Report on an inspection visit to police custody suites in Lincolnshire

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

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Fact page

Note: Data supplied by the force.

Force

Lincolnshire Police

Chief constable

Chris Haward

Police and crime commissioner

Marc Jones

Geographical area

Lincolnshire

Date of last police custody inspection

23–29 September 2015

Custody suites

- Boston: 14 cells
- Grantham: 14 cells
- Lincoln: 22 cells
- Skegness: 13 cells

Annual custody throughput

9,639 arrivals between January and December 2021

Custody staffing

- 1 chief inspector
- 2 custody inspectors
- 65 trained custody sergeants (19 required at any time to cover custody 24/7 – the remainder as support and contingency)
- 36 detention officers

Health service provider

Castle Rock Group (CRG)

Summary

This report describes our findings following an inspection of Lincolnshire Police custody facilities. The inspection was conducted jointly by HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) and HM Inspectorate of Prisons (HMIP) in May 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.

We last inspected custody facilities in Lincolnshire in 2015. We found that of the 43 recommendations made during the 2015 inspection, the force has fully or partially achieved 32.

To help the force improve, we have made two recommendations to it and (and the police and crime commissioner). These address our main causes of concern. We have also highlighted a further 15 areas for improvement. These are set out in section 6 of this report.

Leadership, accountability and partnerships

There are clear governance structures in Lincolnshire Police to oversee the safe and respectful provision of custody. Regional and local force meetings scrutinise different aspects of custody provision. The force has made good progress in some areas since our last inspection.

There are four custody suites in Lincolnshire, located at Boston, Grantham, Lincoln and Skegness. Three suites are old and don't always meet detainees' needs well enough. However, we found a strong culture of treating detainees well and with respect. This helps mitigate some of the practical difficulties created by the physical environment in providing a good level of care to detainees.

There were generally enough staff on each shift to manage custody safely. But meeting detainees' needs promptly when the suites are busy is a challenge.

The force has adopted authorised professional practice (APP) and has its own policies. But these aren't always followed, especially in relation to managing detainee risk. The force mainly meets the requirements of the Police and Criminal Evidence Act 1984 (PACE) and its codes of practice, other than for reviews of detention.

The force monitors a good range of performance information. There are some gaps, and some information is inaccurate. This prevents the force from effectively assessing some aspects of its performance, especially for how well it deals with detainees with acute mental health problems.

The force doesn't have effective oversight of the use of force in custody. Despite efforts to improve information about the use of force in custody, it is still not good enough. There is little quality assurance of use of force incidents. Our review of incidents showed they weren't always managed well and techniques weren't always used correctly. The force can't show that when force is used in custody, it is always necessary, justified and proportionate. This is a cause of concern.

The quality of recording on custody records is better than we usually see, although important information is sometimes missing. There are good quality assurance processes which scrutinise a wide range of custody activities.

The force has a good understanding of and commitment to meeting the public sector equality duty. It assesses disproportionality against some important activities such as strip searches.

There is a clear priority to divert children and vulnerable adults away from custody. The force works well with partner organisations to achieve this. There is good joint working to keep children out of custody and stop them from entering the criminal justice system. There is also work with mental health services to meet the needs of those with mental ill health, but outcomes for these individuals need to improve both in and out of custody.

Pre-custody: first point of contact

Frontline officers have a good understanding of how a person may be vulnerable. They take account of this when deciding whether to arrest them. Officers do their best to keep children out of custody and only use it as a last resort. However, the support for frontline officers dealing with incidents involving people with mental ill health isn't always good enough to help them decide the most appropriate action to take.

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

Custody staff mostly interact courteously with detainees and are patient and reassuring. Privacy is generally maintained for detainees. But detainee dignity isn't always protected – for example, when clothing is removed. There is good understanding of how to meet detainees' individual and diverse needs, but some improvements are needed to always achieve this.

The identification of detainee risk is generally good, but it isn't always managed well enough. Custody officers set detainee observation levels, and custody detention officers (CDOs) carry out checks well. However, as in our previous inspection, custody staff routinely remove clothing with cords or footwear from detainees and use anti-rip clothing often without adequate rationale. Shift handovers still don't include all the staff on duty and detainee risks aren't shared with all staff. This approach to managing risk is now a cause of concern.

Custody officers generally book detainees into custody promptly and appropriately authorise their detention. They clearly explain to detainees their rights and entitlements and provide them with written information. However, investigations aren't always carried out as quickly as they could be, with waits for solicitors, appropriate adults (AAs) and interpreters. Some detainees spend longer than necessary in custody.

Reviews of detention aren't always carried out well enough and aspects of them don't always meet the requirements of PACE Code C. Custody officers clearly explain what it means to detainees when they are released on bail or under investigation. Detainees can make a complaint in custody if they wish to do so.

In the custody cell, safeguarding and health

Overall, cleanliness throughout the custody suites is good, and they are well maintained. There are potential ligature points throughout the estate mainly due to the design of toilets, fit of doors and some loose hatches.

Detainees generally spoke positively about the care they received in custody, but some aspects of it could be better. They are told about the care provisions available and most are given a leaflet detailing these. Food and drinks are offered regularly, as are showers, but offers of exercise or reading/distraction material less so.

Custody and frontline officers have a strong awareness of their safeguarding responsibilities for children and vulnerable adults and make referrals as needed.

Custody staff try to get AAs as soon as possible, but provision isn't always good enough. Therefore, some children and vulnerable adults wait a long time before receiving support.

Custody staff engage with children well, but there are few arrangements to help mitigate the effects of detention on them. Some good use is made of bail and releasing children under investigation to try and reduce the time they spend in custody. However, we found some long detention times and some where cases could have been dealt with more quickly. Children charged and refused bail often aren't moved to alternative accommodation arranged through the local authority as they should be.

Healthcare in custody is provided by experienced and competent practitioners, and most detainees can see a healthcare practitioner (HCP) promptly. HCPs give care and support appropriate to detainees' needs, with kindness and compassion.

The liaison and diversion (L&D) service provides good support to vulnerable detainees and makes appropriate referrals for those who misuse alcohol and/or drugs.

However, the force doesn't know how well it deals with detainees with acute mental health problems. It gathers little information to show why, how and when they are transferred from custody or the outcomes achieved for them.

Release and transfer from custody

Custody officers engage well with detainees to make sure any risks are addressed or mitigated before detainees are released and that they can get home safely. However, for those transferring to court or recalled to prison, digital person escort records (dPERs) aren't always completed well. Custody officers also have little involvement with these detainees to make sure their risks are identified and mitigated.

Detainees remanded to court are generally collected promptly, and arrangements with the court work well.

Causes of concern and recommendations

Cause of concern: managing detainee risks

The force isn't managing detainee risks well enough. It hasn't addressed concerns from our previous inspection, it isn't consistently following APP guidance and it often takes a risk-averse approach. Our concerns are:

- Custody staff continue to remove clothing with cords and footwear without an individualised risk assessment.
- Anti-rip clothing continues to be used often and without adequate rationale. Clothing is sometimes removed by force and detainee dignity isn't always maintained.
- Not all the detainees' risks are shared with all the staff on duty because handovers continue to be conducted separately for custody officers and custody detention officers (CDOs).

