deciding whether arrest is the appropriate course of action. They only take children to custody as a last resort. When possible, they find alternative solutions. The force's children and young persons' team gives some good support to officers who are dealing with children.

Support for officers dealing with incidents involving people with mental ill health is good. Advice and help from the street triage service helps them decide whether a person should be detained under section 136 of the Mental Health Act 1983 and taken to a health-based place of safety, or if there are alternative health solutions.

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

Custody staff interact well with detainees. They are patient and reassuring. Generally, detainees have their individual and diverse needs met well. However, there isn't always enough privacy for detainees when they are booked into custody. Nor is enough attention given to maintaining detainee dignity, especially when clothing is removed.

The approach to identifying detainee risk is generally good. Observation levels are generally commensurate with presenting risks. Rousal checks on detainees under the influence of drugs or alcohol are carried out well. But the management of risk needs some improvement. The force isn't consistently meeting the requirements of Authorised Professional Practice guidance in several areas of risk management.

We are concerned that anti-rip clothing continues to be used frequently, and often without adequate reason. We found occasions when it was a disproportionate response to managing risk and, in our view, its use wasn't justified. Other ways of managing the risks could have been used. We raised this in our previous inspection but have found no improvement. It is now a cause of concern.

Custody and detention officers generally book detainees into custody promptly, and appropriately authorise detention. They give detainees good and detailed explanations about their rights and entitlements. But cases aren't always dealt with as quickly as they could be, leading to detainees possibly spending longer than necessary in custody.

Reviews of detention are usually carried out well but aspects of them don't consistently meet the requirements of PACE Code C 2019 and they aren't always in the best interests of the detainee. Custody officers give good explanations of the conditions of release to detainees who are released on bail or under investigation. Those wishing to make a complaint while in custody can do so before they are released.

In the custody cell: safeguarding and healthcare

General conditions in the custody suites are good. Cells are reasonably well maintained and have some natural light and little graffiti. But some of the cells are only superficially clean.

There are potential ligature points in both suites, mainly due to the design of intercoms and vents. We gave a comprehensive illustrative report, detailing these and the general condition of the suites, to the force during this inspection.

Detainees are generally well looked after. Those we spoke to were positive about their care in custody. Food and drinks are provided regularly, and detainees who are attending court in the morning are generally offered a shower. Reading and distraction activities are also available.

Custody staff have a good awareness and understanding of the need to safeguard children and vulnerable adults. Girls are assigned a female staff member to look after their welfare. Custody officers generally request appropriate adults promptly so that children and vulnerable adults have support as soon as possible. But provision isn't always good enough and some detainees wait a long time before an appropriate adult arrives.

There is some good care shown to children in custody. Staff try to mitigate the effect of the custody environment on them, and the force aims to keep children in custody for as short a time as possible and to avoid overnight detention. However, some children aren't dealt with quickly enough. And although few children are charged and refused

bail, when they are, they are rarely moved to accommodation arranged through the local authority, as they should be.

Health services have changed completely since our last inspection and now meet the health and substance misuse needs of detainees. The force and its healthcare provider, Castle Rock Group, work well together, and contract management is exemplary. The patients we spoke with appreciated the care given by the healthcare staff.

Drug and alcohol workers from the charity Change Grow Live work in the custody suites to meet the needs of detainees with substance or alcohol misuse problems. They offer assessments and access to treatment provided by community Change Grow Live drugs services.

Detainees with mental ill health are well supported by liaison and diversion workers, who are based in the custody suites, and mental health professionals providing the street triage scheme. Detainees requiring a Mental Health Act assessment in custody are detained under section 136 of the Mental Health Act 1983 and taken to a health-based place of safety. This approach has been agreed with mental health services. Although it needs further evaluation, it has significantly reduced the time that detainees spend in custody before they are moved out of custody.

Release and transfer from custody

The force has a clear focus on ensuring detainees are released safely. Custody officers plan release from detainees' arrival onwards, to make sure any risks are addressed or mitigated. There are arrangements to help detainees get home safely.

Custody staff generally engage well with detainees transferring to court or prison. Digital person escort records are completed by detention officers, but custody officers don't always check the content of these to make sure they include all relevant information.

Once detainees are remanded, they are generally presented before the first available court – either in person or at virtual court, which is an improvement since our last inspection. It means most are held for no longer than necessary.

Causes of concern and recommendations

Cause of concern: use of force

There is little governance and oversight over the use of force in custody. Hertfordshire Constabulary can't show that when force is used, it is necessary, justified and proportionate. Information to show how often and what force is used, and by which officers, is often missing or inaccurate. The force doesn't review use of force incidents to assess how well they are handled. When we reviewed incidents, we had concerns over whether the force used was necessary, justified, and proportionate in some cases, especially when clothing was forcibly removed from detainees or when incapacitant spray was used.

Recommendation

The force should scrutinise the use of force in custody to show that when force is used in custody, it is necessary and proportionate. This scrutiny should be based on accurate information and robust quality assurance, including viewing CCTV footage of incidents.

Cause of concern: use of anti-rip clothing

Anti-rip clothing continues to be used frequently. The reasons to justify its use are often not adequate. Sometimes its use appears punitive or pre-emptive and a disproportionate response to managing risks that could be mitigated better through higher levels of observation. Detainee dignity isn't always maintained, especially when clothing is removed by force.

Recommendation

Anti-rip clothing in custody should only be used as a last resort when it is a necessary and proportionate response to mitigate the risk to the detainee. The reasons and justification for its use should be clearly recorded and based on appropriate risk assessment. Detainee dignity should be maintained when clothing is removed.

Introduction

This report is one in a series of inspections of police custody carried out jointly by HM Inspectorate of Constabulary & Fire and Rescue Services (HMICFRS) and HM Inspectorate of Prisons (HMIP). These inspections are 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).

The joint HMICFRS/HMIP national rolling programme of unannounced police custody inspections, which began in 2008, makes sure that custody facilities in all 43 forces in England and Wales are inspected regularly.

OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of, and conditions for, detainees. HMIP and HMICFRS are two of several bodies making up the NPM in the UK.

Our inspections assess how well each police force fulfils its responsibilities when detaining people in police custody, and the outcomes for them. This includes how safely they are managed and how respectfully they are treated.

Our assessments are made against the criteria set out in our *Expectations for Police Custody*. These standards are underpinned by international human rights standards and are developed by the two inspectorates. We consult other expert bodies on them across the sector and they are regularly reviewed. This helps to achieve best custodial practice and drive improvement.

The expectations are grouped under five inspection areas:

- leadership, accountability and partnerships;
- pre-custody: first point of contact;
- in the custody suite: booking in, individual needs and legal rights;
- in the custody cell: safeguarding and health care; and
- release and transfer from custody.

The inspections also assess compliance with the Police and Criminal Evidence Act 1984 (PACE) codes of practice and the College of Policing's Authorised Professional Practice – Detention and Custody.

The methodology for carrying out the inspections is based on:

- a review of a force's strategies, policies and procedures;
- an analysis of force data;
- interviews and focus groups with staff;
- observations in suites, including discussions with detainees; and
- an examination of case records.

We also analyse a representative sample of custody records from all suites in the force area for the week before the inspection starts. For Hertfordshire Constabulary we analysed a sample of 111 records. The methodology for our inspection is set out in full at Appendix I.

Section 1. Leadership, accountability and partnerships

Expected outcomes

There is a strategic focus on custody, including arrangements for diverting the most vulnerable from custody. There are arrangements to ensure custody-specific policies and procedures protect the wellbeing of detainees.

Leadership

Hertfordshire Constabulary has a clear governance structure for the safe and respectful provision of its custody services. An assistant chief constable has strategic responsibility for the provision of custody services. The assistant chief constable is supported by a chief superintendent. A superintendent and chief inspector are responsible for the day-to-day management of custody.

Hertfordshire Constabulary is formally collaborating with Bedfordshire Police under section 22 of the Police Act 1996. This provides further oversight of both forces' custody services.

The force has meetings at operational and strategic levels to oversee and manage custody services.

- An organisational service review (OSR) meeting takes place monthly. This is chaired by the assistant chief constable and provides the main oversight and scrutiny of services.
- An organisation service delivery board (OSDB) considers any matters escalated by the OSR.
- A custody user group chaired by the chief superintendent meets monthly to oversee operational custody arrangements, including the provision of healthcare to detainees.
- A daily management meeting considers staffing and resourcing issues, as well as any emerging concerns such as cells being out of use.

Appropriate stakeholders are present at the meetings.

