Report on an unannounced inspection visit to police custody suites in

Sussex

by HM Inspectorate of Prisons

and HM Inspectorate of Constabulary and Fire & Rescue Services

4 –15 November 2019

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

Glossary of terms

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

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Fact page[1]

Force
Sussex Police

Chief Constable
Giles York

Police and Crime Commissioner
Katy Bourne

Geographical area
The counties of East Sussex and West Sussex

Date of last police custody inspection
7-18 November 2016

Custody suites	**Cell capacity**
Brighton Investigation and Detention Handling Centre (IDHC)	36 cells
Crawley Police Station	27 cells
Eastbourne IDHC	22 cells
Hastings Police Station	10 cells
Worthing IDHC	19 cells
Chichester IDHC (closed since November 2018)	19 cells

Annual custody throughput
1.11.18 - 31.10.19: 24,163 detainees

Custody staffing
Five inspectors
59 sergeants
Nine detention supervisors
69 custody assistants

Health service provider
Mitie Health Care

[1] Data supplied by the force.

Executive summary

S1 This report describes the findings following an inspection of Sussex Police custody facilities. The inspection was conducted jointly by HM Inspectorate of Prisons (HMIP) and HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) in November 2019, as part of their programme of inspections covering every police custody suite in England and Wales.

S2 The inspection assessed the effectiveness of custody services and outcomes for detained people throughout the different stages of detention. It examined the force's approach to custody provision in relation to safe detention and the respectful treatment of detainees, with a particular focus on vulnerable people and children.

S3 We last inspected custody facilities in Sussex Police in 2016. Because of concerns following that inspection, and the limited progress made against our recommendations when we visited the force a year later to assess this, we prioritised the force for a full re-inspection. This inspection found that of the 34 recommendations made during that previous inspection, 13 had been achieved, five had been partially achieved and 15 had not been achieved. One recommendation was no longer relevant.

S4 To aid improvement we have made five recommendations to the force (and the Police and Crime Commissioner) addressing key causes of concern, and have highlighted an additional 14 areas for improvement. These are set out in Section 6.

Leadership, accountability and partnerships

S5 Sussex Police had a clear governance structure to provide accountability for the delivery of custody, with oversight at both strategic and operational levels. Despite this, although there had been some improvements since our last inspection, there had been too little progress overall in the areas of concern we had identified.

S6 There had been limited progress in improving the physical conditions of the custody suites. There had been investment in the suite at Hastings, and the Chichester suite had been closed. However, there were many potential ligature points across the custody estate, including some that were still remaining since our previous inspection. Four of the custody suites (including Chichester) were provided and maintained under contractual arrangements with Tascor, which made it more difficult, and hindered the force's ability, to make some of the improvements needed. Although the force had taken some actions to offset or manage the risks posed by the potential ligature points, these were not enough to consistently ensure safe detention.

S7 Staffing levels were generally sufficient to meet the demand in custody, although staff were not always deployed effectively. While initial training for custody officers was good, their ongoing support and development was more limited, and the force had insufficient oversight over the training provided to the custody assistants employed by Tascor.

S8 The force followed *Authorised Professional Practice – Detention and Custody* as set by the College of Policing,[2] and had its own local custody policies to provide additional guidance to staff. However, some of the practices we observed did not follow either guidance.

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[2] https://www.app.college.police.uk/app-content/detention-and-custody-2

S9 The force was still not consistently meeting the requirements of code C of the Police and Criminal Evidence Act 1984 (PACE) codes of practice for the detention, treatment and questioning of persons, particularly for reviews of detention.

S10 The force's approach to monitoring and managing performance was limited. While the availability of data had improved, there remained gaps in key areas, such as the waiting times for Mental Health Act assessments. This meant the force could not comprehensively assess how well it was delivering its custody services so it could identify performance concerns and address them consistently.

S11 Governance and oversight of the use of force in custody remained insufficient. Data on the use of force in custody were not readily available or reliable, and not all officers completed use of force forms as required. This meant that Sussex Police could not assure itself, the Police and Crime Commissioner and the public that the use of force in custody was always safe and proportionate.

S12 The quality of recording of important information on detention logs required improvement. There were many gaps, including the justification and rationale for key decisions. The recording of details for detainees waiting for mental health assessments was particularly poor. Quality assurance processes were inconsistent, and were not embedded or robust enough to identify the concerns we found.

S13 However, the force monitored adverse incidents in custody well and used these to identify learning and inform training. It was also open to external scrutiny and responded positively to issues raised by independent custody visitors.

S14 The force was committed to meeting the public sector equality duty. Data on gender, age and ethnicity of detainees were comprehensive and monitored at a strategic level.

S15 The force had a clear priority to divert children and vulnerable people away from custody, and engaged well with partners to achieve this. However, this did not always result in improved outcomes for detainees. While children were only taken to custody as a last resort, and although the number charged and remanded was low, few were moved out of custody to alternative local authority accommodation, as required.

S16 Although there was support from mental health services to help keep individuals with mental ill health away from custody, those who entered custody and then required a mental health assessment were poorly served. Too many of these vulnerable detainees were held in custody for too long when they should have been moved to a health-based place of safety.

Pre-custody: first point of contact

S17 Frontline officers had a good understanding of vulnerability and took account of this when deciding whether or not to arrest an individual or find alternative solutions. They received enough information from call handlers and on their mobile handheld devices to help them make these decisions.

S18 Children were only arrested when it was absolutely necessary. Officers used a range of community resolutions[3] and early intervention options to keep children out of custody.

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[3] The resolution of a less serious offence or antisocial behaviour incident through informal agreement between the offender and victim rather than progression through the criminal justice process.

S19 Frontline officers were well supported by the mental health street triage schemes, which helped avoid some detentions under section 136 of the Mental Health Act 1983[4] by finding more appropriate health-based solutions. When the scheme mental health workers were not on duty, officers relied on the wider mental health services, which did not provide the same level of support. When individuals were detained under section 136, officers reported long waits at hospitals or health-based places of safety pending the detainee's mental health assessment.

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

S20 Custody staff were patient and positive with detainees, and most interactions were clear, courteous and reassuring. There was, however, little privacy for detainees being booked into custody. Detainees were not always advised that cells, and the toilets in them, were covered by CCTV. Not all the cell toilets were obscured on CCTV monitors; this was a significant concern for detainee dignity that had not been addressed following recommendations in our two previous inspections.

S21 Custody staff were aware of and paid good attention to meeting the diverse needs of detainees. They were especially confident in relation to transgender detainees, for whom they had received clear guidance. Aspects of care for women, detainees practising a religion and those with disabilities were better than at the last inspection but could be improved further. A high number of foreign national detainees entered custody and priority was given to providing them with appropriate interpreting services, either in person or via telephone.

S22 The approach to identifying risk was good but the management of risks was not always sufficient. Initial risk assessments were comprehensive but did not always result in the setting of an observation level that was sufficient to manage presenting risks, particularly when detainees were under the influence of alcohol and/or drugs and should have been roused every 30 minutes. However, checks on detainees were conducted at the required frequency, and when rousing had been specified it was carried out correctly, usually by the same staff, and was well documented.

S23 Most detainees had clothing with cords, footwear and jewellery removed routinely without an individual risk assessment, even if they were deemed low risk, which was a disproportionate response to managing risk. Higher levels of observation were used but staff tasked with the role of watching these detainees were not always briefed appropriately or properly focused on their duties. Anti-rip clothing continued to be used sparingly. Responses to cell call bells were not always prompt. All custody staff now carried anti-ligature knives. The content of handovers between staff shifts was good but they did not always include all the staff involved or take place in areas with adequate CCTV cover.

S24 Most detainees were booked into custody quickly after their arrival, and good explanations were given of the circumstances and necessity for their arrest before detention was authorised. Detainees were informed of their rights and entitlements in custody and these were clearly explained to them. Although leaflets detailing rights and entitlements were generally offered to detainees, these, along with the PACE codes of practice, were significantly out of date in all but one suite. Not all cases were progressed as quickly as they could have been, and updates on progress were not always recorded on custody records.

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

S25 The approach to PACE reviews of detention continued to remain poor overall. Most reviews were completed on time, although some were too early. Very few were conducted face to face, including some for children, even though force policy required this. Although 'Live Link' in the suites allowed face-to-face reviews via a computer screen, most inspectors carried out telephone reviews instead, which did not follow PACE code C guidance. In addition, in telephone reviews it was often not clear that the detainee had been spoken to. When a review was carried out while the detainee was sleeping, they were not told that this had been done as soon as was reasonable. Recording of reviews in custody records was mostly poor.

S26 When detainees were released on bail or under investigation, this was explained to them clearly. Bail was used and managed appropriately, but cases involving detainees released under investigation were poorly managed and not properly closed.

S27 The approach to complaints had not improved since our last inspection. There was limited promotion of information to detainees about complaints procedures, and custody staff were inconsistent in how they dealt with complaints made in custody.

In the custody cell, safeguarding and health

S28 The custody suites were generally clean. Custody officers were responsible for daily checks of the suite, including cells, but these were often cursory and had not identified the defects we found, particularly many of the potential ligature points that we had identified to the force in our previous inspection. We provided the force with a further comprehensive report illustrating our concerns.

S29 There were prominent notices advising detainees that CCTV was operating in most custody suites. However, there were some blind spots in CCTV coverage and insufficient screens to allow monitoring of all areas in custody.

S30 In our observations and reviews of CCTV footage, we saw good examples of staff de-escalating situations and so potentially avoiding the use of force on detainees. We reviewed 12 cases involving the use of force in custody in depth; these were well managed overall and when force was used it was necessary and proportionate. We referred one case back to the force for learning; this involved the prolonged prone restraint of a detainee, which was potentially unsafe. Not all staff were up to date with their personal safety training, and there was no consistent approach to quality assuring use of force incidents, which was poor for such an important area.

S31 The force had guidance for the authorisation and conduct of strip searches of detainees in custody. Positively, this included the requirement that strip searching of children be authorised by an inspector. However, the percentage of detainees who were strip searched had increased since our previous inspection and was higher than the average for other forces we have inspected since March 2016; the reasons for this were not clear.

S32 Custody officers took time to speak with detainees when they were being booked into custody and many detainees told us that staff treated them well. However, some aspects of care provided were often not good enough. Although a satisfactory range of food and drinks was offered, some detainees had lengthy waits before they received food. Showers had insufficient privacy and were normally only offered early in the morning for those due to attend court. The exercise yards were little used, and the limited range of books and magazines were not routinely offered. The stocks of replacement clothing and footwear were basic and offered infrequently, which meant that detainees walked around suites in socks or barefoot.