Recommendation

Custody staff should only remove clothing with cords and footwear from detainees when justified by an individualised risk assessment. Anti-rip clothing should only be used as a last resort when it is a necessary, and proportionate response to mitigate the risk to detainee and their dignity should be maintained. The reasons for the removal of items of clothing or use of anti-rip clothing should be clearly recorded. Handovers should be conducted in a way that means all staff duty on duty are aware of all detainee risks.

Cause of concern: use of force

The force doesn't have effective oversight of the use of force in custody. While recognising the force's efforts to improve, it still doesn't have enough information to scrutinise when and how force is used. The details of incidents aren't always recorded, or recorded accurately enough, on custody records, and not all officers submit use of force forms. There is little quality assurance to assess how well incidents are managed. Our review of incidents showed that not all of them were managed well. This means that Lincolnshire Police can't show that when force is used in custody it is always necessary, justified and proportionate.

Recommendation

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

Introduction

This report is one in a series of inspections of police custody carried out jointly by HMICFRS and 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 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. HM Inspectorate of Prisons (HMIP) and CQC 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 promote improvements.

The expectations are grouped under five inspection areas:

- leadership, accountability and working with partners;
- pre-custody – first point of contact;
- in the custody suite – booking-in, individual needs and legal rights;
- in the custody cell: safeguarding and healthcare; and
- release and transfer from custody.

The inspections also assess compliance with the PACE 1984, its 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 Lincolnshire Police, we analysed a sample of 96 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

There are clear governance structures for custody services in Lincolnshire. There are both regional and local force arrangements to oversee the safe and respectful provision of custody.

Lincolnshire Police, along with Leicestershire, Nottinghamshire and Northamptonshire, is part of the East Midland Criminal Justice Service (EMCJS) – a collaboration under section 22 of the Police Act 1996. These joint arrangements scrutinise different aspects of custody provision across all the forces, including the identification and management of risks. Lincolnshire Police takes part in regular board meetings and uses information from these at its own governance meetings. The force has made good progress in some areas, for example in healthcare for detainees, since our last inspection.

At force level, the Lincolnshire Police assistant chief constable for crime and justice oversees custody, supported by a detective chief superintendent and a detective superintendent. A chief inspector has responsibility as the head of custody, with two custody inspectors, for the overall management of custody services.

Custody is represented at force meetings where governance and other matters are discussed. These include:

- the crime and command meeting, chaired by the detective chief superintendent, which considers any matters escalated from the custody chief inspector;
- the force health and safety meeting, which considers risks for custody;
- the force performance board meeting, chaired by the deputy chief constable, which considers any concerns about custody; and
- the monthly meeting, chaired by the chief inspector, which considers operational matters and monitors an action plan to address issues raised at regional meetings.

The contracts for the provision of CDOs and healthcare are appropriately monitored and well managed.

The head of custody and the two custody inspectors manage and support custody services in meeting detainees' needs. This includes providing guidance, sharing learning, and quality assurance of the service. Local policing teams are responsible for the line management of custody officers.

The force has 65 trained custody officers in the local policing teams with 19 officers required each day to cover the four custody suites in Boston, Grantham, Lincoln and Skegness. Some officers regularly work in custody, but others told us they hadn't done so for a few months. Officers are given training so they can remain competent, but we found different levels of experience and confidence.

CDOs are provided by Mitie. The contract changed in April 2022 and most staff transferred over. There are 36 CDOs supervised by 4 senior custody detention officers, which provides sufficient cover.

We found there were generally enough staff on each shift to manage custody safely. But when the suites are busy, it is difficult to meet detainees' needs promptly, and we saw some long waits for detainees to be booked in. There also weren't always enough female staff to meet the needs of women in custody, and staff sometimes didn't have time to take their meal breaks.

Initial training for both custody officers and CDOs is comprehensive. This is delivered by the in-force training team. Custody officer training is three weeks and is followed by a ten-day shadowing period. Officers complete a performance booklet, which is signed off by a mentor or more senior officer in custody. This is further reviewed and approved by custody managers.

CDO training is five weeks and is followed by a mentoring period. We were told that Mitie will provide CDO training in future as part of the recent change of contract. This potentially limits the input and influence the force will have on the training.

All staff are also given two days' refresher training each year.

The custody estate is dated, and some facilities don't meet detainees' needs. There has been little investment, other than in the Lincoln suite. This adversely affects detainee care and dignity. For example, some detainees have to ask to go to the toilet or for the cell toilet to be flushed.

We found a strong culture among those working in the custody suites of treating detainees well and showing them respect. Staff do their best to meet detainees' needs and achieve good outcomes for them. This helps mitigate some of the practical difficulties created by the physical environment.

The force has adopted APP guidance and has its own policies. However, these aren't always followed, especially when managing detainee risk. For example:

- handovers aren't completed with all staff present;
- not all staff routinely carry anti-ligature knives; and
- staff conducting level 3 (constant observation by CCTV) and level 4 (physical supervision at close proximity) observations aren't always properly briefed.

The force records adverse incidents appropriately. (An adverse incident means any incident which, if allowed to continue to its ultimate conclusion, could have resulted in death or serious injury to any person.) It shares learning from incidents with staff via a newsletter 'custody matters'. There have been no deaths in custody suites in Lincolnshire since our last inspection. In 2019, a death following custody was referred to the Independent Office for Police Conduct in line with reporting guidelines.

Area for improvement

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

Accountability

Performance information is monitored at the force's own local operations meeting and regionally at the EMCJS custody meeting. This allows the force to compare its performance with the other forces and more easily determine where it needs to improve.

A good range of information is available including:

- the number of detainees entering custody;
- waiting times for booking detainees into custody;
- the numbers released on bail and released under investigation (RUI);
- cases where detention is refused; and
- children entering custody.

However, there are some gaps and inaccuracies in the data. For example, the force doesn't know how long detainees wait for a mental health assessment in custody, how long immigration detainees spend in custody after an IS91 notice is served or how long children and vulnerable adults wait for an AA. Some data is inaccurate, including the numbers of detainees transferred from custody under section 136 of the Mental Health Act 1983 to a health-based setting. This prevents the force from effectively assessing some areas of performance.

PACE, its codes of practice and other legislation are generally followed but not always when reviews of detention are carried out. There is good attention to make sure that Code G criteria are met before detention is authorised, and detainees are given the rights and entitlements in line with Code C. But some aspects of reviews of detention don't meet the requirements of PACE Code C. For example, detainees aren't always informed that a review has taken place when they were asleep (15.7 Code C), and reviewing inspectors don't always record the reasons why a review is conducted by phone rather than in person (15.14 Code C).

The force doesn't have effective oversight of the use of force in custody. It is working hard to improve recording of the use of force in its custody suites so it has enough information to understand when, why and how it is used. It cross references incidents on the custody system (Niche) against those held on the use of force system. An inspector monitors this and reminds staff to complete use of force forms.

However, despite these efforts, we found that the justification for the use of force and the details of incidents weren't always recorded on the custody record, and not all staff are completing use of force forms as required. There is little quality assurance of incidents where force is used and no viewing of these on CCTV unless it is for an adverse incident or a complaint. Our own review of 15 cases showed incidents weren't always managed well and techniques weren't always used correctly. The lack of accurate information and quality assurance means the force can't show that when force is used in custody, it is always necessary, justified and proportionate. This is a cause of concern.