Custody provision has improved since our last inspection – especially the healthcare services. In our last inspection of Hertfordshire Constabulary, we made 43 recommendations. We found 33 of these have been fully or partially achieved. However, some important areas haven't improved.

The force has two custody suites: one at Hatfield and one at Stevenage.

There are 5 dedicated custody inspectors, 30 custody officers, and 55 detention officers. The force has set minimum staffing levels for each suite that it monitors, but some detention officer vacancies, together with sickness, make it difficult to consistently meet them. The force is recruiting detention officers to fill the vacant posts. It uses sergeants from local policing who are trained in custody to cover custody officer shortages.

We found that staff weren't always working in the most efficient way. The way tasks are allocated means some staff are busier than others. At times, they are over-stretched and struggle to cover all their duties, such as answering call bells promptly. They also can't always take refreshment breaks.

Training is comprehensive. There is an initial five-week training course for custody and detention officers. Before they are accredited for working in custody, custody officers have three weeks of classroom training followed by a two-week mentoring period. Detention officers have four weeks of classroom training, which includes personal safety training. Then they are mentored by other staff while working in custody, before being signed off to work on their own. The training content is wide-ranging and includes specific areas of vulnerability, such as neurodivergent needs.

Continual professional development training takes place on a ten-week cycle. All custody and detention officers receive one training day during this period. The training is given by the custody policy unit and covers a variety of topics, including any national or legal updates.

The force has adopted Authorised Professional Practice (APP) for detention. It also has its own policies. But we found the force didn't always follow the guidance, especially when managing detainee risk. For example, daily and weekly checks in the suites aren't consistently carried out and not all staff attend handovers.

The approach to recording and investigating adverse incidents in custody (any incident that, if allowed to continue to its conclusion, could have resulted in death or serious injury to any person) is well understood. Learning from adverse incidents is shared. There have been no deaths of people in police custody suites in Hertfordshire since our last inspection.

Area for improvement

The force should consistently follow APP guidance, and its own policies and guidance.

Accountability

The force collects and monitors different information to show how well custody services perform. Senior officers receive monthly performance reports that include information such as:

- the numbers of detainees entering custody, broken down by ethnicity, gender and age;
- waiting times for detainees to be booked into custody;
- how many detentions are refused;
- the timeliness of inspector reviews;
- complaints; and
- child detentions.

Summary information about the findings from the quality assurance of custody records is also presented.

There are a few gaps in the information collected. For example, the force can't break down overall detention times to show how long detainees spend in custody before and after they are charged. Nor does it record the number of people who attend for voluntary interviews. There are also some inaccuracies in the information collected, such as how long immigration detainees spend in custody after they have been served their immigration papers. But the range of information is better than we normally find in our other custody inspections.

Although the force gathers a lot of information, senior managers aren't always using this to make improvements. For example, they haven't assessed how overall detention times relate to how quickly cases are dealt with, or what proportion of cases the force finalises during the first period of detention. This would allow the force to assess whether it keeps detainees in custody for longer than necessary. Similarly, the information shows that daily safety checks in the custody suites aren't regularly carried out and haven't been for some time, but the force has taken little action to improve performance.

However, in other areas the force has acted to improve performance. For example, it recognises that appropriate adult (AA) support for children and vulnerable adults needs to be better. It has introduced improved monitoring of request and arrival times to help understand what needs to change and how it can do this.

There is generally good attention to meeting the requirements of the Police and Criminal Evidence Act 1984 (PACE) and its codes of practice. Custody officers only authorise detention if the PACE Code G necessity criteria are fully met. Detainees receive their rights and entitlements properly. But some aspects of reviews of detention don't meet the requirements of PACE Code C. For example, officers don't always inform detainees when a review has taken place while they were asleep, and detainees aren't always given the opportunity to make representations, as required by paragraphs 15.7 and 15.3 of PACE Code C.

The governance and oversight of the use of force in custody isn't good enough. The force can't assure itself, the police and crime commissioner, or the public that the

use of force in custody is always necessary and proportionate. This hasn't improved since our last inspection and is now a cause of concern.

There is little strategic or operational oversight of the use of force in custody, and most of the information needed to allow scrutiny is either missing or inaccurate. Use of force forms aren't always completed, so some incidents are missing from the use of force monitoring system and aren't always recorded on custody records.

There is little quality assurance of use of force incidents at operational level. The force views few incidents on CCTV to assess how well they are handled. In our own review of incidents, we had significant concerns over whether the use of force was always justified and proportionate, and over how incidents were managed. We referred four cases back to the force to review.

The quality of recording on custody records isn't always good enough. Some important decisions aren't properly recorded, and some entries are confusing. While we did see some very detailed entries on custody records, important information was sometimes missing, for example the justification for the removal of clothing, when cell call bells were muted, and when force or restraint was used. Some entries on detention logs aren't chronological, which makes it difficult to follow what has happened.

The use of some pre-populated texts in the Athena IT system, together with the actions recorded by staff, can lead to contradictory information being recorded.

There are some quality assurance arrangements. Custody records are regularly reviewed by custody inspectors. The 5 inspectors review 15 custody records every month. They choose a mixture of male and female detainees, those who are vulnerable, and children. They assess different areas including detainee welfare, how care needs are met, whether clothing is removed, and how promptly appropriate adults are called and arrive.

Every three months, the force works with Bedfordshire Police to review each other's records and provide some external scrutiny. There is also specific quality assurance for children held overnight. The custody policy team reviews the quality assurance findings and identifies any themes that can inform future training for custody and detention officers.

However, the quality assurance hasn't identified the concerns we found. It would benefit from having those carrying out the reviews assess the quality of information held on custody records, rather than focusing on the completion of tasks. For example, reviewing the reasons why some decisions, such as the removal of clothing, have been taken, and identifying where information might be missing. There has recently been some work to try and make the quality assurance system more fit for purpose, and so able to target different areas of concern on a month-by-month basis.

The force has a good understanding of, and commitment to, meeting the public sector equality duty. Custody staff have received training on the Equality Act 2010. The force has also held unconscious bias awareness sessions for staff.

There is a clear commitment to monitoring custody outcomes to make sure they are fair. Custody data is broken down by age, gender and ethnicity to assess any potential disproportionality against some important activities such as strip searches. However, because detainees aren't always asked to define their ethnicity, the data may not be accurate or complete. This potentially affects how the information is used and limits the effectiveness of the force's approach.

The force is open to external scrutiny. Independent custody visitors have good access to suites and conduct weekly visits. We met some independent custody visitors during our inspection, and they spoke positively about how custody operates.

We were told that custody staff are responsive to issues raised and that the force deals with concerns effectively. But we found that there was a continuing problem with not enough blankets being available to give to detainees, which suggests the force isn't acting on all of the feedback.

The police and crime commissioner has access to custody information and attends strategic meetings where custody and performance are discussed.

Areas for improvement

- The force should use its performance information better to improve its custody services. Gaps and inaccuracies in information should be addressed.
- Recording on custody records should be accurate and include all relevant information and the reasons for decisions made. Quality assurance should be strengthened to focus on the quality of services provided.

Strategic partnerships to divert people from custody

There is a clear priority to divert children and vulnerable adults away from custody. The force works well with its partners and other organisations to achieve this. There is a focus on prevention activities, and the force has diversion schemes to keep children and vulnerable people out of custody and prevent them from offending.

A multi-agency schools and gang team offers diversion opportunities for children. The team proactively screens arrest lists to identify children at risk from gang activities. The team then intervenes to try and divert these children away from these activities. The force's children and young persons' team also works with other organisations to offer interventions aimed at preventing children from offending and entering the criminal justice system.

The force works closely with The Prince's Trust to divert people into activities and help prevent offending. It offers access to Project Nova, which is a national scheme providing support for veterans. It also works with the local authority and the charity Change Grow Live to offer drug and alcohol schemes to prevent further offending.

The force works well with its mental health partners to offer alternatives to custody for those with mental ill health. The mental health triage scheme gives valuable support to people both inside and outside custody. It is more extensive than we usually see.

Section 2. Pre-custody: first point of contact

Expected outcomes

Police officers and staff actively consider alternatives to custody and in particular are alert to, identify and effectively respond to vulnerabilities that may increase the risk of harm. They divert away from custody vulnerable people whose detention may not be appropriate.

Assessment at first point of contact

Frontline officers have a good understanding of what makes a person vulnerable. They treat all children as vulnerable. They told us factors such as mental ill health or learning difficulties all contributed to a person's vulnerability but emphasised the importance of taking a case-by-case approach, so that they also considered individual circumstances and situations, including the person's safety. It is clear officers recognise the importance of vulnerability when deciding whether arrest is the appropriate course of action.