S33 All officers showed a good understanding of the needs of safeguarding children and vulnerable adults. For children, custody officers made arrangements for appropriate adults (AAs) promptly, and positively the force monitored this. Once called, AAs usually arrived quickly. There were also effective arrangements to secure AAs for vulnerable adults, although they were not always called promptly and in some cases did not attend until the time of the interview. There was guidance to help custody officers decide whether a detainee needed the help of an AA and we saw several vulnerable adults receiving this support. But in some cases an AA had not been considered when there was information that one might be needed. However, overall the force was ensuring good access to AAs and was better in this than we have found in most other forces.

S34 Some good care was shown to children in custody. Custody officers established a positive relationship with them and their responsible adult (parent/guardian/carer) was notified quickly. Telephone calls and visits were facilitated if possible and, if appropriate, children could stay in secure waiting rooms with their parents or AA rather than waiting in a cell. All children were seen by the liaison and diversion service, and girls were assigned a female member of staff to care for their needs. However, children were not prioritised for booking in, reviews of their detention were not always conducted face to face in line with force policy, and easy-read rights and entitlements material was not routinely given out.

S35 There was a strong focus on minimising the time children spent in custody and avoiding overnight detention. Children charged and refused bail were closely monitored, including with partners, but there had been little progress in providing alternative accommodation. The number of children affected was low, but only one child out of 14 requests made was moved to alternative accommodation in the previous year. There was little consistent oversight of other children entering custody and those detained overnight pending their investigation.

S36 Strategic oversight of health delivery and quality assurance measures had improved since the previous inspection and were now good. Although there were no embedded health care professionals in the suites, we found no evidence that detainees were not receiving the appropriate support. Health care professionals were experienced, had the appropriate competencies, and provided prompt and appropriate support to detainees. Consultations still took place with the door open and with custody staff present, which was inappropriate. Apart from Hastings, none of the clinical facilities in the suites had been improved and they still did not meet infection prevention standards; those at Worthing and Brighton remained unfit for purpose.

S37 Detainee access to prescription medication was facilitated, including community-prescribed opiate substitution treatment. Symptomatic relief for detainees experiencing withdrawal was provided, and it was positive that nicotine replacement was now available and used. Medicines management arrangements were robust.

S38 There were no dedicated substance misuse workers to offer face-to face support for detainees with drug and alcohol problems. Sussex Liaison and Diversion Services (SLDS) offered an effective service that included onward referral to community services and outreach support. Positively, naloxone (a drug used to counteract opiate overdose) was available in all custody suites.

S39 The mental health liaison and diversion service, also delivered through SLDS, provided good support with a seven-day largely embedded service across all suites. The street triage service was positive and offered the opportunity for vulnerable people to be diverted from custody.

S40 Detainees were generally no longer brought into custody under section 136 of the Mental Health Act. However, the custody records were not clear about how custody staff had made

decisions to use section 136 in custody. Force information for the year to the end of October 2019 showed that 200 detainees were detained under section 136 while in custody, which was a significant number. Delays in access to inpatient beds, conveyancing issues and difficulties in securing approved mental health professionals and doctors meant that far too many detainees with acute mental health needs did not have these met in custody. This necessitated their detention under section 136 before their period of detention ran out, but so they could be transferred to a hospital for an assessment. These detainees spent far too long in custody, which was inappropriate and a poor outcome for them.

Release and transfer from custody

S41 There was an improved focus on ensuring detainees were released safely. There was particular attention to managing the safe release of children and vulnerable detainees and, where necessary, relevant agencies were often involved to support the release of the detainee.

S42 Travel warrants and some bus tickets were available for those who did not have the means to get home, but police transport was also sometimes used to take detainees home. There were enhanced safeguarding arrangements for individuals arrested under suspicion of committing serious sexual offences, but custody officers did not always satisfy themselves of this before releasing them. Although information on support agencies was available for detainees on release this was rarely offered, and was in English only. The practice of releasing detainees was generally better than what was recorded on custody records, which was mostly poor.

S43 Person escort records (PERs) varied in quality and did not always include sufficiently detailed information, as at our previous inspection. It was inappropriate that additional loose-leaf documentation containing risk assessments and medical details were attached unnecessarily to PERs.

S44 Detainees who had been held overnight and required to appear in court were processed promptly and most were not held in police custody for longer than necessary. The courts generally accepted detainees before 2pm, but those who had been arrested on warrant or who were ready to be dealt with early in the day were sometimes refused much earlier than this. This meant that some detainees spent longer in custody than necessary, and this had not improved since our previous inspection.

Causes of concern and recommendations

Causes of concern S45-S48 were present, and identified, during our 2016 inspection. We now expect the force to address them urgently.

S45 Cause of concern: The force did not consistently meet the requirements of PACE code C for the detention, treatment and questioning of persons.

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

S46 Cause of concern: Governance and oversight of the use of force were not sufficient. Data on use of force incidents were not comprehensive or reliable, and not all officers involved in incidents completed use of force forms, as required. This limited any meaningful oversight by

senior managers. There was insufficient monitoring and cross-referencing to CCTV footage by supervisors to quality assure incidents, and ensure the techniques used were proportionate and safely deployed.

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

- **ensure that all officers complete use of force forms for any incident they are involved in**
- **collect and monitor comprehensive and reliable data**
- **establish robust quality assurance arrangements including viewing incidents on CCTV.**

S47 Cause of concern: The force's approach to monitoring and managing performance was limited. There were gaps in the data collected for some key areas, and performance concerns were not always identified and addressed. Custody records often lacked detail, including the reasons or justification why some decisions were made, and there was little quality assurance of them.

Recommendation: **The force should collect comprehensive information across its range of custody services and use this to manage performance effectively. The quality of custody records should be improved, and quality assurance should ensure they meet the required standard.**

S48 Cause of concern: There were many potential ligature points across the estate, which posed a significant risk to detainees and the force. CCTV coverage in the suites was not good enough to manage risk as there were blind spots and insufficient screens to view and monitor all areas of custody. including all the cells. The cell toilets in three suites were not obscured from view on CCTV screens, which affected detainee dignity.

Recommendation: The force should take urgent action to mitigate the risks posed by ligature points and ensure that there is adequate CCTV coverage across the suites. Toilets should be obscured from view on CCTV monitors.

S49 Cause of concern: Too many detainees with mental ill health were held in custody for far too long waiting for mental health assessments and, where needed, onward transfer to a mental health bed. A significant number of detainees were detained under mental health powers while in custody (section 136 of the Mental Health Act), and taken to hospital for their mental health assessment because this had not been completed before their period of detention ran out. Custody record keeping for these detainees was particularly poor, and the force had insufficient information to use as a basis for working with partners to improve outcomes for detainees.

Recommendation: The force should urgently improve outcomes for detainees with mental ill health and ensure they do not remain in custody for longer than necessary. It should work with partners at a strategic level to ensure that detainees receive the service they are entitled to and that mental health assessments are carried out promptly. The force should collect and monitor information to show the outcomes achieved for detainees, and ensure that the custody record accurately reflects the decisions and actions taken.

Introduction

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

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

Our assessments are made against the criteria set out in the *Expectations for Police Custody.*[5] These standards are underpinned by international human rights standards and are developed by the two inspectorates, widely consulted on across the sector and regularly reviewed to achieve best custodial practice and drive improvement.

The *Expectations* are grouped under five inspection areas:

- Leadership, accountability and partnerships
- Pre-custody: first point of contact
- In the custody suite: booking in, individual needs and legal rights
- In the custody cell: safeguarding and health care
- Release and transfer from custody.

The inspections also assess compliance with the Police and Criminal Evidence Act 1984 (PACE) codes of practice and the College of Policing's *Authorised Professional Practice - Detention and Custody.*[6]

The methodology for carrying out the inspections is based on: a review of a force's strategies, policies and procedures; an analysis of force data; interviews with staff; observations in suites, including discussions with detainees; and an examination of case records. We also conduct a documentary analysis of custody records based on a representative sample of the custody records across all the suites in the force area open in the week before the inspection was announced. For Sussex Police we analysed a sample of 141 records. The methodology for our inspection is set out in full at Appendix II.

The joint HMIP/HMICFRS national rolling programme of unannounced police custody inspections, which began in 2008, ensures that custody facilities in all 43 forces in England and Wales are inspected, at a minimum, every six years.

Wendy Williams
HM Inspector of Constabulary

Peter Clarke CVO OBE QPM
HM Chief Inspector of Prisons

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[5] http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/inspection-criteria/
[6] https://www.app.college.police.uk/app-content/detention-and-custody-2/

Section 1. Leadership, accountability and partnerships

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

Leadership

1.1 Sussex Police had a clear governance structure for custody. Under the direction of an assistant chief constable (ACC), a superintendent had responsibility for the delivery of custody and criminal justice services, supported by a chief inspector who had day-to-day operational oversight of the five suites. This structure provided clear accountability for safe detention.

1.2 There were meetings at both strategic and operational levels for oversight of custody services. The chief inspector chaired a monthly meeting with the five custody inspectors, which informed a wider criminal justice and custody senior leadership team meeting chaired by the superintendent. There was also strategic oversight at a force accountability board chaired by the ACC.

1.3 Because of concerns we had at our previous inspection of the force three years ago, and further concerns when we visited a year later to assess progress against our recommendations, we prioritised the force for a full re-inspection. In this inspection, despite the governance structures in place, we found that too little progress has been made to address several important areas we had previously identified as causes of concern.

1.4 Improvement to the custody estate had been limited. The force had closed its suite at Chichester since our last inspection and there had been refurbishment work at Hastings. However, there remained many potential ligature points in suites across the estate, including ones we had identified in 2016. These continued to pose a significant risk to detainees and the force. This was a cause of concern at our last inspection and we expect the force to act urgently to mitigate the risks posed. (See cause of concern and recommendation S48.)

1.5 Generally, staffing levels were sufficient to meet the demand in custody. However, staff were not always deployed in the most effective way, with custody officers still completing tasks better suited to the custody assistant role, such as taking detainees to their cells. This detracted from the custody officer focus on their primary role of ensuring that detainees were kept safe and well cared for. The force was aware that the way staff were used needed improving and had plans aimed at achieving this.