The quality of recording on custody records is better than we usually see, but some decisions aren't properly recorded. We saw some very detailed entries on custody records, particularly for rousal checks of detainees under the influence of alcohol or drugs, assessments by healthcare practitioners and the provision of food and showers. However, important information is sometimes missing, especially for the justification for the removal of clothing and the necessity for force or restraint.

There are good quality assurance processes to assess how well custody performs. The custody inspectors dip sample a selection of 40 records each month across the suites, with 20 different aspects of custody activities scrutinised. In addition, EMCJS conducts a regional audit, and there is an action plan to address any issues identified.

The force has a good understanding of, and commitment to, meeting the public sector equality duty. It has provided training and guidance for staff on the Equality Act 2010, so they understand their responsibilities. 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 disproportionality in some important activities such as strip searches. Disproportionality is monitored at a regional meeting across five forces chaired by the Lincolnshire ACC.

The force is open to external scrutiny, and independent custody visitors have good access to suites. Visits are conducted weekly, and custody staff address concerns raised. Themes from visits are discussed with the inspectors or chief inspector.

While there is no regular sharing of performance information, the police and crime commissioner (PCC) is involved in strategic meetings where custody is discussed. The PCC attends the strategic criminal justice board, which reviews some matters relevant to custody such as diversion from the criminal justice system and equality and diversity concerns.

Areas for improvement

The force should:

- improve the accuracy of its performance information and address any gaps so that it has a good understanding of how well it performs across all areas of custody; and
- make sure that important decisions about detainees are consistently recorded on the custody record.

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 partner organisations to achieve this. There is a strong commitment by the force and Lincolnshire County Council children's services to work together to keep children out of custody and stop them from entering the criminal justice system. Regular joint meetings and the joint diversionary panel support this commitment at an operational level.

The force works with mental health organisations to provide alternatives to custody for those with mental ill health, and there are some arrangements to support this. A mental health professional is available in the control room from 2 to 10pm daily. A triage car was previously available to attend incidents, but the mental health service can't currently staff this. Outcomes for people with mental ill health need to improve in and out of custody.

The L&D team provides support for detainees and diverts them to different support arrangements. This aims to reduce further offending and keep them out of custody.

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 how a person may be vulnerable. They said factors such as mental ill health, physical disabilities and age all contribute to vulnerability. All children are regarded as vulnerable because of their age. Officers also said they consider whether a person can look after themselves.

The force has a definition of vulnerability, but officers take a case-by-case approach. They use their own knowledge and experience, and advice from colleagues or supervisors, when making assessments. They take account of a person's vulnerability when deciding whether to arrest them or find an alternative way of dealing with an incident.

The force provides training on vulnerability as part of the induction for new officers. Later training is more limited, although there has been some recent training on mental health. However, officers can refer to guidance on different topics on the force intranet.

Call handlers in the force control room (who take calls from members of the public) generally provide enough information to help officers attending incidents. We were told the quality of the information could sometimes be better but call handlers do check force systems and the Police National Computer (PNC) and give any information about individuals to officers. Officers also use their own local knowledge and can look up information themselves using their mobile devices. Officers told us they usually felt well informed when deciding what action to take.

Frontline officers do their best to keep children out of custody and only use it as a last resort. The force has a strong focus on achieving this. Officers recognise that custody isn't a suitable environment for children. They explore alternatives to custody where possible. These include:

- taking a child home and discussing the incident with parents or guardians;
- taking the child to other family members if a situation at home needs calming down;
- arranging voluntary interviews at a later date; and
- resolving the matter directly between the child and victim.

Officers also refer children to the multi-agency joint diversion panel. The panel tries to prevent children from entering the criminal justice system by offering other options – for example, arranging and managing community resolutions. It has arrangements with other organisations to divert children away from criminal activity. For example, the fire service works with children involved in arson offences.

The force has agreed a protocol with social services to try and avoid the criminalisation of children in care. The protocol aims to make clear the roles of care workers and police when incidents occur in care homes. Officers told us this doesn't always work as intended in practice. They are often called to care homes and find it difficult to reach agreement on what action to take, especially when the care home wants the child arrested. However, the focus remains on trying to avoid arrests where possible.

Frontline officers know that custody officers will refuse detention unless they can fully justify the arrest of a child. We found some examples of detention being refused. Sometimes the seriousness of the offence leaves no alternative other than an arrest but, overall, the number of children entering custody has reduced in recent years.

The support for frontline officers dealing with incidents involving people with mental ill health isn't always good enough. A mental health professional works in the force control room from 2 to 10pm checking health records for individuals and offering telephone advice to officers. Officers told us that this is very useful, but the support is limited because the advice is only available during these hours.

At other times, officers telephone the mental health crisis team. However, they said calls aren't always answered and sometimes the advice isn't helpful. Officers may also telephone the mental health professionals at the health-based place of safety but again there can be difficulties getting through. Officers told us there used to be a street triage car but this has stopped. All of this makes it more difficult for officers to decide whether to detain a person under section 136 of the Mental Health Act 1983.

People detained under section 136 should be taken to hospital or the health-based place of safety by ambulance. Long waits for ambulances mean officers often ask an inspector for permission to use a police car instead. Officers told us that when they arrive at the hospital or health-based place of safety, there can be further long waits before the person is seen by a mental health professional. This is a poor outcome for the person in mental health crisis and a poor use of police officer time.

When officers attend an incident where an offence has been committed, they consider the circumstances and take the person to hospital if they have serious concerns about their mental health. Otherwise, or if the seriousness of the offence leaves no option, they take the person to custody to continue the investigation. Any mental health concerns are dealt with in custody. Custody isn't used as a place of safety for those detained under section 136. But officers said they were sometimes called to custody to take detainees further detained under section 136 to hospital or a health-based place of safety for an assessment.

Frontline officers decide whether to use police cars or police vans to transport detainees to custody depending on their behaviour. If a detainee is non-compliant, they use a van. In the Spalding area of Lincolnshire, the force has a scheme with Mitie to transport detainees to the Boston custody suite. This allows police officers to continue dealing with the investigation and respond to incidents rather than committing them to significantly long travel times to custody.

Officers we spoke with didn't have experience of transporting people with mobility needs or wheelchair users. They said there are no specific arrangements, but they would use common sense to find a solution.

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

There is a strong culture of treating detainees with respect. Custody staff mostly interact courteously with detainees and are often patient and reassuring with them.

Some booking in areas lack screening between desks to protect detainee privacy. Officers usually overcome this by dealing with one detainee at a time at the custody desk. However, some booking in desks are high, making it difficult for officers to speak easily with detainees.

Detainees are offered the opportunity to speak with a member of staff in private. They are also asked about caring obligations and staff make efforts to meet these. Most detainees are given a ‘Respect’ leaflet describing what they are entitled to ask for. There is a specific leaflet for detainees in custody for the first time.

Shower areas are generally private or supervised discreetly. There are signs to show that CCTV operates in the suites but these aren’t always displayed prominently enough for detainees to see. However, detainees are told about CCTV and where it covers, including in cells, and that toilet areas are obscured from view. Strip searches are conducted in areas either not covered by CCTV or where staff make sure monitors can’t be seen during the process.

However, some practices are disrespectful and don’t adequately protect detainee dignity. Detainees aren’t always provided with adequate replacement clothing or encouraged to dress themselves when their clothing is removed. Some stay in an undignified state of undress for too long, including being naked in their cell or walking around custody inappropriately dressed. Footwear is routinely removed, and alternatives aren’t always provided. This leads to many detainees walking around custody in their socks. The lack of facilities in some suites, such as toilets in cells, means detainees have to ask to use the toilet or for it to be flushed.