The force gives training on different aspects of vulnerability. Officers told us they had recently received training on autism, children and mental health. There is also information available on the force's intranet and its vulnerability protocol document. Not all of the officers we spoke to were aware of the information available to help them, but they said they felt confident in recognising when a person is vulnerable and how to take this into account.

Frontline officers said that information from call handlers in the force control room (where calls from members of the public are taken) was generally good. The call handlers give officers the information held on the force's IT system, including details of any previous investigations or safeguarding concerns.

Officers have information available on their mobile devices, but don't usually have time to access it. Instead, they request the call handlers, or sometimes their own supervisors, find out any additional information. They told us they were generally well enough informed to make arrest decisions or to find alternative ways to deal with people.

Children are only arrested and taken to custody as a last resort, after all other alternatives have been explored. Officers recognise that custody isn't an appropriate environment for children, and that custody officers will refuse detention unless the

need for it is robustly justified, particularly if it is late at night and might involve detaining a child overnight.

To avoid arresting children, officers consider arranging voluntary attendance interviews at a future date. They also consider taking children home and discussing the situation with parents or guardians. If a child can't immediately return to their home address, officers consider finding other family members who can care for them.

The force's children and young persons' team gives some good support to frontline officers dealing with incidents involving children. The team works with individual children to help them avoid entering the criminal justice system and to prevent further offending. It offers residential placement courses and mentoring schemes. It also manages and supervises community resolutions as an alternative solution to arresting a child. Frontline officers spoke positively about the team's work. They value the advice and help it offers when they are deciding how to deal with children.

The number of children entering custody over the past three years has decreased. But sometimes the seriousness of the offence or the need to keep the child safe means officers have no option other than to arrest. In the cases we examined, it was difficult to see how arrest could have been avoided.

Support for officers dealing with incidents involving people with mental ill health is good. The street triage service has dedicated cars with police officers and mental health professionals able to attend incidents, speak with those in mental health crisis and help officers decide what to do. This includes deciding whether the person should be detained under section 136 of the Mental Health Act 1983 and taken to a health-based place of safety, or whether alternative health solutions can be arranged. The service is available seven days a week from 8.00am to 4.00am. In the four hours where the service isn't available, officers can phone a mental health professional for advice.

Frontline officers spoke highly of the triage service and its value in helping them make appropriate decisions. In their view, it means less people are detained under section 136 because alternative options can be explored and arranged.

Frontline officers can take people who are in distress because of mental ill health, but who don't need to be detained under section 136, to the NightLight shelters that operate throughout Hertfordshire. These are run by the charity Mind, and are open Thursday to Monday. Mental health professionals are available to offer advice and help with, for example, housing. Printed cards about the shelters are available for officers to hand out to people who might need support. This may lead to them contacting the shelter rather than the police when they need help.

When people are detained under section 136, they should be transported by ambulance to the hospital or health-based place of safety. Officers told us that, in practice, long waits for ambulances often meant they asked for an inspector's authority to take the person in their police vehicle. They also told us of long waits with people at hospitals or the mental health-based place of safety before a Mental Health Act assessment took place. This isn't good use of police time and is a poor outcome for detainees.

Frontline officers don’t take those detained under section 136 to custody as a place of safety. However, if a person is suspected of committing an offence, they arrest them unless there are clear signs they are in mental health crisis. Any mental health needs are then addressed in custody by the liaison and diversion team or the street triage service. If it is decided that a Mental Health Act assessment is needed, the person is detained under section 136 in custody and taken to hospital or a health-based place of safety, in line with force policy. Any investigation is halted until the outcome of the assessment is known.

Frontline officers decide whether to use police cars or police vans to transport detainees to custody depending on their behaviour. If detainees are non-compliant, a van is used. Police vans are also used if a person has difficulties with mobility. In these cases, a wheelchair or other mobility aids are transported with them as needed.

Section 3. In the custody suite: booking in, individual needs and legal rights

Expected outcomes

Detainees receive respectful treatment in the custody suite and their individual needs are reflected in their care plan and risk assessment. Detainees are informed of their legal rights and can freely exercise these rights while in custody. All risks are identified at the earliest opportunity.

Respect

Custody staff engage well with detainees. They are generally patient and reassuring. The mural in the booking-in area at Stevenage makes the suite a more pleasant and less intimidating environment for detainees. Desks are a suitable height and there is enough space between them to allow some privacy when booking in.

But conversations can be overheard, and detainee privacy isn't always possible. The suites can be noisy, which further limits effective communication. Detainees are told they can speak to a member of staff in private, but there isn't a separate discreet booking-in area for dealing with sensitive matters.

Detainee dignity isn't always protected well enough. Detainee clothing is often removed. This is sometimes done by force, including cutting it off. When anti-rip clothing is given to detainees, they aren't generally encouraged to wear it, or given any help to put it on. This means some detainees are left naked in their cells. We saw some detainees walk around the suites, including to interview, in anti-rip clothing, which isn't adequate replacement clothing. Some detainees are left without footwear. These practices are disrespectful to detainees.

Staff tell detainees that CCTV operates in the suite, but signs promoting this aren't displayed prominently enough. Toilets are pixelated on CCTV monitors, and detainees are told this. The search areas can't be seen on CCTV, which protects detainee dignity. Some shower areas can be seen from corridors, but they are supervised sensitively to offer some privacy.

Area for improvement

The force should protect detainee dignity at all times. Clothing should be removed from detainees in a respectful manner and adequate replacement clothing and footwear should be provided. Detainees shouldn't be left naked in cells.

Meeting diverse and individual needs

Custody staff are alert to and generally meet individual and diverse needs.

With the exception of having an easy-to-access or adapted cell, the custody suites are equipped well enough for detainees with physical disabilities. Custody staff individualise the care they offer, and we found no unmet needs. Adjustments in the suites include:

- step-free exercise yards;
- step-free showers;
- an adapted toilet;
- access to a hearing loop;
- coloured bands on cell walls to help detainees with sight impairments;
- information available in Braille;
- easy-read information about legal rights and entitlements;
- thicker mattresses, to raise the height of cell benches for those who struggle with mobility; and
- ready access to a wheelchair.

We found awareness of neurodiversity was limited, despite staff having had training. Some custody staff couldn't explain well enough how the custody environment can affect detainees with neurodivergent needs, nor what actions they could take that might mitigate this. Their responses were generally restricted to saying they would request an AA.

The force generally meets the needs of women well. In most cases, female carers are allocated to be responsible for women's welfare. Generally, they visit the detainee to speak with them and identify any needs. Women are offered menstrual care products during booking in. A good range of feminine hygiene products is available, but disposal arrangements rely on custody staff taking used products away. This is unsatisfactory.

There is good use of private telephone interpreting services during booking in for detainees who speak little or no English. The use of telephone interpreting for other important custody processes is inconsistent, which potentially limits detainee understanding. Custody staff can access rights and entitlements leaflets in a range of languages. They give these to detainees as needed.

Custody staff have good awareness of the needs of transgender detainees. They described appropriately how they would treat them. But some custody records use incorrect pronouns, which don't reflect the detainees' gender identity. This is inaccurate and confusing, and potentially upsetting for detainees.

The provision for detainees wishing to observe their faith is reasonably good. Custody staff identify religious needs during booking in. A good range of religious books and items are available and stored respectfully. Ramadan took place during our inspection and, although the force hadn't circulated the information, custody staff had a reasonable awareness and met the needs of detainees observing Ramadan.

Risk assessments

The force's approach to identifying risk is generally good, but its management of risk needs some improvement. Detainees are usually booked in promptly but can wait for lengthy periods in holding rooms or in vehicles before their detention is authorised. There is little management of queues to triage risks or to prioritise children or vulnerable detainees, which doesn't follow APP guidance.

Initial risk assessments focus appropriately on identifying risks, vulnerability factors and welfare concerns. Custody and detention officers interact well with detainees to complete risk assessments. They ask relevant supplementary and probing questions when needed. They also cross-reference with the Police National Computer warning markers and previous custody records to help identify additional risks. Arresting and escorting officers are routinely asked if they have any relevant information to contribute.

When several custody officers are on duty, it is clear who has primary responsibility for each detainee. This is documented on records.

Custody officers set observation levels that are generally commensurate with presenting risks. Detainees under the influence of alcohol or drugs are on Level 2 rousal checks (as set out by APP guidance). They are roused by detention officers in the right way, but checks aren't always well recorded. Rousal checks are mostly carried out by the same staff each time, which is important in making sure staff can readily identify changes in a detainee's behaviour or condition.