1.6 Initial training for custody officers was good, with a three-week in-house training course. This should have been followed by shadowing more experienced officers, but because of limited resources some officers had not been able to do this before undertaking their duties. This meant they might not have been well enough prepared or supported for their new role.

1.7 Although custody assistants employed by Tascor gave us some information about the training they had received, the force was unable to provide any training programme for custody assistants to assure itself that staff working in the suites were suitably and adequately trained.

1.8 Ongoing continuous professional development was managed through training days factored into the shift pattern, but not all staff attended these and so they were not receiving the most up-to-date training. Staff were less positive about e-learning training than the face-to-face sessions they had received on vulnerability, well-being and meeting diverse needs.

1.9 The force followed *Authorised Professional Practice – Detention and Custody* as set by the College of Policing and its own additional custody policies and guidance documents. However, not all the practices we observed followed either guidance – we include examples of these throughout the report.

1.10 Adverse incidents in custody were reported and monitored by the force organisational learning board to identify learning and feed this into training. There had been no deaths in custody since our previous inspection.

1.11 Oversight of the health care contract was good and health services for detainees had improved. The force also monitored and engaged with Tascor, which provided the custody assistants in the custody suites.

Area for improvement

1.12 **The force should ensure that all custody staff consistently follow the College of Policing *Authorised Professional Practice – Detention and Custody* and its own guidance so that detainees receive the appropriate treatment and care.**

Accountability

1.13 The force's approach to monitoring and managing performance was limited – this had been a cause of concern in our previous inspection. While the availability of data had improved, gaps remained. These included data on the use of force in its custody suites, requests for assessments under section 2 of the Mental Health Act 1983, and immigration detention. Custody performance data were considered at the force accountability board but there was little evidence that any performance concerns were identified and addressed consistently. The lack of a robust performance management framework underpinned by accurate data hindered the force from understanding and comprehensively assessing how well it was delivering its custody services, identifying trends and informing learning. (See cause of concern and recommendation S47.)

1.14 The force had insufficient mechanisms to assure itself, the Police and Crime Commissioner and the public that the use of force in detention and custody was always safe and proportionate. Data on incidents in custody suites were not available from the custody system, and those provided from another system (Pronto) were not comprehensive or reliable. In many cases, not enough detail was recorded on detention logs to justify why force or restraint had been used. While use of force was considered at the force legitimacy board, there was little robust oversight of this as the information underpinning it was unreliable. There was insufficient monitoring by supervisors and little cross-reference to CCTV records to ensure the techniques deployed were proportionate and safe. This had been a cause of concern at our previous inspection and remained one in this inspection. (See cause of concern and recommendation S46.)

1.15 Not all practices we observed followed the requirements of code C of the Police and Criminal Evidence Act 1984 (PACE) codes of practice for the detention, treatment and questioning of persons, notably on the conduct of PACE reviews, which in many cases were poor. Too many reviews took place over the telephone, and some detainees had their

detention extended without being told or given the opportunity to make representations. As at our previous inspection, this remained a cause of concern. (See cause of concern and recommendation S45.)

1.16 The quality of recording on detention logs required improvement. There were many gaps. These included the justification and rationale for the use of force and restraint, or actions such as strip searches, which custody officers are required to note on the custody record. There was little information recorded on detainee care. The records did not reflect some of the good practice we observed in the suites.

1.17 The custody records made it particularly difficult to follow the experience of detainees with mental ill health. There was little detail to judge how quickly mental health assessments were carried out, or to establish what subsequently happened. This was poor, especially given the vulnerability of these detainees and the high number entering custody.

1.18 There was some quality assurance through the review of custody records. However, this was driven by individual officers rather than as a consistent and embedded process. This quality assurance was not sufficiently robust or focused on quality to identify the concerns we found in our review of cases.

1.19 The force was committed to meeting the public sector equality duty. There were comprehensive data on the gender, age and ethnicity of detainees, which were monitored at a strategic level. Senior officers were identified as 'champions' for each equality strand and responsible for ensuring that Sussex police met individual needs, as both an employer and service provider. There had been some training to help staff identify and meet diverse needs.

1.20 The force was open to feedback and external scrutiny. There was an effective independent custody visitor (ICV) scheme, and the force responded to issues raised by the ICVs promptly and had made progress in some areas. The force also engaged well with groups representing diverse communities who were invited to comment on new policies and provide independent scrutiny.

Partnerships

1.21 The force had a clear strategic priority to divert vulnerable detainees away from custody and staff had a good understanding of this. This was supported by some good community outreach work to support individuals and prevent or minimise offending. There was also a strong focus on preventing children from entering the criminal justice system and keeping them out of custody. This included early intervention options, such as the 'Reboot' programme, commissioned by the Police and Crime Commissioner to intervene with children at risk of offending by offering support and a range of diversionary activities.

1.22 There was some good engagement with partner agencies to move children who had been charged and refused bail from custody into other accommodation pending their court appearance. However, this had not resulted in any progress with little accommodation available for children to move to. However, the number of these children was low and had reduced since our previous inspection.

1.23 The force had a clear commitment to improving services for those with mental ill health. The mental health street triage schemes were helping prevent some vulnerable individuals from being detained under section136 of the Mental Health Act (see footnote 4) by providing more appropriate health-based solutions, and those who were detained were taken to health-based places of safety and not police custody. However, force information showed that 200 people had been detained in custody under section 136 in the year to 31 October

2019. They had been arrested for an offence but were subsequently identified as requiring a mental health assessment (under section 2 of the act). The force could not provide data on waiting times for these assessments, but in the cases we looked at there were long waits, with further delays if a mental health bed was needed. In some cases, the assessments were not completed while the detainee was in custody, leading to them being detained under section 136 – often when they had been in custody for nearly 24 hours (the legal limit for detention). These detainees were then taken to hospital as a place of safety to wait for an assessment and a mental health bed.

1.24 The force was working in partnership to improve the position, but the mental health services were not meeting the demand in custody for mental health assessments. The force did not have sufficient or reliable information about what was happening to detainees with mental ill health in custody to assess the extent and impact of its use of section 136 powers, and to support discussions and drive improvement strategically. Outcomes for detainees were poor; too many vulnerable detainees were held in Sussex police custody suites for far too long when they should have been moved to a health-based place of safety. (See cause of concern and recommendation S49.)

Section 2. Pre-custody: first point of contact

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

Assessment at first point of contact

2.1 Frontline officers had a good understanding of individuals' vulnerability and that factors such as age, mental health, substance misuse, chaotic life styles and the situation a person found themselves in could influence this. All children were regarded as vulnerable because of their age. There was a force definition of vulnerability and guidance for officers, and recognising and understanding different aspects of vulnerability were threaded through most training, although not all officers had opportunities to attend training sessions. It was clear that frontline officers took account of the force's strong focus on vulnerability and safeguarding when deciding whether to arrest an individual or explore alternatives to keep them out of custody.

2.2 Frontline officers told us that they generally received enough information from the call handlers to help them deal with incidents and could request more if needed. They obtained extensive information from their handheld mobile devices, such as Police National Computer (PNC) warning markers or an individual's history. They felt well informed when making their decisions.

2.3 Children were only taken into custody as a last resort. The necessity test to arrest children was stringently applied, and frontline officers expected custody officers to challenge them on whether custody was the only option. Officers considered voluntary interviews[7] for children and practical solutions, such as discussing the child's behaviour with their parents or taking children to other relatives as a temporary measure while any incident was resolved. Community resolutions (see footnote 3) were also used, and officers could refer children for early intervention and diversion schemes, including the 'Reboot' scheme (see paragraph 1.21). Although there had been an increase in the number of children entering custody in the previous year, in the cases we looked at and observed, arrest had been the appropriate option due to the nature of the alleged offence and/or the risks posed to the child or others.

2.4 Three mental health street triage schemes operated across the force area and offered good support for frontline officers dealing with individuals with mental ill health. None of the schemes were available 24 hours and their working hours varied. Officers reported that when the scheme mental health professionals were able to attend incidents, they could sometimes avoid detaining a person under section 136 of the Mental Health Act (see footnote 4) by finding more appropriate health-based solutions.

2.5 When the mental health triage was not available, frontline officers relied on help from the various mental health services. Although they provided telephone advice to the officer, and the mental health workers would sometimes speak to the individual on the telephone and arrange appointments for them to see mental health professionals, officers said this was not as effective as the triage scheme in finding alternatives to detention.

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[7] Where suspects involved in minor offences attend a police station by appointment to be interviewed about these, avoiding the need for arrest and subsequent detention.

2.6 Demand from individuals with mental ill health was high, and officers said they were often called to incidents where self-harm was involved. In the previous 12 months, 1,240 individuals, including 62 children, had been detained under section 136 because of the risk to themselves or others. The force area includes Beachy Head, a notorious suicide spot, which placed significant pressure on both the police and mental health services. The force and its mental health partners had developed plans setting out the actions to take for some individuals who regularly visited Beachy Head to better manage these incidents and their demand on services.

2.7 Frontline officers said they took individuals detained under section 136 to hospital or health-based places of safety for a mental health assessment. However, where individuals had committed an offence, they arrested them and took them to custody for any mental health concerns to be dealt with.

2.8 Frontline officers reported long waits with detainees at hospitals or health-based places of safety for their mental health assessments. This included waits with detainees who had not received their mental health assessment under section 2 of the Mental Health Act while in custody and who had been detained under section 136 so that an assessment could take place at a mental health facility. (See paragraphs 1.23 and 4.59.)

2.9 Officers called ambulances to transport detainees with mental ill health to health facilities and followed in their police cars. If an ambulance was not able to attend within a reasonable time, officers used their police cars to transport these detainees.

2.10 Officers transported detainees to custody in police cars or police vans, depending on the risks posed. There were no arrangements for detainees who used wheelchairs, but officers said they would take necessary measures, such as using an adapted taxi or police van that could accommodate people in wheelchairs.

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

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

Respect

3.1 Custody officers took time to explain detention procedures to detainees, especially those in custody for the first time, and to engage positively with them. Many detainees told us that staff had treated them well. In all suites we saw staff speaking and acting in a calm, patient and constructive way with detainees, including several whose behaviour was challenging.

3.2 During booking in, we did not routinely see custody officers offering detainees the opportunity to speak to them in private, in accordance with changes to PACE code C, paragraph 9.3A.