Meeting diverse and individual needs

Custody staff can describe how they try to meet diverse needs, but this isn't always achieved.

Lincoln has sufficient facilities for detainees with disabilities or impaired mobility. The other suites have an accessible toilet but don't have adapted facilities in the cells, exercise yards or showers. Each suite has at least one extra thick mattress to raise the height of low benches. All have a wheelchair, and detainees can keep mobility aids or are offered a chair in their cell, subject to risk assessment.

There are hearing loops but some staff don't know how to use them. Coloured bands to assist those with impaired sight aren't available in all cells. Information about rights and entitlements is readily available in Braille and 'easy read' formats.

Staff have a reasonable awareness of neurodiversity and how this affects detainees. We saw good and considered care for neurodivergent detainees.

Suites, except Skegness, have at least one glass-fronted cell available. This is particularly helpful for those with claustrophobia.

Women are told that they can speak to a female member of staff in private and they are allocated a named officer or staff member. However, these staff aren't always readily available, and they don't always contact or engage with the women they are assigned to. We saw cases where women weren't spoken to after booking in, despite custody records showing that they had been. Women are asked if they have any menstrual care needs, and each suite stocks a reasonable range of products. However, disposal arrangements rely on staff taking used products away. This isn't satisfactory.

The provision for detainees who speak little or no English is variable. There is some good use of the telephone interpreting service during booking in. But it isn't always used for this or other important processes, such as taking biometric samples, general care and welfare checks, and release. Some staff get by using hand gestures, particularly for welfare checks. This could limit detainee understanding of what is happening and what they can expect in custody. Telephones are used on loudspeaker, which reduces privacy for detainees. We also saw some health consultations which were overheard.

Rights and entitlements are available in a range of languages, and most staff are aware of other translated documents that they can access if necessary.

There is good awareness of the needs of transgender detainees, and all staff described appropriate treatment.

On arrival, detainees are routinely asked about religious needs and can observe their faith while in custody. Each suite has a supply of respectfully stored religious items but these cater only for Christianity, Islam and Judaism. Positively Kosher food is readily available. Qibla markings showing the direction of Mecca are present in all cells.

Areas for improvement

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

- making adequate provision for detainees with disabilities;
- making sure female staff contact and engage with the women they are assigned to;
- having satisfactory disposal arrangements for menstrual care products;
- using private telephone interpreting services at all points during detention where important information needs to be given or requested; and
- providing sufficient religious texts and items in all the main faiths.

Risk assessments

The identification of risk is generally good, but it isn't always managed well enough. Some aspects of managing risk haven't improved since our last inspection and are now a cause of concern.

Detainees are often booked in promptly. But when it is busy, there can be a long wait in holding rooms before their detention is authorised. Queues aren't managed well. Staff don't assess risks or prioritise booking in children or vulnerable adults as set out by APP guidance.

Initial risk assessments focus appropriately on establishing risks, vulnerability factors and welfare concerns. Custody officers and CDOs interact well with detainees to complete risk assessments and ask relevant supplementary and probing questions when required. They routinely cross reference information with the PNC warning markers, previous custody records and intelligence systems to help establish additional risks. However, they don't always ask arresting and escorting officers if they have any information to contribute.

Custody officers generally set observations at a level commensurate with presenting risks. Detainees under the influence of alcohol and/or drugs are monitored through level 2 rousal checks (as set out by APP guidance). They are roused by CDOs in the right way and the detail of these checks is accurately recorded. In most cases, the same staff complete rousal checks. This is important as it makes it easier to establish changes in a detainee's behaviour or condition when under the influence of alcohol or drugs.

Checks that don't involve rousing the detainee are sometimes carried out by looking through the cell spyhole. This isn't an acceptable welfare check and doesn't follow APP guidance. However, detainees are mostly checked at the required frequency with times accurately recorded in detention logs.

When the assessment indicates a heightened level of risk, detainees are observed more closely at either level 3 (constant observation by CCTV) or level 4 (physical supervision at close proximity). The officer(s) responsible for the observations should be fully briefed by the custody officer. However, the quality of briefings is inconsistent

and they don't always take place. Custody records don't always include details of the briefing or the identity of the officers involved. These practices don't follow APP guidance.

Officers conducting these duties aren't always properly focused when they should be vigilant in supervising detainees. Some of the areas where level 3 monitoring takes place are too cramped. Officers conducting the level 3 or 4 observations should complete observation logs, but these aren't always used and when they are, they aren't always scanned onto the detainee's custody record. More positively, custody staff continue to conduct welfare checks and carry out rousals if required on detainees who are subject to level 3 or level 4 observations.

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

Anti-rip clothing continues to be used often and without adequate rationale. The detainee's clothing is also sometimes removed by force. Detainee dignity isn't always maintained when clothing is removed. In many cases, clothing is removed as a first response rather than considering other ways of managing the risk.

Detainees in anti-rip clothing are often placed on low-level observations, suggesting their risks aren't considered to be significant. We saw clothing removed when detainees were on a constant level of observation without good reason given why this was necessary. These practices are a disproportionate response to managing risk and lead to poor outcomes for detainees, particularly when force is used. Risks could be better managed by increased levels of observation and talking with detainees. This hasn't been addressed since our last inspection.

There is no collective handover between all the incoming and outgoing custody staff to make sure that all relevant information is passed on to those taking over responsibility for detainees. Custody officers hand over separately from the CDOs, and there is no routine sharing of information afterwards. We saw that some detainee risks raised at these separate handovers weren't then shared with all staff on duty. HCPs aren't involved in the handovers, even when in the suite. After the handover, custody officers visit detainees in their care, but they don't always speak to, or otherwise engage with, the detainees. These practices don't follow APP guidance or the force's own custody procedures. We raised these concerns in our last inspection.

Cell call bells are audible, and staff generally respond to them promptly. However, not all custody staff carry anti-ligature knives. This limits the ability to respond if needed on entering a cell and compromises detainee safety. This is poor practice.

The management and control of cell keys are poor. They are sometimes handed to non-custody staff. This reduces custody staff's control 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 (physical supervision at close proximity) watches are conducted and recorded in line with APP guidance;
- all custody staff carry anti-ligature knives; and
- custody staff maintain control of cell keys.

Individual legal rights

Detainees are usually booked into custody quickly. They are booked in one at a time so there are some long waits when the suites are busy and more than one detainee is waiting. For example, we saw three children arrive together at Skegness (following their planned arrest) while another detainee was waiting to be booked in. The last of the detainees waited over three hours. This isn't satisfactory.

Custody officers appropriately authorise detention. Arresting officers provide detailed circumstances of arrest and good explanations for the necessity to detain (PACE Code G). Custody officers always check with the detainee if they understand why they have been arrested and are being detained. At Lincoln, CDOs book detainees into custody. Custody officers oversee this and authorise the detention.

The force uses voluntary attendance interviews as an alternative to arrest, although less often than previously. Some of these interviews take place in the custody suites where there are recording facilities. This defeats one of the aims of voluntary attendance as a means of keeping people away from the custody environment. The force is increasing its supply of interviewing kits to allow more of these interviews to be conducted outside of the custody area.