Checks that don't involve rousing the detainee are often carried out solely by looking through the cell spyhole. This isn't an acceptable welfare check and doesn't follow APP guidance. However, most checks take place at the required frequency.

When custody officers identify a heightened level of risk, detainees are observed more closely at either Level 3 (constant observation by CCTV) or at Level 4 (physical supervision at close proximity). The officers responsible for the observations should be fully briefed by the custody officer on the risks the detainees pose. But we found the briefings didn't always take place, and the quality of them was inconsistent. Custody records don't always include details of the briefing, or the identity of the officers involved.

Officers responsible for close supervision duties aren't always properly focused. For example, we saw some officers using their mobile device when they should have been vigilant in supervising detainees. Custody staff should also continue to conduct welfare checks and carry out rousals, if needed, on detainees who are subject to Level 3 or Level 4 observations, but this doesn't always happen. These practices don't follow APP guidance.

As in our previous inspection, most custody staff continue to routinely remove any footwear or clothing with cords from detainees, rather than making an individualised risk assessment. This doesn't follow APP guidance. Staff don't always document when clothing has been removed, or record the justification for it.

Anti-rip clothing continues to be used too frequently and often without adequate rationale, a concern we raised in 2015. On occasion, the use of anti-rip clothing appears to be punitive or pre-emptive. Officers appear to use it as a first response, instead of considering other ways of managing the risks. In many cases the justification given for its use was only that the detainee hadn't answered the risk assessment questions, rather than because of specific concerns about risks posed. These practices are contrary to APP guidance.

Detainees who have their clothing removed are often placed on low-level observations, suggesting their risks aren't considered to be that significant. Even when detainees are under constant observation, their clothing is often still removed.

These practices are a disproportionate response to managing risk, and lead to poor outcomes for detainees, particularly when force is used to remove clothing. We found occasions where, in our view, the use of anti-rip clothing wasn't justified. The risks could have been better managed with higher levels of observation and by talking with detainees. This is a cause of concern that we expect the force to address immediately.

The content of handovers is properly focused. But there is still no collective handover between all the incoming and outgoing custody staff to make sure that all relevant information is passed on, and healthcare practitioners (HCPs) are rarely involved with handovers. These practices don't follow APP guidance. Positively, after the handover, custody officers visit and fully engage with all the detainees in their care.

Cell call bells are audible, and we found that they were generally responded to promptly via an intercom system. As at our last inspection, we saw cell call bells muted without the custody officer's authority, and without the justification for this documented in custody records. Cell call bell data supplied by the force shows that call bells aren't always answered promptly and are often muted for significant time periods. When we brought to this to its attention, the force acted promptly to investigate further.

Not all custody staff carry anti-ligature knives. This limits the ability of staff to respond if they enter a cell and find a detainee is using a ligature to self-harm, which compromises detainee safety.

The management and control of cell keys is poor. They are often handed to non-custody staff. This diminishes the control that custody staff should maintain over detainees and others in the suite.

Areas for improvement

The force should improve its approach to risk by making sure that:

- custody officers triage queues for booking in;
- checks on detainees aren't conducted through spyholes;
- Level 3 (constant observation via CCTV) and Level 4 (close proximity) watches are conducted and recorded in line with APP guidance;
- custody staff don't routinely remove cords and footwear from detainees without an individualised risk assessment;
- handovers between shifts are attended by all custody staff;
- cell call bells are answered promptly and aren't muted without proper authority, which is documented in custody record;
- all custody staff carry anti-ligature knives; and
- custody staff maintain control of cell keys.

Individual legal rights

Many detainees are booked into custody promptly, but some wait a long time. Information given to us by the force shows that in the year to 28 February 2022, detainees waited an average of 41 minutes between arriving at the custody suites and their detention being authorised. The reasons for any delays weren't always clearly recorded, but mainly occurred due to waiting for custody staff to become available when the suites were busy.

Custody officers appropriately authorise detention. Arresting officers give detailed circumstances and grounds for the arrest, and good explanations for its necessity, as required by PACE Code G. Custody officers refuse detention if the necessity for it can't be clearly shown.

The force uses voluntary attendance interviews as an alternative to custody. Voluntary attendance is where suspects involved in minor offences attend an interview at a police station by appointment, avoiding the need for arrest and subsequent detention. However, the force doesn't know how often it uses voluntary attendance, as it doesn't collect this information.

Some voluntary interviews take place in rooms in the custody suites. This exposes voluntary interviewees to the custody environment, which undermines voluntary attendance's purpose as a diversion from custody.

Investigations aren't always dealt with expeditiously, leading to some detainees potentially spending longer than necessary in custody. We found some detainees waited a long time before being interviewed, and it wasn't always clear why. In some cases we examined, it was several hours before an officer from the case investigation team was allocated to them. We were told the case investigation teams didn't always have enough officers to assign to cases promptly. There is generally little chasing by custody officers to try and get cases progressed more quickly.

Information given to us by the force shows that the number of immigration detainees entering custody has decreased over the past three years. In the year to 28 February 2022, immigration detainees spent an average of 19 hours and 56 minutes in custody. But this information isn't broken down to show the time spent in custody after authority to detain (IS91) papers are served. At this point, detainees should be collected by immigration services, leaving police custody as soon as possible.

Custody and detention officers give good and detailed explanations to detainees about their rights and entitlements. This includes their three main rights, which are to:

1. have someone informed of their arrest;
2. consult a solicitor and access free independent legal advice; and
3. consult the PACE codes of practice.

Officers also give good explanations of the other eight rights and entitlements. These include access to medical help; allowing legal representatives to see the records or documents about the reasons for detention; and the maximum period detainees can be detained for.

We saw officers routinely giving detainees a leaflet explaining these rights and entitlements. The leaflets also include other useful information. Officers also offered detainees the current PACE codes of practice to read. Easy-read versions of the rights and entitlements are readily available. They are given to children and vulnerable adults when needed.

There are posters advising detainees of their right to free legal advice displayed in the holding and booking-in areas, with text in different languages. But they aren't all prominently displayed. The force ordered extra posters during our inspections and told us they planned to put them up in places where detainees can easily see them.

There are enough interview and consultation rooms for detainees to consult their legal representatives in private. There are also rooms at both custody suites where detainees can speak to their legal representatives in private on the telephone.

None of the custody officers we spoke with were aware of the requirements of Annex M of PACE Code C (translation of important custody documents and records). Nor were they sure how to get translated detention documents and records for non-English-speaking detainees or those who have difficulty understanding English.

Samples of DNA obtained from detainees are kept in locked freezers and are regularly collected. This maintains the integrity of the samples and makes sure they aren't left for long periods of time in freezers.

Areas for improvement

- Detainees should be booked into custody and have their cases dealt with as quickly as possible, so they don't spend longer than necessary in custody.
- Detainees should be given documents about important custody processes in a language they can understand, as required by Annex M of PACE Code C (translation of important custody documents and records).

Reviews of detention

Reviews of detention are generally carried out well, but aren't always in the best interests of the detainee. Some aspects of the reviews don't always meet the requirements of PACE Code C.

The custody inspectors at each suite carry out most reviews of detention. We saw detainees treated courteously and reminded about their rights and entitlements well. The inspectors asked detainees about their welfare, including the provision of food, drinks and other care.

However, on a few occasions, continued detention was authorised without giving detainees the opportunity to make representations about this. In some instances, inspectors didn't tell detainees that their continued detention was being authorised. This doesn't meet the requirements of PACE Code C paragraph 15.3.

When detainees are asleep while reviews of detention are carried out, they aren't consistently reminded at the earliest opportunity that a review has taken place and told its outcome. In some cases, we found this wasn't done until the second review or until after the handover, when custody officers visited detainees. This doesn't meet the requirements of PACE Code C paragraph 15.7.

When reviews take place earlier than they are due, the reasons why this is in the best interests of the detainee aren't clearly explained on the custody record.

Despite the availability of live link video facilities, some PACE reviews are still being carried out by telephone. PACE Code C paragraph 15.9B states that telephone reviews aren't allowed if live link is available and practicable to use. We were told a lack of connectivity made it difficult to use live link, so the telephone was used instead. However, the reasons for live link not being practicable to use weren't recorded, as required.

Pre-populated entries on the force's IT system make the custody record confusing. It is difficult to assess whether reviews have been conducted properly and in the best interests of the detainees.

Area for improvement

The force should carry out reviews of detention in the best interests of the detainee and consistently follow all aspects of PACE Code C.

Access to swift justice

Access to swift justice needs to be better, especially for detainees released under investigation.

Our analysis of custody records showed 63 percent of cases were finalised during the first period of detention. The detainees in the other cases were bailed or released under investigation.