3.3 Although small screens at the reception desks ensured that detainees being booked in at the same time could not see each other, there was very little privacy during risk assessment and other formalities. At Eastbourne, Brighton and Crawley, custody officers at the desks were seated well above the detainee, and at some sites, the detainee was asked to stand back from the desk (on footprints painted on the floor). These initial interviews took place in large open areas, with people frequently moving about. These factors meant that custody officers and detainees had to raise their voices to be heard, and therefore overheard. In a few instances, especially at Crawley, the custody officer asked the detainee to move closer so that the conversation could be more private.

3.4 At Brighton, Eastbourne and Worthing, the CCTV screens covering the cells did not obscure the toilets, so that staff could see detainees using them. In our previous two inspections we recommended that the toilets should be obscured on the monitors (see paragraph 4.4). We were told that the design of the IT system did not permit this, and that remedial action would have to wait until the renewal of the system, for which plans were currently being progressed. This was not adequate given the severe adverse impact on the dignity and privacy of detainees, and the approach also did not follow the College of Policing *Authorised Professional Practice* guidance or meet the requirements of recent amendments to PACE code C. (See cause of concern and recommendation S48.)

3.5 Detainees' shoes were routinely removed on their arrival, even in one case where a woman's shoes were soft and had no laces. Replacement footwear was often not offered, and we saw many detainees in the suites with no shoes, and some were barefoot in the cells, which were not always sufficiently warm. At Hastings and Crawley, shoes and any clothing removed from the detainee were routinely left on the floor outside their cell.

3.6 At all suites, except Hastings, the showers for detainees were not private as they had low stable doors and were situated in the corridor.

3.7 In all suites, except Crawley, there were now sufficient signs in the cell corridors and common areas to notify detainees that CCTV was in operation, although staff did not always point these out when locating the detainee into the cell (see paragraph 4.4).

3.8 Staff were alert to the signs of vulnerability in individual detainees, and custody officers picked up indications of need, sometimes making referrals to the liaison and diversion or other services. Custody officers received 'well-being' training, which covered a range of aspects of vulnerability in detainees, and had found this valuable. Custody assistants said that they had not received such training.

Area for improvement

3.9 The force should improve its approach to the dignity of detainees by ensuring that:

- **conversations that cover confidential matters take place in private, and informing all detainees that they can speak privately to custody staff**
- **all detainees are given replacement footwear when their own has been removed**
- **detainees can shower in privacy.**

Meeting diverse and individual needs

3.10 Custody staff had a good understanding of the diverse needs of those in their care, even though few said that they had received recent face-to-face training in this area. Many custody officers had completed e-learning on unconscious bias from the College of Policing. There had been good communication of a new policy on support for transgender people, although not all custody officers had been made aware of this or given training. Staff gave examples of appropriate approaches in working with transgender detainees.

3.11 Women detained in the suites were treated with reasonable care, but there was not always a female member of staff readily available to be their point of contact, although one was always allocated to any girl under 18. Several custody teams had no female staff, and in custody suites not in police stations it was difficult for custody officers to bring in a female officer when required. In one suite, staff reported that a female health care professional was used if necessary, at the risk of confusing roles. Many staff viewed the importance of having a female staff member present only during the searching of female detainees. A well-produced leaflet, 'Rights for women when detained in custody' was given to all detained women on arrival. There was a sufficient range of sanitary items for women in each suite, which was better than at the previous inspection, and the supply was checked regularly, but they were not normally offered until a request was made. We met one woman who needed menstrual care products but did not know that she could ask for them.

3.12 There were some facilities and adaptations for people with disabilities in all sites, although provision varied. Hastings had the most comprehensive. All suites had a wheelchair available, and one cell with sightlines painted on the walls to assist those with visual impairment. In all suites but Crawley this cell also had a lowered call bell by the bench. There were adapted toilets at all sites, but those at Brighton, Eastbourne and Worthing were outside the custody area and not available for detainee use. Thicker mattresses were available in all suites for those who required one, which was an improvement on the previous inspection; Hastings had these in every cell.

3.13 The provision of religious artefacts for detainees had improved to a reasonable standard. Although the items held varied between the suites, the most common faiths were catered for. In most suites (except Crawley), religious items were adequately stored in closed boxes, with guidance for staff, although their storage was sometimes untidy, which was disrespectful for some religions.

3.14 In most cases, but not all, detainees were asked during their booking in to identify their ethnicity from a choice of options. Many foreign nationals passed through the suites, and staff readily used the professional telephone interpreting service when required. All booking-in desks had dual-handset telephones for this purpose. Face-to-face interpreting was also often used: we saw an interpreter present to assist one detainee from their initial risk assessment through to release. There were sometimes long waits for an interpreter for some languages. Staff routinely offered to contact detainees' relevant embassy, high commission or consulate, and custody officers printed out copies of the rights and entitlements material in a foreign language when required.

3.15 There were no hearing loops in any suite, and no evidence that alternative arrangements were made to assist detainees with impaired hearing. A hearing aid was removed from one woman on arrival, with no reason given or recorded, and not returned until she left. She told us she had difficulty hearing staff, and that this had caused problems for her.

3.16 We were told that it was almost never possible to source British Sign Language interpreters, and there were no DVDs 'signing' the content of rights and entitlements. Each suite had a Braille copy of PACE code C, in the outdated 2015 version, but none had the rights and entitlements document in Braille. Easy-read copies of rights and entitlements were available but were not always routinely issued when there was a need (see paragraph 4.33).

Area for improvement

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

- **there is always a female member of custody staff available for each suite to be the point of contact for female detainees**
- **menstrual care products are always offered to women**
- **there are adequate facilities, including adapted toilets, available for all detainees with mobility difficulties.**

Risk assessments

3.18 Detainees did not wait outside custody suites in vehicles and most were booked in quickly (see paragraph 3.28). There were, however, some longer waits of over 40 minutes when the suites were busy. There was little control of queues to manage risks in the holding rooms or to prioritise any children and vulnerable detainees through the booking-in process.

3.19 During booking in, custody officers and detention supervisors focused appropriately on the welfare of detainees and identifying risks and vulnerability factors. They interacted well with detainees to complete standard risk assessments, responded to individual need and in most cases asked suitable supplementary and probing questions. There was routine cross-referencing to Police National Computer (PNC) warning markers and previous custody

records to enhance the assessment of risk. But arresting and escorting officers were not always asked if they had any further relevant information to inform risk assessments.

3.20 Initial care plans did not always set observations at a level that matched the presenting risk. It was particularly concerning that the observation levels set for detainees who were under the influence of alcohol and/or drugs did not always include the required rousing checks, which posed significant risks. In general, observation levels were reviewed regularly but sufficient justification about why these had been changed was not always recorded on custody records (see paragraph 1.16).

3.21 Staff adhered to the required frequency of checks on detainees and there was some continuity of staff conducting the checks, which assisted the identification of changes in a detainee's behaviour or condition. Where rousing had been stipulated, staff carried out thorough rousing checks for detainees under the influence of alcohol and/or drugs in accordance with annex H of PACE code C, and these were well recorded.

3.22 All custody staff carried anti-ligature knives, which was an improvement since our previous inspection. Responses to cell call bells were mostly prompt, but there were sometimes delays, which posed potential risks to detainees who could have required assistance.

3.23 Detainees whose risk assessment indicates a heightened level of risk should be observed at Level 3, constant observation via CCTV, or at Level 4, physical supervision in close proximity, and we expect the officers conducting these roles to be fully briefed by the custody officer. This was not always the case and it was poor practice that some officers were not properly focused on their duties, for example, using their handheld devices when they should have been observing detainees.

3.24 While a minority of custody officers now allowed detainees to retain clothing with cords, footwear and jewellery, based on their individual risk assessments, most continued to remove these items routinely from detainees, regardless of their risk levels; this was a disproportionate response to managing risk. Anti-rip clothing continued to be used sparingly and most custody officers opted to use higher levels of observation to mitigate risks, which was positive.

3.25 Staff shift handovers had improved since our last inspection. The content was generally good and had a sufficient focus on risk and welfare. However, not all custody assistants took part in these, and in two suites they took place in areas not covered by CCTV. Health care professionals were not involved in handovers, which was a missed opportunity. At the start of a new shift, we saw at least one of the custody officers visiting the detainees in their care but most had little, if any, meaningful interaction with them.

Area for improvement

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

- **detainees who are under the influence of alcohol and/or drugs should be placed on observation levels that include rousing**
- **staff should answer cell call bells promptly**
- **officers conducting CCTV or close proximity observations of detainees should be briefed appropriately**

- **detainees' clothing, footwear and jewellery, and items such as hearing aids and glasses, should only be removed following an individual risk assessment**
- **all custody staff should be involved collectively in shift handovers, and these should be recorded on CCTV.**

Individual legal rights

3.27 We observed arresting and escorting officers explaining well why the detainee had been arrested and why the arrest was necessary. Custody officers satisfied themselves that the necessity for arrest met the requirements of PACE code G (the 'necessity test'), asking supplementary questions to clarify information if needed before authorising detention. On one occasion we saw the detention of an individual appropriately refused because the custody officer decided a voluntary attendance interview (see footnote 7) outside of custody was more suitable.

3.28 Force data and our custody record analysis showed that most detainees had relatively short waiting times, normally less than 20 minutes, before they were booked into custody. Similarly in our observations in custody suites, only a few detainees had longer waits, and many detainees walked straight through to the booking-in desks (see paragraph 3.18). When detainees reach the suite, arresting officers completed a custody arrival sheet that was time-stamped, which was an improvement from our 2016 inspection.

3.29 There were a range of alternatives to custody, such as voluntary attendance, community resolutions (see footnote 3) and penalty notices, along with wider diversion schemes. Force data showed an increase of 15 per cent in voluntary attendees over the last three years, with voluntary attendance interviews carried out in rooms outside the custody suites.

3.30 The number of immigration detainees had decreased from 300 to 174 (42 per cent) over the last 12 months. The force could not supply data about immigration detention times and was not monitoring this area. In the few cases we saw, detention ranged between 22 and 45 hours after the IS91 warrant of detention was served, which was too long. However, as at our previous inspection, without information it was difficult for the force to assess whether the escort contractor was prolonging a detainee's time in police custody by failing to collect them promptly. This lack of data continued to be a cause of concern. (See cause of concern and recommendation S47.)

3.31 Not all cases were investigated and progressed promptly. In some cases, detainees arrested during the evening were not dealt with until the following afternoon, many hours into their detention. Custody staff told us they were not aware of a process to triage or prioritise cases, but that they would chase up cases involving children and vulnerable adults to get them dealt with more quickly. Updates about the investigation were not always recorded on the custody record, although they were sometimes noted on the custody electronic whiteboard, so it was not always clear if cases were progressed as quickly as possible. Sometimes there were delays waiting for interpreters to arrive.