Investigations don't always progress quickly enough, leading to some detainees spending longer in detention than necessary. Arresting officers carry out investigations. However, custody officers told us that if the investigation is taken by another team, they often don't find out who will be dealing with the detainee until after the morning management meeting. We saw a detainee with a medical condition released with no further action because the custody officer couldn't find out who would be dealing with the case and wasn't prepared to detain her unnecessarily.

Further delays to detention occur because of difficulties in getting interpreters out promptly and waits for solicitors and AAs to attend.

In Skegness, the difficulties with legal representatives and The Appropriate Adult Service (TAAS) are particularly problematic and potentially leads to detainees spending longer in custody. We saw a case where TAAS couldn't attend until seven hours after request and the legal representative until thirteen hours.

We didn't see any immigration detainees during our inspection. The force was unable to provide information on how long immigration detainees are kept in custody after they have been served with their authority to detain (IS91) papers. Overall, immigration detainees spend 24 hours and 3 minutes on average in police custody. We were told by custody staff at the Boston suite that border force officers are in the same building, which means a quicker response.

Detainees have their rights and entitlements clearly explained and are provided with written information. Custody officers give detainees a rights and entitlements leaflet.

There are enough copies of the most recent edition (August 2019) of PACE Code C booklets. These are routinely offered to detainees.

Posters in different languages advertising the right to free legal advice are prominently displayed in all suites other than Grantham.

Most of the custody officers we spoke to were aware of the requirements of Annex M (translation of important documents and records). However, these aren't always given to detainees who need them.

The suites use different versions of the 'easy read' document on rights and entitlements for children and adults who need help in understanding their rights. Some versions are clearer than others. They aren't always handed out when it seems clear they are needed or routinely given to all children.

There are enough interview and consultation rooms for detainees to consult their legal representatives in private. Those wishing to speak to their legal representatives on the telephone can also do so privately. Legal representatives can view a copy of their client's custody record on request.

Custody officers are aware of how to contact the relevant embassies, consulates or high commissions for foreign nationals coming into custody if the detainee requests this. We saw this procedure was followed for detained foreign nationals.

DNA is stored in locked freezers and is regularly collected from the suites. We observed CDOs taking samples. However, detainees weren't always given an explanation about how the sample would be retained and disposed of.

Areas for improvement

- Detainees should have their cases dealt with as quickly as possible, so they don't spend longer than necessary in custody.
- The force should agree a consistent version of the 'easy read' rights and entitlements document and make sure this is given to all detainees who might benefit from it.

Reviews of detention

Reviews of detention aren't always carried out well enough and don't consistently meet the requirements of PACE.

Most reviews are carried out by local policing inspectors. They are often conducted early with few or unsatisfactory reasons why. We found telephone reviews carried out in the early hours of the morning when the detainee was asleep rather than at the due time when the detainee would have been awake.

When reviews occur when the detainee is asleep, they aren't always reminded at the earliest opportunity that a review has taken place, informed of their rights and given the opportunity to make any representations. This doesn't meet the requirements of PACE Code C paragraph 15.7.

In some of the reviews we saw, detainees weren't informed of all their rights, and detention was authorised without always giving detainees the opportunity to make any representations. This doesn't meet the requirements of PACE Code C paragraph 15.3.

However, during reviews, we saw inspectors treating detainees courteously and discussing their welfare.

Live link is available to carry out reviews. But we were told it is rarely used because poor connectivity makes its use impracticable. Inspectors use the telephone instead. The force doesn't always record the reasons why live link isn't used, which doesn't meet the requirements of PACE Code C paragraph 15.9B – this states that telephone reviews aren't allowed if live link is available and practicable to use.

Recording of reviews is inconsistent and sometimes doesn't reflect some of the good practice we observed.

Area for improvement

The force should make sure that it complies with all aspects of PACE when carrying out reviews of detention.

Access to swift justice

Our custody record analysis shows the force finalised 61 percent of investigations during the first period of detention. The force bailed detainees or released them under investigation in the remaining cases.

The force monitors those who are bailed or released under investigation. Local team inspectors manage RUI cases to make sure they are progressed. Overall performance is reviewed by the EMCJS.

However, officers told us they struggle to progress these investigations due to their workloads.

Custody officers clearly explain to detainees released under investigation the possible offences they may commit if they interfere with victims or witnesses while the investigation is ongoing. They are given a notice outlining this and asked to read and sign it.

Complaints

Detainees can make a complaint while in custody. Posters are prominently displayed in all custody suites explaining how to do this. But there are no leaflets to give to detainees about how to complain while in custody.

Although all staff we spoke to were clear about the procedure for taking a complaint from a detainee, we saw a couple of instances when detainees wishing to make a complaint didn't have it taken or recorded on the custody record.

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 estate in Lincolnshire has four full-time designated suites at Boston, Grantham, Lincoln (South Park) and Skegness. There are potential ligature points throughout the estate mainly due to the design of toilets, fit of doors and some loose hatches. During the inspection, we gave the force a comprehensive illustrative report detailing these as well as general conditions.

Overall, cleanliness throughout the suites is good. There is some natural light in all cells (except one cell in Boston) and no evident graffiti. The suites are well maintained but the conditions vary with some of the older suites lacking facilities in cells such as sinks, toilets and in-cell toilet flushes. Space for level 3 CCTV monitoring at Boston and Skegness is limited as the CCTV monitors are immediately adjacent to custody staff workstations.

Daily and weekly safety maintenance checks of the physical environment, including cells and communal areas, aren’t always completed as required by APP guidance. Repairs sometimes aren’t completed quickly, and some cells throughout the estate have been out of use for several months awaiting replacement parts.

CCTV covers most of the suites and all the cells. Notices that CCTV is in operation aren’t always prominently displayed where detainees can see them and there are none in any of the cells.

Custody staff have some awareness of emergency evacuation procedures, and there are enough handcuffs to evacuate cells if needed. Few of the staff we spoke to had taken part in a physical evacuation in the last year, and some never had, to make sure the procedures work in practice. Force data shows that there has been an evacuation drill at each suite in the last year, but these didn’t identify any of the staff who took part. This was raised in our previous inspection.

Areas for improvement

The force should:

- address the safety issues involving potential ligature points and, where resources don't allow them to be dealt with immediately, the risks should be managed to make sure that custody is provided safely;
- complete daily and weekly safety maintenance checks in line with APP guidance; and
- make sure all custody staff have practiced 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 is mostly proportionate to the risks or threats posed by the detainee. However, not all incidents are managed well.

We reviewed 15 cases of recorded force on CCTV. We saw examples of good communication deescalating situations to avoid using force. But, when force was used, incidents weren't always managed well, and there wasn't always enough oversight and direction by the custody officer.

Restraint techniques were often deployed correctly, though this wasn't always the case. Not all techniques were used correctly or successfully applied. We saw instances where poor control techniques led to an escalation of the incident and further force used when it could have been avoided.

It wasn't always clear from custody records and our observations on CCTV that the removal of clothing was necessary and justified. Its removal resulted in using force that could potentially have been avoided. We are further concerned that officers didn't always maintain the detainee's dignity when removing the clothing.

We referred five cases to the force for learning. Four cases involve the use of poor techniques. In three of those cases, it doesn't appear that the dignity of the detainee had been fully considered by the officers involved. The final case involves the use of force in an enclosed space and a situation that may have exposed the detainee and the officers involved to injury and the escalation of force.