Bail is generally managed well. At the time of our inspection there were 1,091 people currently on pre-charge bail, awaiting the outcome of the investigation. Ninety of these were waiting for a Crown Prosecution Service charging decision.

However, cases where detainees are released under investigation aren't managed well. A high number of people are released under investigation, and many cases take too long to complete. It has taken some time for the force to address this, but arrangements are now in place to manage cases better and tackle the backlog.

When detainees are released on bail, custody officers clearly explain the consequences of breaching bail, and of breaching any of the conditions. When a suspect is released under investigation, custody officers also clearly explain the possible outcome of the investigation, which can include no further action, court summons or a voluntary interview. They are given a notice outlining the offences they may commit if they interfere with victims or witnesses during the investigation.

Complaints

Detainees can make complaints while in custody. Custody staff are clear on the procedure for taking a complaint from a detainee. The custody inspectors we spoke to said they take complaints from detainees and try to deal with them before the detainee is released.

Information on how to make a complaint can be found in the custody information leaflet, which is given to detainees during the booking-in process.

However, there were no prominently placed posters in the custody suites about how to make a complaint, and there was no information available about how to contact the Independent Office for Police Conduct (IOPC). During the inspection, the force told us it had ordered posters for display.

Section 4. In the custody cell, safeguarding and health care

Expected outcomes

Detainees are held in a safe and clean environment in which their safety is protected at all points during custody. Officers understand the obligations and duties arising from safeguarding (protection of children and adults at risk). Detainees have access to competent healthcare practitioners who meet their physical health, mental health and substance use needs in a timely way.

Physical environment is safe

The custody facilities in Hertfordshire comprise two full-time designated suites at Hatfield and Stevenage. While fairly modern, they lack some of the facilities we would expect to find in buildings of this age. For example, there are no adapted cells for detainees with limited mobility, no separate booking-in area, and no glass-fronted cell doors to aid those who experience claustrophobia. The back offices, which are used for both shift handovers and to conduct Level 3 CCTV monitoring, are too small.

General conditions throughout the custody estate are good, with cells reasonably well maintained. But some are only superficially clean – we saw debris lying on bench surfaces. There is no regular programme of deep cleaning.

There is some natural light in all cells, and little graffiti.

There are potential ligature points in both suites, mainly due to the design of intercoms and vents. We gave the force a comprehensive illustrative report, detailing these and the general condition of the suites, during this inspection.

Daily and weekly safety maintenance checks of the physical environment, including cells and communal areas, don't always take place. These are required by APP guidance. We were told that repairs are mostly completed quickly.

CCTV coverage in the custody suites is limited and of poor quality. Signs saying that CCTV is in operation aren't always prominently displayed, and there are none in any of the cells.

Most custody staff are aware of emergency evacuation procedures and there are enough handcuffs to evacuate cells if needed. But none of the staff we spoke to had taken part in a physical evacuation to make sure the procedures work in practice. There is some confusion about where detainees should be evacuated to. Force data

shows that not all the custody shift teams have taken part in an evacuation drill in the past year.

Areas for improvement

The force should:

- keep all cells clean to the required standard;
- address the safety issues involving potential ligature points and, where resources don't allow them to be dealt with immediately, manage the risks to make sure that custody provision is safe;
- make sure daily and weekly safety maintenance checks are completed according to APP guidance;
- improve the quality and coverage of CCTV in the suites, and prominently display notices advising CCTV is in operation; and
- brief and train all custody staff in the procedures to be followed in the event of a fire or other emergency requiring the custody suite to be evacuated, in line with APP guidance.

Safety: use of force

When force is used on detainees in custody, it isn't always proportionate to the risks or threats posed. While some incidents are managed well, others aren't. This sometimes leads to escalating the use of force. When clothing is forcibly removed, the necessity for this isn't always justified or clear.

Information about the use of force and the recording of it on custody records is generally poor, and Hertfordshire Constabulary doesn't know how often it is used in custody. This was also the case in our previous inspection. It is now a cause of concern.

We reviewed 25 cases of use of force on CCTV. In the cases we looked at, we saw examples of staff using good communication to de-escalate situations, avoiding using force. But where force was used, incidents weren't always managed well and they sometimes lacked supervision or oversight by the custody officer. While restraint techniques were often deployed correctly, this wasn't always the case. We saw cases where poor control led to incidents escalating, resulting in more force being used when it could potentially have been avoided.

Several of the cases involved the forcible removal of clothing from detainees. The detainees' clothing was replaced with anti-rip clothing. The justification for the removal of clothing wasn't always recorded, and in our view, it wasn't always justified – especially when the risks were already managed by constant watch of the detainee by officers. The removal of clothing resulted in uses of force that could potentially have been avoided. We also have concerns that officers don't always maintain the detainees' dignity well when removing the clothing.

In three cases, we saw incapacitant spray deployed in the custody suite. Data given to us by the force shows that incapacitant has been used 22 times over a recent

12-month period. This is more use than we would expect to see in a controlled custody environment. We have concerns that the use of incapacitant isn't always proportionate to the risks posed.

We referred four cases to the force for learning. Two cases involved the use of incapacitant; one case related to the length of time the detainee stayed in limb restraints and whether the force used was justified; and one case related to the necessity for the removal of the detainee's clothing and the length of time the detainee stayed in a spit hood.

Officers who use force on detainees in custody don't always submit individual use of force forms as required by the National Police Chiefs' Council's guidance. We asked for use of force forms for the incidents we examined during our case audits and viewed on CCTV, but not all of them could be provided. On some of the forms the quality of the information was poor.

The recording on some custody records of use of force incidents didn't always reflect what we saw happening on the CCTV footage. This poor standard of record-keeping means it isn't possible for Hertfordshire Constabulary to know what type of force is used in custody, and how often.

There is little quality assurance of the use of force incidents in custody. Supervisors don't routinely review incidents or view CCTV footage. There is no force policy or procedure requiring them to do so.

Handcuffs aren't always removed quickly enough from compliant detainees.
The reasons why handcuffs have been used aren't always recorded, and the time handcuffs are removed isn't recorded.

The strip searches we reviewed were generally recorded, justified, and carried out appropriately.

Not all custody and detention officers are up to date with their personal safety training. The force is planning to address this.

Area for improvement

Detainees should stay handcuffed for no longer than necessary, and the use and removal of handcuffs should be clearly recorded on the custody record.

Detainee care

Detainees are generally well looked after. Those we spoke to were positive about their care in custody.

Detainees are told about the range of available services and facilities during booking in. Custody officers visiting detainees after shift handovers, and inspectors conducting reviews of detention, are particularly proactive at reminding detainees what is available to them and providing it if requested. Offers of care and provision during other welfare visits are generally more limited.

The food preparation areas are clean and well equipped but the microwaves in both suites are dirty. The range of food and drinks available meets most dietary requirements. It includes microwaveable meals, cereal bars, fresh sandwiches, tea, coffee, squash and water. These are all offered and provided regularly. There are arrangements to buy provisions for detainees for whom custody food is unsuitable.

The water dispensed from sinks in cells isn't suitable for drinking but there aren't any signs to tell detainees this.

In-cell toilets are mostly clean and, unless there is a good reason not to, detainees are routinely given a small box of tissue paper. This is positive. But detainees aren't given soap or paper towels as a matter of course.

Showers are in good condition. A small supply of towels and toiletries is available. Detainees attending court in the morning are generally offered a shower and are given clean clothing if needed. Other than this, showers aren't widely offered.

Plenty of stocks of replacement clothing and footwear are available. They include jogging bottoms, jumpers, underwear, and sliders or flip flops. There is generally good attention to providing replacement footwear, but we saw detainees walking around in socks or bare feet.

Each cell has a mattress and pillow in good condition. Stocks of blankets were available during the inspection but, in some cases we examined, detainees were offered and given used blankets because clean ones weren't available. This practice is unhygienic and should stop.

Each suite has at least one large exercise yard where detainees can access fresh air. We saw some good use of the yards during our visits, particularly for detainees who struggled in confined spaces.

A good range of reading material is available, including free newspapers and books for children. There is little reading material in other languages other than a few books in Russian and Polish. This means not all detainee needs can be met.

Other distraction activities are readily available including pencils, puzzle books and stress balls. These were appreciated by detainees who were given them.

Visits don't generally take place, and the dedicated visitor rooms aren't prepared well enough to accept visitors.

Safeguarding

Custody staff have a good awareness and understanding of the need to safeguard children and vulnerable adults. They receive regular training on various vulnerability areas such as autism, mental health and 'the voice of the child'. This aids their understanding of, and approach to, detainees, especially children.