3.32 Detainees were informed of their rights and entitlements, and custody officers explained these well. A leaflet copy of their rights was generally offered, but in all suites, except Crawley, this was an out-of-date 2014 version. Most custody officers we spoke to were unaware that there were newer versions. This did not meet the requirements of paragraph 3.2 of PACE code C. As at our previous inspection, many copies of code C were also out of date, and this had not been addressed. (See cause of concern and recommendation 3.45.) Pre-printed foreign language rights and entitlements were also out of date, although most

suites printed the forms when required. Suites displayed posters advertising access to free legal advice in foreign languages, but in one suite only half the languages were displayed.

3.33 Under certain circumstances, a detainee's right to have someone informed of their arrest can be delayed ('incommunicado'), if authorised by an inspector. We observed six cases where detainees were held incommunicado. Although the decisions all seemed justified in the circumstances presented, there was not always sufficient detail in the custody record to show this or how the incommunicado had been dealt with, including when it was lifted and whether the detainee had been informed. We also saw a further three cases of children who were arrested together as co-suspects and held incommunicado, although in all of them the parents had been notified that their child was in custody.

3.34 Custody officers clearly explained the use and retention of DNA when detainees signed to authorise custody assistants to take their fingerprints, photograph and DNA. DNA samples were placed in sealed bags, checked overnight and regularly collected on weekdays. The sample fridges in the custody suites had locks, but we were told they were not always used. Not locking the fridge or leaving samples unattended could affect their integrity.

PACE reviews

3.35 The approach to PACE reviews was poor, did not always meet the requirements of PACE code C, and had not improved since our last inspection. (See cause of concern and recommendation S45.)

3.36 Most reviews were conducted on time but some were too early. In one case in our custody record analysis, a detainee was reviewed after only two hours and 22 minutes in custody, and 30 were conducted at least one hour early. Only nine of 110 first reviews in our analysis took place face to face. Where telephone reviews were used it was often not clear that detainees had been spoken to because insufficient information was recorded on the custody record, and sometimes it was recorded that detainees were asleep when there was evidence on the custody record to the contrary.

3.37 When a telephone review or review of a sleeping detainee had taken place, detainees were not always told about this at the earliest opportunity and the outcome. This did not meet the requirements of paragraph 15.7 of PACE code C. This improved during the inspection after we brought it to the force's attention. We observed detainees being told that a review had taken place and that their continued detention had been authorised, but not all were offered an opportunity to make representations about their continued detention. This did not meet the requirements of paragraph 15.3 of PACE code C. In one case where a face-to-face review took place, the inspector did not tell the detainee their continued detention was authorised.

3.38 The force had installed a 'Live Link' video system in each custody suite to enable face-to-face PACE reviews with the detainee, although custody staff told us that reviewing officers preferred to use the telephone. This did not follow guidance in PACE code C paragraph 15.9B that reviews of detention must not be carried out by telephone if Live Link is available and it is practicable to use.

3.39 Recording of reviews in custody records was mostly very poor, with few details included. There was a reliance on pre-completed text entries; these were not helpful in providing an accurate account of how a review had been conducted, what matters had been covered tailored to each individual, and whether welfare issues had been considered. (See cause of concern and recommendation S47.)

Access to swift justice

3.40 We saw detainees being released under investigation (RUI), and they were given good explanations about the consequences of their behaviour if they attempted to interfere with the course of justice. Bail was not often used but when it was, it was appropriate, and any relevant conditions were also applied.

3.41 Of the 141 detainees in our custody record analysis, 74 had their cases concluded within the first period of detention. The remaining 67 were either RUI or given police bail. Not all suites had a process to manage the RUI cases, and force data for October 2019 showed 6,140 RUI cases. Although the force had started to address this, these detainees did not have access to swift justice. We were told that investigating officers did not have enough time to deal with RUI cases and supervision of cases was limited.

3.42 In addition, when cases were dealt with, they were not always closed properly. We were shown cases where the investigation had been concluded – for example, 'no further action' – but the custody computer system had not been updated and so the information on the PNC was not accurate, which was a data protection breach. All the custody officers we spoke to were aware of the problem but little was done to address it.

Complaints

3.43 Force data on custody complaints for the six months to 1 November 2019 showed that there had been 28 complaints, of which 22 (78%) related to PACE code C – for example, having access to a health care professional or medication administered late.

3.44 The rights and entitlement documents contained advice on how to make a complaint, but most suites did not display posters explaining how detainees could make a complaint. Custody officers had mixed views on the action they would take if a detainee wanted to make a complaint. Some said they would complete the online form while others would tell the detainee to make a complaint once they had been released. In one case, a detainee had wished to complain about an injury to his hand he said had been caused on his arrest. This case had not been referred to a health care professional or an inspector, as required by paragraph 9.2 of PACE code C. This situation had shown little improvement since our 2016 inspection, and it remained unclear if detainees were able to make a complaint while they were still in custody.

Area for improvement

3.45 **Complaints procedures should be well promoted, and detainee complaints should be taken while they are still in custody.**

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

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

Physical environment is safe

4.1 There had been limited progress on some of the required improvements we highlighted in our 2016 inspection. Four of the custody suites were provided and maintained under contract with Tascor. This made it more difficult and hindered the force in making some of the improvements needed, because these had to be negotiated with the contractor. (Chichester was no longer in use and was not inspected during this visit.) The refurbishment of the custody suite at Hastings had led to improvement. Otherwise there had been limited or no progress in addressing our previous cause of concern about the estate. There were many significant potential ligature points in most suites, some of which we identified to the force previously. Although the force had taken some actions to offset or manage the risks posed by the potential ligature points, these were not enough to consistently ensure safe detention. We provided the force with a further comprehensive report illustrating our continuing concerns. (See cause of concern and recommendation S48.)

4.2 Cleanliness was good overall. Custody officers conducted daily checks of the cells and custody suites, but we observed these were often inconsistent, cursory and did not identify the defects we found. Any defects or faults were recorded locally, reported online to a central department and generally responded to and addressed promptly, but staff told us some repairs could take a considerable time if they required an external contractor.

4.3 The cell call bells that we tested functioned correctly.

4.4 Notices advising detainees that CCTV was in operation were prominently displayed in most suites but cells had no signs to advise detainees that CCTV cameras were installed there. The toilet areas in cells in some suites were not obscured on CCTV monitors, which we identified as an area for improvement in our previous two inspections. There were some gaps in CCTV coverage and a lack of CCTV monitors in the suites. (See paragraph 3.4 and cause of concern and recommendation S48.)

4.5 Custody staff were aware of emergency evacuation procedures, and how and where to evacuate detainees in an emergency. There had been several fire evacuation drills at all the suites in the previous year but these had not included all staff. There were sufficient sets of handcuffs in the custody suites to evacuate the cells safely if required.

Area for improvement

4.6 **There should be thorough daily and weekly maintenance checks, and these should be conducted consistently. The recording and quality assurance of cell checks should be improved.** (Repeated recommendation 6.5)

Safety: use of force

4.7 Our CCTV review of incidents and observations showed both operational and custody staff engaging well with detainees and demonstrating patience and respect, which potentially avoided using force. We saw examples of staff using de-escalation techniques to mitigate and minimise the use of force, and found that when force was used it was both necessary and proportionate.

4.8 We reviewed custody records and CCTV footage of 12 cases in which force had been used against detainees in custody. All the incidents had generally been dealt with well, and the force used had been proportionate and appropriate. However, we referred one case back to the force for learning; this was about the time that the detainee had been held in the prone position without a break, which was potentially unsafe.

4.9 Not all custody officers were up to date with their personal safety training, and the force could not tell us how many custody assistants working in the suites were up to date with this training. This is important as all custody staff should be qualified and able to use force safely to ensure the safe detention of detainees and the safety of staff.

4.10 Information on the use of force was not reliable or comprehensive, which meant Sussex Police could not demonstrate that when it was used on detainees it was appropriate and proportionate. The information available did not include all the use of force tactics deployed, and when force was used in custody it was not always recorded fully or accurately on the custody record. Not all officers involved in incidents submitted a use of force form, although the ones we saw completed were comprehensive and detailed. (See cause of concern and recommendation S46.)

4.11 Sussex Police recognised the importance of monitoring and quality assuring the use of force in custody to show that its use by officers was safe and proportionate. However, there was no agreed or consistent process setting out any quality assurance arrangements, and we found little supervisory monitoring of the use of force in custody. This was poor for such an important area of activity and, along with the lack of information cited above, remained a cause of concern. (See cause of concern and recommendation S46.)

4.12 Detainees who arrived in custody in handcuffs usually had these removed promptly. However, although staff recorded on the custody record when a detainee arrived handcuffed, they did not record when the handcuffs were removed, which would have allowed the force to assure itself and others that detainees were not kept handcuffed unnecessarily.

4.13 The force had guidance for the authorisation and conduct of strip searches of detainees. This included the requirement that strip searching of children was, unless in urgent circumstances, authorised by an inspector. Force data force showed that 7.4% of adult detainees, and 8.2% of children had been strip searched in the year to 31 October 2019. Our own custody record analysis showed an increase in the percentage of strip searching since our previous inspection in 2016, and a level higher than the average of other forces we have inspected since March 2016. The reasons for the increase were not clear, but the force was investigating to satisfy itself that its use of strip search powers was necessary and fully justified.

Areas for improvement

4.14 **Sussex Police should ensure that all custody officers and custody assistants are suitably trained and qualified in the use of force.**

4.15 Sussex Police should monitor and analyse its use of strip searches to provide assurance that when carried out these are necessary and fully justified.

Detainee care

4.16 Many of the detainees we spoke to said that their practical needs had been met and they had been well cared for.

4.17 There were sufficient stocks of microwaveable meals, including vegetarian and halal options, as well as hot drinks, and all were well within their use-by dates. Our custody record analysis showed that meals and drinks were offered to most detainees: 88% of the sample had been offered a meal. However, there were often long gaps between the offers of meals entered in these custody records. Although we observed that meals were generally offered with sufficient frequency in the daytime, some detainees had to wait for long periods before they were offered food, especially if they arrived in the evening or at night. Staff said they were flexible in sourcing food outside, or allowing food to be brought in by families where there was clear specific need and sufficient control over their content. Guidance on the dietary and cultural suitability of the food provided was now consistently displayed in all suites.