The force provided information on how many use of force forms were submitted for the incidents we looked at on CCTV. From this, it is clear that officers who use force on detainees in custody don't always submit individual use of force forms as required by National Police Chiefs' Council guidance. Although incidents are usually noted on the custody record, the detail recorded didn't always reflect what we saw happening on the CCTV footage.

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.

The gaps in information and lack of quality assurance mean it is difficult for the force to show that when force is used in custody, it is necessary, justified and proportionate. This is a cause of concern.

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

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

Most custody officers and all CDOs are up to date with their officer safety training.

Detainee care

There is a good culture of treating detainees well. However, some aspects of detainee care could be better. Detainees generally spoke positively about the care they received, but some said they didn't know what was available or what they could ask for. The lack of facilities in some cells, such as toilets and sinks, affects how well detainees can be cared for – especially when staff are busy and unable to respond quickly, for example to requests to use the toilet.

The range of care provisions available is generally explained to detainees when they are booked into custody, and most are given a leaflet about this. When inspectors conduct face-to-face reviews of detention and when custody officers visit detainees after shift handovers (subject to the detainee being awake), they are generally proactive in offering access to the available range of detainee care. Offers and provisions during other welfare visits are sometimes more limited and may depend on how busy the custody suite is.

Food preparation areas are generally clean and tidy, and cutlery is sanitised between uses. Food and drinks are offered regularly. The range of food is limited to instant porridge and microwaveable meals, but options are suitable for most dietary requirements. Supply issues are affecting current availability of food choices, including vegan meals. The dietary guidance about the content of food is prominently displayed.

Food can be purchased for detainees who remain in custody for longer periods or for whom custody food is unsuitable.

Not all cells have sinks. In those that do, water isn't drinkable from the sinks in Lincoln and the new cells at Boston. There are no signs in Boston to advise detainees about this.

The offer and provision of showers is reasonably regular. Some cells don't have toilets or have flushes on the outside of the cell so detainees have to ask staff to do this for them. Where there are sinks in cells, or in communal handwashing areas, there are no soap or paper towels.

Exercise yards are available in all suites but vary in size, and some don't provide shelter from bad weather. Offers to use the outside exercise yards aren't as proactive as they could, or should, be.

Each custody suite has a range of books and magazines with some materials suitable for children and in languages other than English. But they aren't given out routinely. Basic distraction packs, including puzzles and word searches, are available, but again these aren't offered or given out routinely.

A small supply of toilet paper is now provided when a detainee is put in their cell. Rolls are, however, often stored unhygienically on gates or worktops.

All clothing with cords and footwear are routinely removed. There is enough replacement clothing available, but it isn't always provided. Some detainees walk around the suite in a poor state of dress including to interview, for example in anti-rip clothing, which isn't acceptable. Plimsoles and poor-quality foam slippers are available as replacement footwear. These aren't readily provided so many detainees walk around in their socks or bare feet.

All cells are equipped with a pillow and thin mattress. Some are damaged, and some mattresses are so thin they offer little comfort. Some detainees complained to us about the mattresses and being uncomfortable. Once this was brought to the force's attention, it acted to remedy this. Sufficient clean blankets are available and are routinely provided. Additional blankets are given if detainees request them.

Areas for improvement

The force should improve the care of detainees by:

- providing appropriate access to handwashing;
- making sure detainees at Boston know they can't drink the water from sinks in cells;
- routinely providing reading materials and other distraction activities;
- routinely providing adequate replacement footwear and clothing; and
- making sure pillows and mattresses are in good condition and offer sufficient comfort.

Safeguarding

Custody staff and frontline officers have a strong awareness of their safeguarding responsibilities for children and vulnerable adults. This is reinforced through induction training on topics such as children, AAs, and mental health. Speakers from external organisations like the local authority's children's services provide sessions to offer a wider perspective.

The force promotes safeguarding responsibilities and the need for officers to complete safeguarding referrals (known as public protection notices) through large posters displayed in custody suites. Arresting or investigating officers make referrals to the force's safeguarding hub for all children who have been arrested and any vulnerable adults. Custody officers are expected to check whether safeguarding concerns have been identified and referrals made. They also make their own referrals if needed. However, there is little reference to safeguarding in custody records making it difficult to know whether these issues have been considered or addressed.

The L&D team provides extra safeguarding for children and vulnerable detainees. Since the start of 2022, all children in custody are visited by a practitioner and offered help through referrals to various support services. Other groups with specific needs, such as women, are also prioritised for assessment. When L&D practitioners aren't on duty, the HCPs visit these detainees instead. The force and its partner organisations monitor how well these arrangements work and have received positive personal testimony from some of those who have received this support. They are now trying to understand why some children don't engage with the L&D team to improve take-up of the service.

Girls are usually assigned a same-sex member of staff to support them and oversee their welfare while in custody, in accordance with legal requirements (Children and Young Persons Act 1933). However, we found that these arrangements don't always work well when there are no females working in custody and officers from elsewhere in the force are asked to perform the role.

Custody staff try to get AAs to support children and vulnerable adults as soon as possible into their detention. They make early requests and ask for attendance at the earliest opportunity. We generally found a good level of recorded detail (such as time of request) in the custody records we examined as well as examples of custody staff chasing attendance when delays occurred.

When family and friends are unable or unsuitable to perform the role, custody staff contact the local authority to arrange an AA. The AAs are provided through a contract with TAAS. A joint service agreement sets out a 24/7 service with attendance expected within two hours of the request.

TAAS performance is monitored based on data collected by them and the local authority. This information suggests that average response times are within the two-hour requirement. In some of the cases we examined, and during our observations, we saw some children and vulnerable adults waiting a long time before an AA arrived. Sometimes there was no AA. Custody staff at all suites reported that long waits weren't uncommon, both during the night and day. The force doesn't monitor its own information on how long detainees wait for an AA.

Custody staff have received training to help them decide when an adult is vulnerable and requires an AA. The force, through its regional EMCJS arrangements, monitors how many vulnerable adults receive this support. However, in some cases we examined, consideration hadn't been given to an AA when there was information to suggest it should have been. In others, AA support was only sought following the advice of healthcare practitioners some significant time into the person's detention period.

Guidance for non-specialist AAs, recently produced by the National Appropriate Adult Network, is available in video format accessed online via a QR code on prominently displayed posters in all custody suite booking in areas. Written guidance is also available for custody officers to print and provide to AAs.

The force avoids the arrest and detention of children wherever possible. The number of children entering custody has broadly declined year-on-year. Custody officers we spoke to required strong justification before detaining children. We found some good examples in our case reviews where children had been appropriately bailed or released under investigation to minimise their time in custody. But we also found some long detention periods and some matters that might have been dealt with more quickly. Force data shows that prior to any decision to charge, children are on average detained for longer than adults. The force doesn't know why this is but intends to examine it further.

Care for children in custody is reasonable, but there are few arrangements to help mitigate the effects of detention. Staff adopt an empathetic approach and engage well with them. However, other than Lincoln, the design of the custody suites offers limited scope to keep children separate from adult detainees. And there is little opportunity to spend time out of their cell with a family member or AA. Distraction packs are available to help occupy children or any other detainee considered likely to benefit from them. However, these have limited content, consisting of printed puzzles and colouring sheets, and there is little stationery to use with them. No other types of items, such as fidget spinners, are available. We also saw that distraction packs weren't always offered to detainees who may have benefitted from them.