Investigating officers take primary responsibility for safeguarding vulnerable detainees. How this has been considered, and any referrals or actions taken, are specifically recorded on the custody record. Custody officers are expected to monitor this to make sure vulnerable adults and children are appropriately safeguarded.

HCPs assess the welfare of all children in custody. We found these assessments happened quickly in most cases and that they were well recorded. If any mental health concerns are identified, liaison and diversion practitioners also become involved.

Girls in custody are assigned a female staff member to offer support and to look after their welfare while in custody, as required by section 31 of the Children and Young Persons Act 1933. Girls are told about their assigned staff member and are offered the chance to speak with them privately. We saw this happening and we also found good examples of it in the custody records we examined. This is an improvement since our last inspection. Custody officers also consider assigning a named staff member to boys or vulnerable adults if it would be of benefit to them.

AA support for children and vulnerable adults isn't always good enough. Custody officers are responsible for arranging AAs to support vulnerable and child detainees. They told us they recognised the importance of asking for AAs early on in detention, especially for children. They generally request AAs as soon as possible, asking them to attend so that the detainees' rights and entitlements can be re-read, and support offered, at the earliest opportunity.

It is force policy that requests for AAs are made within an hour of the detainee arriving, and that the AA arrives within two hours of the request. We saw cases where the request and attendance were prompt, but others where detainees waited a long time before they received support.

In the first instance, family members are considered to support the detainee. Where this isn't possible, or the circumstances make it inappropriate, other arrangements are used. Hertfordshire County Council provides AAs for children between 8.00am and 11.00pm. The Appropriate Adult Service (TAAS) provides AAs outside these times. TAAS are also on call 24/7 to support vulnerable adults.

However, in practice AAs aren't always available to attend promptly or at night. This was a concern in our previous custody inspection and in our child protection inspections. AA provision has been affected by the pandemic, with fewer AAs available from the scheme – particularly those covering the Hatfield area. The force told us that TAAS was trying to recruit more AAs so that it could respond more quickly to requests.

The force recognises AA provision needs to improve. It has introduced child-specific risk assessment forms on custody records. These require custody staff to consider whether AAs have been contacted and asked to attend quickly to support the detainee. Custody officers are expected to record the request and arrival times for AAs, and the force is monitoring records to check this is happening. The force intends to use this information to better understand where the problems are and act to improve the process. We found good recording on some of the cases we looked at, but not on all of them.

Custody officers generally consider whether adult detainees are vulnerable and if they need an AA. Officers record their reasons for deciding whether or not to call an AA. Advice is available from HCPs and liaison and diversion (L&D) workers, and decisions are kept under review. We found cases where AAs had been appropriately called to support vulnerable adults.

During our inspection we saw custody officers giving AAs who were arriving in custody well-detailed verbal explanations of their role. However, written guidance wasn't given out.

Children are only accepted into custody when there are no other suitable alternatives. We saw detention refused when custody officers decided that the detention wasn't necessary.

The force aims to keep children in custody for as short a time as possible. It has some measures to try and achieve this. Force policy states custody staff should triage and prioritise children for booking in to custody, but we saw and were told by staff that this didn't routinely happen in practice. Custody officers regularly review the necessity for detaining a child, and it is discussed at shift handovers. This shows a good focus on children.

Detention times for children are shorter than those for adult detainees, but not all child cases we looked at were progressed well. We saw one girl wait 12 hours for an interview, despite having an AA present from early in detention. It wasn't clear why she had to wait so long.

There is some good care shown to children in custody. The force emphasises the importance of the 'voice of the child' when dealing with children, and it reflects this in its practices. Although children are usually placed in cells, custody staff consider this action carefully. They take noise levels and the behaviour and presence of other detainees into account when deciding which cell to use. They also record the reasons for their decision.

We didn't see any children held outside cells. The force told us this was difficult to do due to the design of the suite and the staffing levels, but custody staff do try and minimise the effect of the custody environment on children.

The force has various distraction items to help children and vulnerable detainees during their time in custody, including puzzles and foam footballs. Custody staff regularly offer and provide these to detainees. They also take account of any welfare needs that they identify during their ongoing 'voice of the child' considerations. Children are routinely given the easy-read rights and entitlement document, which isn't something we always see.

Outcomes for children who are charged and refused bail are mixed. The local authority has a statutory responsibility to arrange accommodation so that they can be moved out of custody, but few of these children are moved.

There is a lack of available secure accommodation within the force area. Of the 18 cases where children were charged and refused bail during the 12 months prior to our inspection, 13 required secure accommodation, but only 1 was moved. Four children required appropriate (non-secure) accommodation; two of them were moved out of custody. The force contributes funding to a non-secure bed within the force area.

Juvenile detention certificates are completed by custody staff when accommodation can't be arranged. However, the quality of these certificates is mixed. We saw limited and contradictory information recorded about the efforts to obtain a move

from custody. There was also little recording of any difficulties being escalated to custody or force managers.

There is some good monitoring of children in custody. There are several performance meetings at both operational and strategic levels that assess outcomes for children in custody. Children are included in inspector dip sampling – the force's quality assurance of a selection of custody records – and the custody policy team reviews cases monthly where children are detained overnight. Any child held overnight is also discussed at the force's daily management meeting.

A separate partnership forum with the local authority also considers children and AA provision. Collectively, this approach provides a good level of oversight and reflects an increased focus on children in custody.

Areas for improvement

- Appropriate adults should always be available to support vulnerable adults and children, including at night.
- The force and the Office of the Police and Crime Commissioner should continue to work with the local authority to improve the provision of alternative accommodation for children who are charged and refused bail, particularly for secure beds.

Governance of health care

Hertfordshire Constabulary commissions health services from Castle Rock Group Healthcare (CRG). Contract management is exemplary. Strategic development and oversight of health services are provided through effective governance processes, including performance and risk meetings. There is a well-established working relationship.

Health services have changed completely since our last inspection. They now meet the detainees' health and substance misuse needs. The patients we spoke with appreciated the care given by CRG staff.

CRG provides suitably registered, trained and supervised nursing and paramedic healthcare practitioners (HCPs) who are based in the custody suites 24 hours a day. A forensic medical examiner is available by telephone, or to visit as required.

HCPs are up to date with their mandatory training, including immediate life support.

Recruitment is still difficult for CRG services throughout Hertfordshire and in the two neighbouring force areas of Bedfordshire and Cambridgeshire. At the time of this inspection, CRG had appointed five new HCPs, but their start dates were delayed due to slow police vetting procedures. Further recruitment activity is in hand. A pilot scheme is planned to improve contact with HCPs when not on site, to arrange medicine for detainees (telemedicine). This will bring services in line with community health practices.

Oversight of services is very good. There are regular audits of emergency equipment and infection control compliance. There is robust assurance of medicine use and stock control.

Each custody suite has a medical room that is solely used by HCPs. The rooms are cleaned per the daily schedule and are 98 percent compliant with infection control compliance standards. Both rooms require some decoration. They have essential equipment, and both sites have strategically placed police automated external defibrillators. All medical equipment is subject to regular checking to make sure it is ready for use.

Neither Hatfield nor Stevenage custody suites have a room reserved for forensic sampling, although consideration is being given to creating one. The current rooms in which forensic sampling takes place are cleaned extensively before use.

Patient clinical records are now electronic and confidential. Interpreting services are available and used when needed. HCPs provide evidence-based assessments and treatments consistent with national guidance, which they can easily access on their computers.

The medical complaints system is confidential and well advertised. Any learning from adverse events and complaints is circulated to staff throughout the three forces' areas. For example, issues of safeguarding in one force area led to a new initiative to remind custody staff and HCPs about the necessity of considering children's safeguarding needs in all three force areas. Complaints are minimal and CRG usually answers these promptly.

CRG maintains an electronic corporate risk register, which identifies clinical and service risks, and details of any action taken to solve problems. Serious and untoward incidents don't often happen. Learning is shared weekly and quarterly throughout the services.

Patient care

Access to HCPs for detainees is now very good. Custody officers appropriately refer detainees for consultation with HCPs. HCPs proactively scan the force's IT system to identify any detainees who may have signs of unknown or undeclared illness, then visit them to discuss these. This reduces unanticipated risks to vulnerable detainees in particular. HCPs show good knowledge of detainees' medical needs.

CRG sometimes doesn't meet the target response times for its services. This is due to HCP shortages. At these times custody staff use the forensic medical examiner telephone advice service, but they find the lack of direct access to an HCP frustrating. Managers discuss missed targets in monthly contract meetings. Financial penalties can be applied under the contract, but the force adopts a sensible and pragmatic approach.