4.18 Basic clothing was provided to detainees, but during the inspection track suit tops and bottoms were only available in larger sizes, so that some smaller detainees could not be given adequate replacements if their own clothing was removed. Towels and blankets were readily available, but replacement footwear was often not provided (see paragraph 3.5) and there was no replacement underwear other than that made of paper.

4.19 Showers were normally only offered early in the morning to those due to attend court; in our custody record analysis, only 14% of detainees were offered a shower. The showers did not give sufficient privacy (see paragraph 3.6 and area for improvement 3.9). Handwashing facilities were satisfactory, and toilet paper was freely available in cells.

4.20 There were exercise yards at each suite, in some cases more than one. These were not in frequent use: in our custody record analysis, only 4% of detainees were offered exercise, even though several were in custody for more than 24 hours. In the sample, none of the eight people held for over 24 hours was recorded as being offered outside exercise.

4.21 All suites had stocks of books and old magazines for use by detainees. The range of books, brought in by staff, was largely restricted to popular novels in English, without much material for younger or less confident readers. There was no budget for reading material. One suite had some puzzle books. We observed that reading materials were not offered in many cases; in our custody records analysis, 11% of the total of 141, and only one of the eight held for over 24 hours, were recorded as having been offered reading material.

Area for improvement

4.22 The force should improve its approach to how it cares for detainees by:

- **providing an adequate range of replacement clothing for detainees who have had items of their own clothing removed**
- **increasing detainees' access to showers and exercise, particularly when they are held overnight or for extended periods**

- **increasing the range of reading materials, especially for younger and less confident readers and for non-English speakers, and offering them consistently.**

Safeguarding

4.23 All officers showed a good understanding of safeguarding and it was clearly seen as everyone's responsibility. Safeguarding and vulnerability were included in training sessions, and there were briefings to help staff recognise how concerns could arise. We observed good attention to safeguarding both vulnerable adults and children, with some good care and arrangements made for their safe release; children were released to the care of a responsible adult.

4.24 Arresting and investigating officers were responsible for ensuring that safeguarding referrals were made to the multiagency safeguarding hubs to assess the further actions needed. Information on the referral forms was available to all officers through the force's computer system. But in practice custody officers relied on the arresting and investigating officers to make them aware of any concerns that they needed to take account of in caring for detainees while in custody and releasing them safely. There were no processes to ensure this took place, such as specific questions when booking a detainee into custody, and we found few entries on the custody records sampled to show how safeguarding concerns were dealt with. However, we did see discussions between custody and other officers that indicated an appropriate focus on safeguarding.

4.25 In general, the force was ensuring good access to appropriate adults (AAs, independent individuals who provide support to children and vulnerable adults in custody), and this was better than we have seen in most other forces inspected.

4.26 Custody officers contacted, or made efforts to contact, AAs for children quickly. When family members were not available to act as an AA, youth offending teams (YOTs) supplied an AA either through their own staff, volunteers or the contracted service used for vulnerable adults – The Appropriate Adult Scheme (TAAS). In the cases we looked at and observed, AAs generally arrived promptly, and if there were delays the reasons were usually clear. AAs were expected to attend to provide support, and so that the rights and entitlements could be re-read, as soon as possible after the child's arrival in custody. This included overnight. AAs either remained or returned as needed for other aspects of custody processing and for any interviews with the child.

4.27 The force collected information on the time an AA for a child was contacted, and arrangements made to attend, and compared this with the time that the child's detention was authorised, so that it could monitor any delays. Although this information was not completely accurate, it allowed the force to assess whether it was securing AAs as soon as practicable, and to make any improvements needed.

4.28 There were effective arrangements to secure AAs for vulnerable adults. When family members or carers were not able to act, custody officers contacted TAAS, which provided a trained AA promptly in line with the one-hour target. However, vulnerable adults could wait longer for AAs as they were not always called straightaway, depending on how the detainee seemed and whether it was at night. AAs were sometimes only asked to attend for the detainee's interview rather than earlier on in detention.

4.29 Custody officers used their judgement to decide whether an adult required an AA due to their vulnerability. They took account of a range of factors, including previous history, and asked for advice from the health professionals working in custody when needed. There was also written guidance to help custody officers decide. We saw several vulnerable adults in

the suites supported by an AA. But in some case records we looked at, an AA had not been considered, even though there was evidence that one might have been needed. The force did not monitor how many vulnerable adults received support from an AA, which would have enabled it to assess whether it was being consistent and whether all vulnerable adults were receiving the support they were entitled to.

4.30 Custody officers told us that they would explain to an AA the role expected of them, if they were not familiar with this. AA guidance could also be printed off to give to an AA, although custody officers used different documents – such as those from the Home Office, the Police Visual Handbook or Surrey and Sussex guidance for AAs – rather than one agreed version. However, we did not see guidance given out to the AAs we saw in custody.

4.31 Custody officers showed some good care to children in custody: they established a positive relationship with them; notified the nominated adult quickly; and usually held children in the children's cells away from adult detainees. They facilitated telephone calls and visits where possible and, if appropriate, children sometimes stayed in the secure waiting rooms with their parents or AA rather than remaining in a cell. We found examples of this in the case records we looked at and during our observations.

4.32 All children were seen by the liaison and diversion service. If a child was brought in overnight when the team was not working, custody officers notified a designated senior member of the team so that they could follow up as needed. Girls were routinely assigned a named female officer to care for their needs. There were some specific release arrangements for children arrested for running drugs across county lines that ensured that safeguarding arrangements were in place, and referrals made to the Metropolitan Police Service specialist 'rescue and response' service for those involved in these offences.

4.33 However, children were not prioritised for booking in to keep them separate from adult detainees in the waiting areas, and some arrangements to meet their specific needs were not consistently used. The force policy that all reviews of detention for children should be carried out by an inspector face to face did not always happen in practice. Although there were easy-read rights and entitlements materials in the custody suites, and a child-friendly guide to help children understand what happens in custody, these were not routinely given out (see paragraph 3.16).

4.34 There was a strong focus on minimising the time children spent in custody and avoiding overnight detention. Custody officers expected any investigation to be progressed quickly, and if this was not possible, they considered bailing or releasing the child under investigation where it was safe and appropriate. However, the number of children held overnight pending an investigation was not monitored. Although custody inspectors were expected to oversee children entering custody, there were no consistent arrangements for this or to assess that any overnight detentions were justified – this would have provided a more comprehensive picture and help identify where any improvements were needed.

4.35 There was, however, some close monitoring of children charged and refused bail. Detailed information was collected on each case and scrutinised by the force's legitimacy board, with further oversight by the children and young person's oversight board, chaired by a chief superintendent. Cases were also monitored with local authority partners through quarterly scrutiny panel meetings to assess whether jointly agreed procedures had been followed, and to consider any different actions that could have been taken.

4.36 There were discussions at a strategic level between the force and its local authority partners about the provision of accommodation for children to be moved to after they were charged rather than remaining in custody, in line with the statutory responsibility of local authorities to provide such accommodation. Despite this engagement, little progress has been made. Few children were charged and refused bail – only 15 in the year to the end of October

2019. Of these, there were 13 requests for local authority secure accommodation but no child was moved. The one request for non-secure accommodation resulted in the child being moved. The remaining child went straight to court without any accommodation needed. The lack of alternative secure accommodation meant children were rarely moved to this. Officers told us that sometimes a child was taken into police protective custody to avoid them staying in a cell overnight. This remained a poor outcome for these children.

Area for improvement

4.37 The force should continue to work with its partners to ensure that children charged and refused bail are not held in custody but transferred to other secure or appropriate accommodation.

Governance of health care

4.38 Mitie Care and Custody delivered physical health services across all suites through a subcontract with Tascor, and Sussex Partnership NHS Foundation Trust. Sussex Liaison and Diversion Services (SLDS) provided criminal justice liaison and diversion services for substance misuse and mental health. There was close collaboration and effective working relationships between the police and health providers.

4.39 Strategic oversight of health delivery was good, and contract performance was monitored through regular joint police and provider meetings. A web-based service user management system was now used to monitor health care demand across the suites, and produced accurate data for analysis. Clinical governance arrangements were effective, with monthly joint governance meetings informing practice.

4.40 Health care professional (HCP) response times were graded according to clinical or forensic need. Performance data provided by the police and our own custody records analysis and case audits showed that most detainees were generally seen promptly. Response times were monitored and in our custody records analysis, the mean time for HCP attendance was 56 minutes. Mitie data showed the response time was met in 97% of cases. Access to forensic medical examiners (FMEs) was available through Mitie if required.

4.41 There were policies to report and manage incidents. We saw evidence that an independent health complaints process was advertised and used effectively.

4.42 HCPs generally worked between two suites, but there was no evidence that this affected detainees' health needs. Following a recent recruitment drive and appointment of several HCPs, there were plans to introduce an embedded service in each suite, which was good.

4.43 Clinical leadership was strong and all staff we spoke to felt supported. All new staff were assigned a mentor and undertook a six-month induction covering all key areas. Staff received regular supervision and annual appraisals, and complied with mandatory training requirements. Registered nurses and paramedics brought a rich skill mix to the team, and the staff we spoke to demonstrated a good knowledge of health care needs of detainees in custody and possessed the necessary competencies.

4.44 Following recent refurbishment, Hastings custody clinical facilities now met infection prevention standards. However, the other four suites remained of concern, and we judged the clinical rooms at Brighton and Worthing to be unfit for purpose. Rooms were cluttered and showed even more signs of wear and tear than at the previous inspection.

4.45 All HCPs told us they saw detainees in the clinical room with custody staff present and with the door open. This was a requirement of Mitie Care but breached patient confidentiality.

4.46 There were appropriate information-sharing protocols. Health care staff had access to professional interpreting services if required, although there were no dual-telephone handsets in clinical areas.

4.47 Each clinical room held a standard emergency bag containing essential life-support equipment. The contents we saw were appropriate and included a defibrillator; monitoring and checking arrangements were regular and appropriate. All custody staff we spoke with had received basic life-support training, and had access to a further emergency bag and automated external defibrillator in each custody suite.

Areas for improvement

4.48 **The clinical treatment rooms and facilities used for detainee care and forensic examinations should be fit for purpose and meet infection prevention standards.**

4.49 **Clinical consultations should take place in a confidential environment, unless an individual risk assessment suggests otherwise.**

Patient care

4.50 Custody staff understood the role of health care, made appropriate referrals and valued the input given. Detainees we spoke to felt supported and that their needs were met. We found experienced and knowledgeable practitioners with the skills to deliver effective support to detainees, and the interactions we observed were respectful and professional. Consent was obtained from the detainee. Health care staff wore uniforms and were easily recognisable.