The force and its local authority partners have good working relationships and a joint working protocol for children in custody, particularly those who are charged and refused bail. However, outcomes for these children remain poor. Of the 29 cases where this occurred in the 12 months prior to our inspection, 17 requests for alternative accommodation were made but only 4 children were moved. The remaining 12 instances didn't require the child to be transferred – for example, because it was deemed impractical to do so within the time available or the child attended court the same day.

The data provided by the force didn't differentiate between requests for secure or non-secure (appropriate) accommodation. But the information has been collected previously and used to inform joint monitoring meetings with the local authority. This has led to new escalation procedures for when alternative accommodation is not provided so that senior managers are involved from the force and the local authority to try and find a solution. However, these arrangements are new, and outcomes haven't yet improved.

Areas for improvement

- Appropriate adults should be readily available to support children and vulnerable adults at all times, including at night. The force should use its own data to further monitor service performance.
- The force should continue to work with local authority partners to improve the provision of alternative accommodation for children who are charged and refused bail.

Governance of health care

Castle Rock Group (CRG) Medical Services provides physical healthcare support to detainees and carries out forensic testing in custody. Lincolnshire Partnership NHS Foundation Trust provides L&D services at the four custody suites.

The force manages the CRG healthcare contract well. Governance arrangements are good and include support from NHS England and NHS Improvement commissioners. There is regular monthly reporting and monitoring of the service. Designated senior officers in the force provide operational oversight of health services and contract performance. CRG is open to challenge and scrutiny, and police staff can directly log any complaints or incidents for investigation. The investigations we looked at were thorough and prompt, and learning was shared with staff.

HCPs and forensic medical examiners (FMEs) are available 24/7, although not embedded in all four custody suites. The force was tendering for a new contract at the time of inspection with the requirement for an HCP to be based in each suite. Pending this, one HCP covers Lincoln and Grantham, while another HCP covers Boston and Skegness. There is some additional cover in Skegness during busy periods. The staff team is almost fully staffed, and a bank of flexible staff covers shifts as required, along with the clinical lead. The FMEs cover the whole of Lincolnshire, which includes non-custody work such as attendance at the sexual assault referral centre when called.

The large geographical area and travel time between suites means there are occasions when detainees wait a long time before they are seen by an HCP or FME. Custody officers told us that detainees weren't always seen within agreed response times. We also saw waits in some of the cases we examined. However, overall, we found most detainees saw an HCP promptly and in line with contractual requirements.

Most HCPs are from a nursing or paramedic background. New starters receive appropriate induction training which helps prepare them for their role. All HCPs have professional supervision and ongoing mandatory training. Some staff aren't fully up to date with this but there are plans to address this.

HCPs told us detainees are always seen in private unless a risk assessment suggests it wouldn't be safe. This is also CRG policy.

All treatment rooms comply with infection prevention and control requirements. HCPs have all the necessary equipment including PPE. There is additional cleaning before and after treatment rooms are used for the collection of forensic samples.

HCPs have access to standardised emergency bags which are checked frequently and contain relevant life support equipment. Custody officers and CDOs have access to an automated external defibrillator and a first aid kit.

Area for improvement

Detainees should have consistent access to HCPs regardless of the suite they are held in.

Patient care

Healthcare is provided by experienced and competent practitioners who are valued by custody staff. The care and support given are appropriate to the detainee's needs. We observed HCPs carrying out clinical assessments of detainees respectfully and with kindness and compassion.

HCPs ask detainees for consent for healthcare interventions in line with the CRG's policy on the Mental Capacity Act 2005. They assess the detainee's capacity and clearly record where a detainee may have impaired mental capacity. Information-sharing protocols allow healthcare staff to share relevant information with custody staff.

HCPs and FMEs complete clinical records for detainees and assess their needs, including physical or mental health, substance misuse, safeguarding and social needs. The clinical records we reviewed contained a plan of care that reflected the assessed needs of the detainee. The healthcare staff update the custody record to make sure custody staff have an up-to-date view of the healthcare needs of the detainee.

However, clinical records are paper-based due to problems with the electronic system. This means healthcare staff can't easily access detainees' health information from the community or any previous occasions in custody. Staff store clinical records securely within each custody suite.

HCPs and FMEs provide a range of care and treatment interventions suitable for detainees and consistent with national guidance and best practice. Patient group directions support staff to make decisions about medication for acute withdrawal from alcohol and drugs. Where appropriate, detainees can continue community prescribed opiate substitution treatment in custody. Police staff have access to paracetamol, salbutamol inhalers and glyceryl trinitrate sprays, which they can give to detainees after consulting an HCP or FME.

HCPs use effective systems and processes to safely prescribe, administer, record and store medicines. They manage controlled drugs appropriately and complete regular audits of medicines to identify any potential errors. They routinely report medicine errors through the electronic reporting system and investigate these promptly.

We expect that detainees can take their medicines with them when they transfer to court custody. However, we were told that detainees can't do this. Instead, HCPs make sure detainees receive their medicines immediately before leaving police custody, where possible.

Custody staff have nicotine replacement therapy available for detainees, but we didn't see this being given to those who may have benefitted from it.

Area for improvement

HCPs and other medical staff should have easy access to previous healthcare information held on the detainee, or any that is available in the community.

Substance misuse

The L&D team sees detainees with drug and alcohol problems in custody and makes referrals to the community substance misuse provider – 'We are with you'.

The L&D practitioners assess the support detainees need, which can also include harm minimisation advice. They offer telephone support for up to 12 weeks after release to help detainees to engage with community services.

Mental health

The L&D team is commissioned by NHS England and NHS Improvement to provide a service to detainees that covers all types of vulnerabilities – for example, social concerns as well as health. Clinical staff from Lincolnshire Partnership NHS Foundation Trust and non-clinical staff from Lincolnshire Action Trust are based in the four suites seven days a week, 9am to 9pm. There is effective oversight from commissioners and good joint working with the force.

All detainees are screened by L&D senior clinicians who arrange any further assessments that might be needed. The team is well-motivated and skilled, providing good support to vulnerable detainees arriving in custody. It helps with housing, social problems and drug and alcohol issues as well as provides specialist assessments and support to detainees with complex mental health problems. L&D staff can refer detainees to a dedicated clinical psychologist who is available 2.5 days a week. The psychologist also facilitates monthly reflective practice with L&D staff to share learning. We don't normally see this provision and regard it as notable practice.

We saw good communication between L&D and custody staff with appropriate referrals made and prioritised. The L&D service is valued by custody staff, and the detainees we spoke to were happy with the care and support they received. However, in the custody records we examined, it was often unclear how mental health needs were being addressed.

Detainees can also access support after their release. The L&D service has established referral arrangements with many and varied community services.

The force doesn't take individuals detained under section 136 of the Mental Health Act 1983 to custody as a place of safety. But we were told custody staff use section 136 to move detainees with suspected acute mental health problems from custody to a health-based place of safety. It isn't clear why this is chosen instead of asking for a Mental Health Act 1983 section 2 assessment in custody. The custody records often lacked detail about how the detainee was dealt with and why.

The lack of information about the use of section 136 and the number of mental health act assessments in custody and waiting times for them means outcomes for these detainees aren't monitored or subject to scrutiny. There are only two beds at the health-based place of safety serving the whole county. This can lead to long waits. We found one case where a detainee had spent over 48 hours in custody waiting for an inpatient bed.