We saw professional, compassionate and good-natured interactions between patients and HCPs. We also saw the safe administration of medicines to patients in custody cells. After interactions with detainees, HCPs make appropriate entries into

clinical records and in the custody record, so that custody staff are aware of all HCP contact with detainees.

Medicine stock management and record keeping are very good. CRG has up-to-date patient group directions that help HCPs to administer timely medicines, such as symptomatic relief for those withdrawing from alcohol or drugs, as clinically indicated.

Nicotine-replacement therapy is available from custody officers, and HCPs monitor how often it is used. Custody staff administer paracetamol following remote prescribing by a forensic medical examiner. This allows prompt pain relief for detainees.

Detainees' own medicines are securely stored and can continue in custody, subject to validation with dispensing chemists. However, the continuation of opiate-substitution therapy isn't consistent as the policy on its use is interpreted in different ways by individual HCPs. During our inspection, the CRG manager started an investigation into why this was happening.

Substance misuse

Hertfordshire County Council commissions Change Grow Live (CGL) to provide drug and alcohol workers in custody suites and courts. The working relationship between Hertfordshire County Council and the force is strong and effective. Custody officers appreciate the support offered by CGL.

The availability of CGL workers is better than at our previous inspections: they are now based in the custody suites from 8.00am to 5.00pm on weekdays, with additional hours used flexibly at times of peak demand including Saturdays. CGL workers are well trained and supervised.

CGL workers receive referrals from custody officers or HCPs, and workers visit cells and scan the records of those entering custody to see if anyone might benefit from their services. Many clients are regular detainees with complex and chronic needs, including dual diagnosis of mental disorder and substance misuse. CGL works closely with HCPs and the mental health team to co-ordinate support for these individuals.

Clients of CGL are offered assessment in custody and participation in treatment provided by community CGL drugs services. Children are signposted to CGL's under-18s services.

CGL workers contribute to the drug interventions programme's 'test on arrest' diversion plan. Outside CGL's working hours, custody officers can arrange CGL appointments so the drug intervention programme's treatment option isn't delayed.

CGL provides a wide range of appropriate treatments in the community, which are suitable to the needs of clients and in line with national guidance. It also offers naloxone training and supplies (to counteract the effects of opiate overdose), a needle exchange and harm-minimisation services.

Mental health

Hertfordshire Partnership University NHS Foundation Trust (the Trust) provides mental health services in the custody suites. The way the force, the Trust and other partners work together is sophisticated, and is underpinned by jointly agreed pathways of care.

The Trust's teams consist of L&D mental health practitioners (MHPs) based in the custody suites and courts. MHPs providing the street triage scheme are based in the force communication room and work in police triage cars. The MHPs are suitably registered, trained and supervised.

Access to mental health services has also completely changed since our last visit. The L&D team is available in custody suites from 8.00am to 8.00pm each day. MHPs triage detainees who are entering custody. They also respond to referrals from custody staff, HCPs and CGL. Hatfield is the busier suite, with more than half of all the patients seen.

As part of a comprehensive multi-agency agreement, the Trust gives support to detainees at courts and virtual courts, to detainees undergoing mental health and social care assessments, and to those engaging in treatment. The Trust also offers advice on diversion from custody for detainees, and signposts children to CAMHS, the NHS's child and adolescent mental health services.

From 8.00am to 4.00am MHPs in the street triage service are available to advise frontline police officers about mental health issues. From 8.00pm they advise and help custody officers, visit custody suites to see detainees and inform police decision-making. The force has access to out-of-hours advice from Trust community services. It can also refer to the local authority emergency duty team, but this is rarely needed.

The multi-agency agreement promotes the use of section 136 of the Mental Health Act 1983 by front line and custody officers to divert people in need to a health-based place of safety. In the year to the end of February 2022, section 136 had been used 237 times in custody to transfer people in mental health crisis out of custody to a health-based place of safety, rather than wait for a section 2 Mental Health Act assessment. HCPs monitor the health of those waiting to transfer under section 136 every 30 minutes. This is a safe way for them to identify risks associated with deteriorating mental health problems.

In 6 of the cases we examined, the average time spent in custody for those detained under section 136 was 8 to 9 hours, with the amount of time ranging from 3 to 12 hours. This reflects the views of CRG, custody, local authority and Trust staff that the use of section 136 in custody leads to detainees being quickly relocated to health-based places of safety. This is a significant reduction in the time detainees in mental health crisis spend in custody. By contrast, using section 2 of the Mental Health Act 1983 to move patients to a place of safety usually takes longer than 24 hours.

The commitment by the force and its partner organisations to using section 136 to relocate custody detainees to hospital-based places of safety as a matter of policy

isn’t something we have seen in other inspections. Elsewhere, we more often see section 136 resorted to because the detainee has spent 24 hours in custody waiting for a section 2 Mental Health Act assessment and, under PACE, can’t be held longer. Hertfordshire Constabulary’s use of section 136 may constitute a good way of working and get better outcomes for detainees.

However, the force needs to gather more data about its use of section 136. This data should include what happens as a result of any Mental Health Act assessments, including the proportion of detainees who return to custody or have their investigation continued because they haven’t been further detained in a mental health facility. The force should also assess whether a person detained under section 136 in custody could have been diverted to a health-based place of safety without having to enter custody.

Section 5. Release and transfer from custody

Expected outcomes

Pre-release risk assessments reflect all risks identified during the detainee's stay in custody. Detainees are offered and provided with advice, information and onward referral to other agencies as necessary to support their safety and wellbeing on release. Detainees appear promptly at court in person or by video.

Pre-release risk assessment

The force has a clear focus on ensuring detainees are released safely. We saw some good care and attention given to detainees on release.

There is an appropriate focus on release planning from arrival and throughout detention. Custody officers consider initial risk assessments, care plans and behaviour in custody, to make sure any risks identified are addressed or mitigated before detainees are released. If officers identify any concerns, they refer to the L&D service or an HCP to conduct a 'fitness to release' assessment. This is to make sure that detainees' needs are assessed and met where possible before release. Where necessary, other relevant organisations are also involved to support the release.

However, we found some custody records didn't include enough detail. For example, there is often no mention of how a detainee is getting home after release.

Detainees who don't have the means to get home safely can make telephone calls to arrange transport. Officers can also give them travel warrants, which can be exchanged for travel on trains. Police officers take children and vulnerable adults home if suitable alternative arrangements can't be made.

Leaflets containing information about national and local support organisations are available, and are given to all detainees on release. However, they aren't always given to those transferring to court. Leaflets are only available in English.

None of the custody officers we spoke to were aware of the enhanced safeguarding arrangements for those arrested under suspicion of committing serious sexual offences. But they were aware of a specialist support leaflet available to give to detainees in these cases.

Detention officers complete digital person escort records (dPERs) and book transport for detainees who are attending court or who have been recalled to prison.

Most custody officers interact well with detainees who are being transferred to court or prison, but they don't always check the content of the dPERs before signing them off at the time of transfer. The dPERs we reviewed didn't include all relevant information.

Area for improvement

Custody officers, in line with APP guidance, should make sure that they record all relevant information in the digital person escort record to ensure the safe transfer of a detainee.

Courts

Once detainees are remanded, they are generally presented before the first available court. Working practices have improved since our last inspection and mean most detainees are held for no longer than necessary.

Video remand hearings, which use video and digital technology, allow some detainees in police custody to appear in court during the week (Monday to Friday) via a virtual link. We were told that any child or vulnerable adult due to appear at court would be transferred to court custody to allow them to appear in person, but the eligibility criteria for other detainees to attend video remand hearings wasn't clear. We were told it was mainly influenced by how many detainees needed to appear at court on a given day, due to the local magistrates' courts having limited cell capacity at their locations.

Detainees remanded for court are generally collected promptly in the morning or appear promptly via the virtual link. Those arrested on warrant during the day aren't accepted directly at the court and are booked into police custody. Staff told us that there is some flexibility with the court, which often accepts detainees later in the afternoon. We saw this happen. It was a good outcome for the detainees involved, as it minimised their time in police custody.

A few detainees who are remanded or receive custodial sentences after a video remand hearing are kept in police custody longer than necessary – sometimes overnight. This is a poor outcome for them as it deprives them of their additional rights as a prisoner (prisoners have more rights and entitlements than detainees). Although this is out of the control of Hertfordshire Constabulary, the force is closely monitoring this situation.