4.51 Health care staff used paper-based records, which were stored securely. The records we examined were good quality, contained key health needs and risks, and were contemporaneous. The introduction of a single electronic recording system was being considered, which was positive. All significant risk and medication issues were inputted to the custody record.

4.52 Medicine management practices were safe, and governance of this area was robust and effective. A range of patient group directions (authorising appropriate HCPs to supply and administer prescription-only medicine) facilitated effective detainee care, and were all signed and in date. Drug cupboards were secure and accessible only to health care staff. There was a proportionate range of stock medicines, including controlled drugs, which were safely stored and fully accounted for. The senior HCPs oversaw date and stock checks, and reconciliation arrangements were effective.

4.53 Symptomatic relief for detainees experiencing alcohol or substance withdrawal was available and underpinned by evidence-based protocols. Nicotine replacement lozenges were now available from custody staff in all suites.

Substance misuse

4.54 None of the custody suites had dedicated substance misuse workers, although the SLDS (see paragraph 4.38) all-age, all-vulnerabilities service engaged with detainees with substance misuse problems, and offered support and referral to dedicated community services for each

suite. Senior liaison and diversion practitioners undertook a daily review of detainee needs in custody, and those with substance misuse problems were seen accordingly. In addition, custody staff knew how to signpost detainees to community substance misuse services and sterile injecting supplies. This approach was effective in meeting need. All custody suites had access to naloxone (a drug used to manage substance misuse overdose).

Mental health

4.55 SLDS delivered mental health services across all custody suites. Practitioners were largely embedded in the suites seven days a week between 8am and 8pm, and had recently expanded to provide an all-age, all-vulnerability service, which was promising. Out-of-hours advice was accessed through local crisis services and street triage.

4.56 Custody staff had a good knowledge of mental health issues and valued the liaison and diversion team. Demand for the service was high, and we saw examples where detainees with mental health needs were not seen. Appropriate referrals were made, depending on presentation, and detainees were triaged by a senior mental health practitioner and clear pathways identified. The team had a rich skill mix and included a speech and language practitioner and a youth clinical nurse specialist. As well as working in custody, the team included health care support workers who worked in the community providing support post-custody if required.

4.57 There were good working relations between the liaison and diversion service and police, with regular interagency meetings informing and developing practice. The team provided initial training to custody staff, which was valued. Training and supervision for mental health staff was good, and staff we spoke to felt supported.

4.58 A street triage scheme jointly delivered by police and mental health staff was regarded as an asset in diverting vulnerable people away from custody.

4.59 Detainees with acute mental health problems were no longer brought into custody under section 136 (see footnote 4) as a place of safety. However, we found 200 cases in the last 12 months – an unprecedented number in our experience – where a person had been detained under section 136 while in police custody. Although the picture was complicated and difficult to understand due to poor record keeping in custody records, these seemed due to difficulties in securing approved mental health professional and section 12 doctors, and access to inpatient beds, and transporting detainees to them; these all led to significant delays before detainees received the services they required. Despite engagement with partners, this had not resulted in required improvements and led to extremely poor outcomes with detainees waiting far too long to be transferred to a health-based place of safety. (See cause of concern and recommendation S49.)

Section 5. Release and transfer from custody

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

Pre-release risk assessment

5.1 There was an improved focus on ensuring detainees were released safely, with particular attention to managing the safe release of children and vulnerable detainees. Where necessary, relevant services, such as health care professionals, were often involved to support the release of the detainee. Pre-release risk assessments (PRRAs) were completed routinely with the detainee, and custody officers engaged well and made appropriate use of the initial risk assessment to assist them establish how the individual was feeling and ensure they were safely released. In our case audits and review of PRRAs, however, some records lacked rigour and did not reflect what we had observed. For example, release arrangements were not recorded routinely and did not always demonstrate how a detainee planned to travel home after release (see paragraph 1.16).

5.2 Travel warrants were available at all the suites, and two suites could also provide bus tickets to facilitate travel for those without the means to get home safely. When these options were not available, custody staff told us they would ask police officers to take detainees home, but this depended on their availability.

5.3 Investigating officers dealing with detainees involved in serious sexual offence cases were responsible for providing enhanced support before their release. However, custody officers did not always satisfy themselves that this had been completed before such detainees left custody.

5.4 All the suites had a range of support leaflets, but these were in English only and rarely offered to detainees. We did, however, see several detainees leaving custody with support leaflets issued by the liaison and diversion team.

5.5 Person escort records (PERs) varied in quality and, as at our previous inspection, did not always include sufficiently detailed information. It was inappropriate that PERs contained additional loose-leaf documentation with risk assessments and details of medications administered and health examinations.

Area for improvement

5.6 **All relevant details relating to a detainee's risk and medical concerns should be recorded within the person escort record.**

Courts

5.7 Detainees required to appear in court after being held overnight were processed promptly and most were not held in police custody for longer than necessary. Custody staff told us that the local remand courts generally accepted detainees up to 2pm, but that detainees

arrested on warrant or who were ready for court early in the day were sometimes refused much earlier than this. While we saw the courts accept some detainees before 2pm, we saw a number who were refused. These included one detainee arrested on warrant who was refused by the court just after 10am, and a 17-year-old boy arrested for a breach of bail who was refused by the court at 12.30pm. As a result, both detainees were held in police custody overnight for longer than necessary. This had not improved since our previous inspection.

Area for improvement

5.8 **Sussex Police should engage with HM Courts and Tribunals Service to ensure that detainees are not held in police custody for longer than necessary.** (Repeated recommendation 7.9)

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

Causes of concern and recommendations

Causes of concern S45-S48 were present, and identified, during our 2016 inspection. We now expect the force to address them urgently.

6.1 Cause of concern: The force did not consistently meet the requirements of PACE code C for the detention, treatment and questioning of persons.
Recommendation: The force should take immediate action to ensure that all custody procedures comply with legislation and guidance. (S45)

6.2 Cause of concern: Governance and oversight of the use of force were not sufficient. Data on use of force incidents were not comprehensive or reliable, and not all officers involved in incidents completed use of force forms, as required. This limited any meaningful oversight by senior managers. There was insufficient monitoring and cross-referencing to CCTV footage by supervisors to quality assure incidents, and ensure the techniques used were proportionate and safely deployed.
Recommendation: **The force should assure itself and others that when force is used in custody it is safe and proportionate. It should:**

- **ensure that all officers complete use of force forms for any incident they are involved in**
- **collect and monitor comprehensive and reliable data**
- **establish robust quality assurance arrangements including viewing incidents on CCTV.** (S46)

6.3 Cause for concern: The force's approach to monitoring and managing performance was limited. There were gaps in the data collected for some key areas, and performance concerns were not always identified and addressed. Custody records often lacked detail, including the reasons or justification why some decisions were made, and there was little quality assurance of them.
Recommendation: **The force should collect comprehensive information across its range of custody services and use this to manage performance effectively. The quality of custody records should be improved, and quality assurance should ensure they meet the required standard.** (S47)

6.4 Cause of concern: There were many potential ligature points across the estate, which posed a significant risk to detainees and the force. CCTV coverage in the suites was not good enough to manage risk as there were blind spots and insufficient screens to view and monitor all areas of custody. including all the cells. The cell toilets in three suites were not obscured from view on CCTV screens, which affected detainee dignity.
Recommendation: The force should take urgent action to mitigate the risks posed by ligature points and ensure that there is adequate CCTV coverage across the suites. Toilets should be obscured from view on CCTV monitors. (S48)

6.5 Cause of concern: Too many detainees with mental ill health were held in custody for far too long waiting for mental health assessments and, where needed, onward transfer to a mental health bed. A significant number of detainees were detained under mental health powers while in custody (section 136 of the Mental Health Act), and taken to hospital for their mental health assessment because this had not been completed before their period of detention ran out. Custody record keeping for these detainees was particularly poor, and the force had insufficient information to use as a basis for working with partners to improve outcomes for detainees.
Recommendation: The force should urgently improve outcomes for detainees with mental ill health and ensure they do not remain in custody for longer than necessary. It should work with partners at a strategic level to ensure that detainees receive the service they are entitled to and that mental health assessments are carried out promptly. The force should collect and monitor information to show the outcomes achieved for detainees, and ensure that the custody record accurately reflects the decisions and actions taken. (S49)

Areas for improvement

Leadership, accountability and partnerships

6.6 The force should ensure that all custody staff consistently follow the College of Policing *Authorised Professional Practice – Detention and Custody* and its own guidance so that detainees receive the appropriate treatment and care. (1.12)

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

6.7 The force should improve its approach to the dignity of detainees by ensuring that:

- conversations that cover confidential matters take place in private, and informing all detainees that they can speak privately to custody staff
- all detainees are given replacement footwear when their own has been removed
- detainees can shower in privacy. (3.9)

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

- there is always a female member of custody staff available for each suite to be the point of contact for female detainees
- menstrual care products are always offered to women
- there are adequate facilities, including adapted toilets, available for all detainees with mobility difficulties. (3.17)

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

- detainees who are under the influence of alcohol and/or drugs should be placed on observation levels that include rousing
- staff should answer cell call bells promptly

- officers conducting CCTV or close proximity observations of detainees should be briefed appropriately
- detainees' clothing, footwear and jewellery, and items such as hearing aids and glasses, should only be removed following an individual risk assessment
- all custody staff should be involved collectively in shift handovers, and these should be recorded on CCTV. (3.26)

6.10 Complaints procedures should be well promoted, and detainee complaints should be taken while they are still in custody. (3.45)

In the custody cell, safeguarding and health care

6.11 There should be thorough daily and weekly maintenance checks, and these should be conducted consistently. The recording and quality assurance of cell checks should be improved. (4.6, repeated recommendation 6.5)

6.12 Sussex Police should ensure that all custody officers and custody assistants are suitably trained and qualified in the use of force. (4.14)

6.13 Sussex Police should monitor and analyse its use of strip searches to provide assurance that when carried out these are necessary and fully justified. (4.15)

6.14 The force should improve its approach to how it cares for detainees by:

- providing an adequate range of replacement clothing for detainees who have had items of their own clothing removed
- increasing detainees' access to showers and exercise, particularly when they are held overnight or for extended periods
- increasing the range of reading materials, especially for younger and less confident readers and for non-English speakers, and offering them consistently. (4.22)