There are good working relationships between the force and Lincolnshire Partnership NHS Foundation Trust. Any concerns are escalated and responded to quickly. Regular meetings take place involving the various agencies in the Crisis Care Concordat to try and improve outcomes for detainees.

Area for improvement

The force should make sure that detainees in custody who have acute mental health needs are dealt with in the most effective way, and that their time in custody is kept to a minimum. It should monitor how well detainee needs are met and work with partners to improve outcomes for them.

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 making sure detainees are released safely. We saw some very good attention and care given to detainees on release.

Custody officers engage well with detainees to complete pre-release risk assessments. They use initial risk assessments and the detainee's behaviour while in custody to make sure any risks identified are addressed or reduced before release. Where there are concerns, custody officers refer detainees to the FME for a fitness to release assessment. They also involve other relevant organisations, such as L&D, to support detainees' release. However, custody records don't always reflect this practice and can lack detail. For example, information may be missing to show how a detainee will get home after release.

Detainees can make telephone calls to arrange transport. Those who don't have the means to get home safely can also access travel warrants for use on trains. We were told police officers often take detainees home, particularly if they are children or vulnerable adults, depending on their other operational commitments.

Most custody officers are aware of the enhanced safeguarding arrangements for those arrested under suspicion of committing serious sexual offences. In these cases, they report a good exchange of information with investigating officers and use this when completing a detainee's pre-release risk assessment.

A leaflet containing information about both national and local support organisations is given to detainees on release. But detainees transferring to court or prison don't always receive this. The leaflet is available in several different languages. Many detainees leaving custody are also provided with support leaflets issued by the L&D team.

CDOs complete digital person escort records (dPERs) and book transport for detainees attending court or who have been recalled to prison. These aren't always well completed, and relevant information such as medical details can be missing.

Custody officers don't check the content of dPERs, which are often signed off by CDOs. This is contrary to APP guidance. Few custody officers speak to or complete any pre-release risk assessment with detainees transferring to court. This means that any risks identified may not be addressed or mitigated before transfer.

Areas for improvement

The force should strengthen its approach to releasing detainees safely by making sure that:

- all relevant information to ensure the safe transfer of a detainee is recorded in the digital person escort record (dPER) in line with APP guidance; and
- custody officers engage with detainees transferred to court or prison to identify and mitigate risks prior to their transfer from police custody.

Courts

Detainees remanded to court are usually collected promptly in the morning. Those arrested on warrant during the day aren't accepted directly at Lincoln Magistrates' Court and are booked into police custody. Staff told us the court has some flexibility and can accept detainees later in the afternoon to appear in person or, sometimes, via a video link facility. This minimises detention time and is better than at our previous inspection.

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

Causes of concern and recommendations

Cause of concern: managing detainee risks

The force isn't managing detainee risks well enough. It hasn't addressed concerns from our previous inspection, it isn't consistently following APP guidance and it often takes a risk-averse approach. Our concerns are:

- Custody staff continue to remove clothing with cords and footwear without an individualised risk assessment.
- Anti-rip clothing continues to be used often and without adequate rationale. Clothing is sometimes removed by force and detainee dignity isn't always maintained.
- Not all the detainees' risks are shared with all the staff on duty because handovers continue to be conducted separately for custody officers and custody detention officers (CDOs).

Recommendation

Custody staff should only remove clothing with cords and footwear from detainees when justified by an individualised risk assessment. Anti-rip clothing should only be used as a last resort when it is a necessary, and proportionate response to mitigate the risk to detainee and their dignity should be maintained. The reasons for the removal of items of clothing or use of anti-rip clothing should be clearly recorded. Handovers should be conducted in a way that means all staff duty on duty are aware of all detainee risks.

Cause of concern: use of force

The force doesn't have effective oversight of the use of force in custody. While recognising the force's efforts to improve, it still doesn't have enough information to scrutinise when and how force is used. The details of incidents aren't always recorded, or recorded accurately enough, on custody records, and not all officers submit use of force forms. There is little quality assurance to assess how well incidents are managed. Our review of incidents showed that not all of them were managed well. This means that Lincolnshire Police can't show that when force is used in custody it is always necessary, justified and proportionate.

Recommendation

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

Areas for improvement

Leadership, accountability and partnerships

- The force should consistently follow APP guidance and its own policies and guidance.
- The force should:
  - improve the accuracy of its performance information and address any gaps so that it has a good understanding of how well it performs across all areas of custody; and
  - make sure that important decisions about detainees are consistently recorded on the custody record.

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

- The force should strengthen its approach to meeting the individual and diverse needs of detainees by:
  - making adequate provision for detainees with disabilities;
  - making sure female staff contact and engage with the women they are assigned to;
  - having satisfactory disposal arrangements for menstrual care products;
  - using private telephone interpreting services at all points during detention where important information needs to be given or requested; and
  - providing sufficient religious texts and items in all the main faiths.
- 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 (physical supervision at close proximity) watches are conducted and recorded in line with APP guidance;
  - all custody staff carry anti-ligature knives; and
  - custody staff maintain control of cell keys.
- Detainees should have their cases dealt with as quickly as possible, so they don't spend longer than necessary in custody.
- The force should agree a consistent version of the 'easy read' rights and entitlements document and make sure this is given to all detainees who might benefit from it.
- The force should make sure that it complies with all aspects of PACE when carrying out reviews of detention.

In the custody cell, safeguarding and healthcare

- The force should:
  - address the safety issues involving potential ligature points and, where resources don't allow them to be dealt with immediately, the risks should be managed to make sure that custody is provided safely;
  - complete daily and weekly safety maintenance checks in line with APP guidance; and
  - make sure all custody staff have practiced 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.
- The force should improve the care of detainees by:
  - providing appropriate access to handwashing;
  - making sure detainees at Boston know they can't drink the water from sinks in cells;
  - routinely providing reading materials and other distraction activities;
  - routinely providing adequate replacement footwear and clothing; and
  - making sure pillows and mattresses are in good condition and offer sufficient comfort.
- Appropriate adults should be readily available to support children and vulnerable adults at all times, including at night. The force should use its own data to further monitor service performance.
- The force should continue to work with local authority partners to improve the provision of alternative accommodation for children who are charged and refused bail.
- Detainees should have consistent access to HCPs regardless of the suite they are held in.
- HCPs and other medical staff should have easy access to previous healthcare information held on the detainee, or any that is available in the community.
- The force should make sure that detainees in custody who have acute mental health needs are dealt with in the most effective way, and that their time in custody is kept to a minimum. It should monitor how well detainee needs are met and work with partners to improve outcomes for them.

Release and transfer from custody

The force should strengthen its approach to releasing detainees safely by making sure that:

- all relevant information to ensure the safe transfer of a detainee is recorded in the digital person escort record (dPER) in line with APP guidance; and
- custody officers engage with detainees transferred to court or prison to identify and mitigate risks prior to their transfer from police custody.

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 throughout 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
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- Andy Reed: HMI Constabulary and Fire & Rescue Services inspection officer
- Kellie Reeve: HMI Prisons team leader
- Fiona Shearlaw: HMI Prisons inspector
- Shaun Thomson: HMI Prisons health & social care inspector
- Mathew Tedstone: CQC inspector
- Joanne White: CQC inspector
- Joe Simmonds: HMI Prisons researcher
- Helen Ranns: HMI Prisons researcher

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