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

Causes of concern and recommendations

Cause of concern: use of force

There is little governance and oversight over the use of force in custody. Hertfordshire Constabulary can't show that when force is used, it is necessary, justified and proportionate. Information to show how often and what force is used, and by which officers, is often missing or inaccurate. The force doesn't review use of force incidents to assess how well they are handled. When we reviewed incidents, we had concerns over whether the force used was necessary, justified, and proportionate in some cases, especially when clothing was forcibly removed from detainees or when incapacitant spray was used.

Recommendation

The force should scrutinise the use of force in custody to show that when force is used in custody, it is necessary and proportionate. This scrutiny should be based on accurate information and robust quality assurance, including viewing CCTV footage of incidents.

Cause of concern: use of anti-rip clothing

Anti-rip clothing continues to be used frequently. The reasons to justify its use are often not adequate. Sometimes its use appears punitive or pre-emptive and a disproportionate response to managing risks that could be mitigated better through higher levels of observation. Detainee dignity isn't always maintained, especially when clothing is removed by force.

Recommendation

Anti-rip clothing in custody should only be used as a last resort when it is a necessary and proportionate response to mitigate the risk to the detainee. The reasons and justification for its use should be clearly recorded and based on appropriate risk assessment. Detainee dignity should be maintained when clothing is removed.

Areas for improvement

Leadership, accountability and partnerships

- The force should consistently follow APP guidance, and its own policies and guidance.
- The force should use its performance information better to improve its custody services. Gaps and inaccuracies in information should be addressed.
- Recording on custody records should be accurate and include all relevant information and the reasons for decisions made. Quality assurance should be strengthened to focus on the quality of services provided.

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

- The force should protect detainee dignity at all times. Clothing should be removed from detainees in a respectful manner and adequate replacement clothing and footwear should be provided. Detainees shouldn't be left naked in cells.
- The force should improve its approach to risk by making sure that:
  - custody officers triage queues for booking in;
  - checks on detainees aren't conducted through spyholes;
  - Level 3 (constant observation via CCTV) and Level 4 (close proximity) watches are conducted and recorded in line with APP guidance;
  - custody staff don't routinely remove cords and footwear from detainees without an individualised risk assessment;
  - handovers between shifts are attended by all custody staff;
  - cell call bells are answered promptly and aren't muted without proper authority, which is documented in custody record;
  - all custody staff carry anti-ligature knives; and
  - custody staff maintain control of cell keys.
- Detainees should be booked into custody and have their cases dealt with as quickly as possible, so they don't spend longer than necessary in custody.
- Detainees should be given documents about important custody processes in a language they can understand, as required by Annex M of PACE Code C (translation of important custody documents and records).
- The force should carry out reviews of detention in the best interests of the detainee and consistently follow all aspects of PACE Code C.

In the custody cell, safeguarding and health care

- The force should:
  - keep all cells clean to the required standard;
  - address the safety issues involving potential ligature points and, where resources don't allow them to be dealt with immediately, manage the risks to make sure that custody provision is safe;
  - make sure daily and weekly safety maintenance checks are completed according to APP guidance;
  - improve the quality and coverage of CCTV in the suites, and prominently display notices advising CCTV is in operation; and
  - brief and train all custody staff in the procedures to be followed in the event of a fire or other emergency requiring the custody suite to be evacuated, in line with APP guidance.
- Detainees should stay handcuffed for no longer than necessary, and the use and removal of handcuffs should be clearly recorded on the custody record.
- Appropriate adults should always be available to support vulnerable adults and children, including at night.
- The force and the Office of the Police and Crime Commissioner should continue to work with the local authority to improve the provision of alternative accommodation for children who are charged and refused bail, particularly for secure beds.

Release and transfer from custody

Custody officers, in line with APP guidance, should make sure that they record all relevant information in the digital person escort record to ensure the safe transfer of a detainee.

Section 7. Appendices

Appendix I: Methodology

Police custody inspections focus on the experience of, and outcomes for, detainees from their first point of contact with the police and through their time in custody to their release. Our inspections are unannounced, and we visit the force over two weeks. Our methodology includes the following elements, which inform our assessments against the criteria set out in our *Expectations for Police Custody*.

Document review

Forces are asked to provide various important documents for us to review. These include:

- the custody policy and/or any supporting policies, such as the use of force;
- health provision policies;
- joint protocols with local authorities;
- staff training information, including officer safety training;
- minutes of any strategic and operational meetings for custody;
- partnership meeting minutes;
- equality action plans;
- complaints relating to custody in the six months before the inspection; and
- performance management information.

We also request important documents, including performance data, from commissioners and providers of health services in the custody suites and providers of in-reach health services in custody suites, such as crisis mental health and substance misuse services.

Data review

Forces are asked to complete a data collection template based on police custody data for the previous 36 months. The template requests a range of information, including:

- custody population and throughput;
- the number of voluntary attendees;
- the average time in detention;
- children; and
- detainees with mental health problems.

This information is analysed and used to provide background information and to help assess how well the force performs against some main areas of activity.

Custody record analysis

An analysis of custody records is carried out on a representative sample of all records opened in the week preceding the inspection in all the suites in the force area. Records analysed are chosen at random. A government statistical formula with a 95 percent confidence interval and a sampling error of 7 percent is used to calculate the sample size. This makes sure that our records analysis reflects the throughput of the force's custody suites in that week. The analysis focuses on the legal rights and treatment and conditions of the detainee. Only statistically significant comparisons between groups or with other forces are included in the report.

A statistically significant difference between two samples is one that is unlikely to have arisen by chance alone and can be assumed to represent a real difference between the two populations. To adjust p-values for multiple testing, $p<0.01$ was considered statistically significant for all comparisons. This means there is only a one percent likelihood that the difference is due to chance.

Case audits

We audit around 40 case records in detail (the number may increase depending on the size and throughput of the force inspected). We do this to assess how well the force manages vulnerable detainees and specific elements of the custody process. These include examining records for children, vulnerable people, individuals with mental health problems, and where force has been used on a detainee.

The audits examine a range of factors to assess how well detainees are treated and cared for in custody. Audits examine, for example, the quality of risk assessments, whether observation levels are met, the quality and timing of Police and Criminal Evidence Act (PACE) reviews, whether children and vulnerable adults get support from appropriate adults when they need it, and whether detainees are released safely. We also assess whether force used against a detainee is proportionate and justified, and is properly recorded.

Observations in custody suites

Inspectors spend a significant amount of their time during the inspection in custody suites assessing their physical conditions, observing operational practices, and assessing how detainees are treated. We speak directly to operational custody officers and staff, and to detainees to hear their experience first-hand. We also speak to other non-custody police officers, solicitors, health professionals and other visitors to custody to get their views on how custody services operate. We examine custody records and other relevant documents held in the custody suite to assess how detainees are dealt with, and whether policies and procedures are followed.

Interviews with staff

During the inspection we interview officers from the force. These include:

- chief officers responsible for custody;
- custody inspectors; and
- officers with lead responsibility for areas such as mental health or equality and diversity.

We speak to people involved in commissioning and running health, substance misuse and mental health services in the suites and in relevant community services, such as local Mental Health Act section 136 suites. We also speak to the co-ordinator for the Independent Custody Visitor scheme for the force.

Focus groups

During the inspection we hold focus groups with frontline response officers and response sergeants. The information gathered informs our assessment of how well the force diverts vulnerable people and children from custody at the first point of contact.

Feedback to force

The inspection team provides an initial outline assessment to the force at the end of the inspection, to give it the opportunity to understand and address any concerns at the earliest opportunity. Then we publish our report within four months giving our detailed findings and recommendations for improvement. The force is expected to develop an action plan in response to our findings, and we make a further visit about one year after our inspection to assess progress against our recommendations.

Appendix II: Inspection team

- Norma Collicott: HMI Constabulary and Fire & Rescue Services inspection lead
- Patricia Nixon: HMI Constabulary and Fire & Rescue Services inspection officer
- Anthony Davies: HMI Constabulary and Fire & Rescue Services inspection officer
- Marc Callaghan: HMI Constabulary and Fire & Rescue Services inspection officer
- Ian Smith: HMI Constabulary and Fire & Rescue Services inspection officer
- Vijay Singh: HMI Constabulary and Fire & Rescue Services inspection officer
- Kellie Reeve: HMI Prisons team leader
- Fiona Shearlaw: HMI Prisons inspector
- Paul Tarbuck: HMI Prisons health & social care inspector
- Joanne White: CQC inspector
- Joe Simmonds: HMI Prisons researcher
- Helen Ranns: HMI Prisons researcher

June 2022 | © HMICFRS & HMIP 2022

www.justiceinspectorates.gov.uk/hmicfrs
www.justiceinspectorates.gov.uk/hmiprisons