6.15 The force should continue to work with its partners to ensure that children charged and refused bail are not held in custody but transferred to other secure or appropriate accommodation. (4.37)

6.16 The clinical treatment rooms and facilities used for detainee care and forensic examinations should be fit for purpose and meet infection prevention standards. (4.48)

6.17 Clinical consultations should take place in a confidential environment, unless an individual risk assessment suggests otherwise. (4.49)

Release and transfer from custody

6.18 All relevant details relating to a detainee's risk and medical concerns should be recorded within the person escort record. (5.6)

6.19 Sussex Police should engage with HM Courts and Tribunals Service to ensure that detainees are not held in police custody for longer than necessary. (5.8, repeated recommendation 7.9)

Section 7. Appendices

Appendix I: Progress on recommendations and areas for improvement since the last report

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

Areas of concern and recommendations

There were a substantial number of potential ligature points across the force custody estate, which presented significant risk to detainees and the force if left unattended. The force was largely unaware of these and, before the inspection, there had been no plans to address or mitigate the risks that these posed. **Recommendation: The force should address the safety issues involving potential ligature points and, where resources do not allow them to be dealt with immediately, the risks should be managed to ensure that custody is delivered safely.** (2.60)	**Not achieved**
Performance information in relation to custody was not comprehensive and there was limited monitoring across the different custody functions, making it difficult for the force and others to assess how well custody services were performing. **Recommendation: The force should develop a comprehensive performance management framework for custody, ensuring the accurate collection of data, and use this to assess performance, identify trends and learning opportunities, and improve services.** (2.61)	**Not achieved**
Governance and oversight of the use of force in custody was inadequate, with insufficient information to demonstrate that all uses of force were both justified and proportionate. **Recommendation: Measures should be put in place immediately that allow all uses of force to be scrutinised, to demonstrates that the application is justified and proportionate.** (2.62)	**Not achieved**
A number of procedures in relation to the provision of custody services were not compliant with code C of the codes of practice relating to the detention, treatment and questioning of persons by police officers. **Recommendation: All staff should comply with code C of the codes of practice, and reviews of detention for children should always be carried out in person. The most recent version of code C should be available in all custody suites.** (2.63)	**Not achieved**
The number of detainees held under section 136 of the Mental Health Act as a place of safety had increased in the previous months. In spite of work	**No longer relevant**

by the force with partners, the position was continuing to deteriorate. In addition, the force was unlawfully detaining vulnerable people, when no other alternative existed, in order to keep them safe. **Recommendation: The force should undertake an urgent review, in collaboration with partners, in relation to the reasons behind the increase in the numbers of vulnerable persons detained in police custody as a place of safety, and take action to avoid the use of police custody as a place of safety for such people.** (2.64)	

Assessment at first point of contact

Police officer 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.

Area for improvement

The force should work more closely with the ambulance service to improve the arrangements to ensure that detainees with mental health problems are transported by ambulance to a place of safety in a timely manner. (4.10)	**Achieved**

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

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.

Areas for improvement

Female detainees should be automatically asked about access to female officers and offered (appropriate) hygiene products during booking in, as per current force policy. The force should also reconsider its ban on the provision of tampons. (5.12)	**Achieved**
In-cell toilets should be obscured on all CCTV camera monitors. (5.13)	**Not achieved**
Booking-in areas should provide sufficient privacy to facilitate effective communication between staff and detainees. (5.14)	**Not achieved**
A full range of religious worship texts and materials should be available and stored appropriately in all custody suites, alongside guidance for staff. (5.15)	**Achieved**
All custody sergeants, detention supervisors and custody assistants should receive the same training opportunities, specifically relating to better understanding of diverse needs, including mental health, vulnerabilities and protected characteristics. (5.16)	**Not achieved**
All staff attending detainees' cell should carry anti-ligature knives. (5.22)	**Achieved**
Detainees' clothing and footwear should be removed only on the basis of an individual risk assessment. (5.23)	**Partially achieved**

All custody staff should be involved collectively in the relevant shift handover. (5.24)	**Partially achieved**
Custody sergeants should ensure that the detainee's correct time of arrival is accurately recorded on custody records. (5.37)	**Achieved**
Hearing loops and the rights and entitlements information in Braille should be available in custody suites. (5.38)	**Not achieved**
The force should ensure that detainees are able to make a complaint while they are still in custody. (5.47)	**Partially achieved**

In the custody cell, safeguarding and health care

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

Areas for improvement

There should be thorough daily and weekly maintenance checks, and these should be conducted consistently. The recording and quality assurance of cell checks should be improved. (6.5)	**Not achieved** (recommendation repeated, 4.6)
Guidance on the dietary and cultural suitability of the food provided should be consistent and available in all suites. (6.28)	**Achieved**
Cell mattresses should be of adequate quality to support all detainees, including additional support versions for those with restricted mobility. (6.29)	**Achieved**
Appropriately diverse selections (age, gender, language, type) of reading materials should be available in all suites. (6.30)	**Not achieved**
The force should continue to work with partners to ensure that children charged and refused bail do not remain in custody overnight but are transferred to alternative accommodation. (6.44)	**Not achieved**
There should be systematic and strategic oversight of all health care provision to determine and monitor outcomes for detainees. (6.50)	**Achieved**
A formal review of treatment rooms and clinical facilities should be undertaken and acted on, to ensure that environments where detainee care and forensic examination occur are fit for purpose. (6.51)	**Not achieved**
The use of closed-circuit television in health care areas should cease. (6.52)	**Achieved**
Waiting times to see a health care professional should be subject to further ongoing analysis, to ensure that graded response times are proportionate in qualitative and quantitative terms. (6.57)	**Achieved**
Detainees should be seen in private unless a risk assessment indicates that this is inappropriate. (6.58)	**Not achieved**
Nicotine replacement support should (be) accessible for detainees who smoke. (6.59)	**Achieved**
Contact activity and support for detainees should be monitored as part of robust health performance management arrangements. (6.62)	**Achieved**
Detainees with alcohol or drug problems should be supported through a comprehensive and integrated level of service within all custody suites. (6.63)	**Achieved**

Detainees with mental health issues should receive prompt assessments, and agreed transfers to hospital facilities should be expedited in a timely manner. (6.68)	**Not achieved**

Release and transfer from custody

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.

Areas for improvement

Attention to pre-release arrangements should be improved. Custody sergeants should ensure that all identified risks are mitigated before release and that this is documented accurately. (7.5)	**Partially achieved**
Sussex Police should engage with HM Courts and Tribunals Service to ensure that detainees are not held in police custody for longer than necessary. (7.9)	**Not achieved** (recommendation repeated, 5.8)
Person escort records should clearly record all know risks for the detainee. (7.10)	**Partially achieved**

Appendix II: Methodology

Police custody inspections focus on the experience of, and outcomes for, detainees from their first point of contact with the police and through their time in custody to their release. Our inspections are unannounced and we visit the force over a two-week period. Our methodology includes the following elements, which inform our assessments against the criteria set out in our *Expectations for Police Custody*.[8]

Document review

Forces are asked to provide a number of key documents for us to review. These include: the custody policy and/or any supporting policies, such as the use of force; health provision policies; joint protocols with local authorities; staff training information, including officer safety training; minutes of any strategic and operational meetings for custody; partnership meeting minutes; equality action plans; complaints relating to custody in the six months before the inspection; and performance management information.

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

Data review

Forces are asked to complete a data collection template, based on police custody data for the previous 36 months. The template requests a range of information, including: custody population and throughput; demographic information; the number of voluntary attendees; the average time in detention; children; and detainees with mental ill health. This information is analysed and used to provide contextual information and help assess how well the force performs against some key areas of activity.

Custody record analysis

A documentary analysis of custody records is carried out on a representative sample of the custody records opened in the week preceding the inspection across all the suites in the force area. Records analysed are chosen at random, and a robust statistical formula provided by a government department statistician is used to calculate the sample size required to ensure that our records analysis reflects the throughput of the force's custody suites during that week.[9] The analysis focuses on the legal rights and treatment and conditions of the detainee. Where comparisons between groups or with other forces are included in the report, these differences are statistically significant.[10]

Case audits

We carry out in-depth audits of approximately 40 case records (the number may increase depending on the size and throughput of the force inspected) to assess how well the force manages vulnerable detainees and specific elements of the custody process. These include looking at records for children, vulnerable people, individuals with mental ill health, and where force has been used on a detainee. The audits examine a range of issues to assess how well detainees are treated and cared for in

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8 http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/inspection-criteria/

9 95% confidence interval with a sampling error of 7%.

10 A statistically significant difference between the two samples is one that is unlikely to have arisen by chance alone, and can therefore be assumed to represent a real difference between the two populations. In order to appropriately adjust p-values in light of multiple testing, $p<0.01$ was considered statistically significant for all comparisons undertaken. This means there is only a 1% likelihood that the difference is due to chance.

custody. For example, the quality of the risk assessments, whether observation levels are met, the quality and timeliness of Police and Criminal Evidence Act (PACE) reviews, if children and vulnerable adults receive timely support from appropriate adults, and whether detainees are released safely. Where force is used against a detainee, we assess whether it is properly recorded and if it is proportionate and justified.

Observations in custody suites

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

Interviews with key staff

During the inspection we carry out interviews with key officers from the force. These include: chief officers responsible for custody; custody inspectors; and officers with lead responsibility for areas such as mental health or equality and diversity. We speak to key people involved in the commissioning and delivery of health, substance misuse and mental health services in the suites and in relevant community services, such as local Mental Health Act section 136 suites. We also speak with the coordinator for the Independent Custody Visitor scheme for the force.

Focus groups

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

Feedback to force

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

Appendix III: Inspection team

Kellie Reeve	HMI Prisons team leader
Martin Kettle	HMI Prisons inspector
Fiona Shearlaw	HMI Prisons inspector
Norma Collicott	HMI Constabulary and Fire & Rescue Services inspection lead
Marc Callaghan	HMI Constabulary and Fire & Rescue Services inspection officer
Viv Cutbill	HMI Constabulary and Fire & Rescue Services inspection officer
Patricia Nixon	HMI Constabulary and Fire & Rescue Services inspection officer
Shaun Thomson	HMI Prisons health and social care inspector
Matthew Tedstone	Care Quality Commission inspector
Joe Simmonds	HMI Prisons researcher
Claudia Vince	HMI Prisons researcher