HMICFRS
His Majesty's Inspectorate of Constabulary and Fire & Rescue Services

Care Quality Commission

Report on an inspection visit to police custody suites in Lancashire

by HM Inspectorate of Constabulary and Fire & Rescue Services and Care Quality Commission

17–31 March 2023

Contents

Fact page

Note: Data supplied by the force.

Force

Lancashire Constabulary

Chief constable

Chris Rowley

Police and crime commissioner

Andrew Snowden

Geographical area

Lancashire

Date of last police custody inspection

2016

Custody suites

West

- Blackpool: 42 cells
- Lancaster: 24 cells

East

Blackburn: 42 cells

South

Preston: 30 cells

Total

138 cells

Annual custody throughput

24,094 between 1 March 2022 and 28 February 2023

Custody staffing

1 chief inspector custody lead

West

- 1 custody management inspector
- 1 bail sergeant

Blackpool

- 15 custody sergeants
- 27 custody detention officers

Lancaster

- 5 custody sergeants
- 10 custody detention officers

East

- 1 custody management inspector
- 1 bail sergeant

Blackburn

- 20 custody sergeants
- 35 custody detention officers

South

- 1 custody management inspector
- 1 bail sergeant

Preston

- 20 custody sergeants
- 30 custody detention officers

Health service provider

Castle Rock Group

Summary

This report describes our findings following an inspection of Lancashire Constabulary custody facilities. The inspection was conducted jointly by HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) and the Care Quality Commission (CQC) in March 2023. It is part of our programme of inspections covering every police custody suite in England and Wales.

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

To help the constabulary improve, we have made one recommendation to it and its police and crime commissioner. This addresses our main cause of concern.

We have also highlighted a further 15 areas for improvement. These are set out in section 6 of this report.

Leadership, accountability and working with partners

Lancashire Constabulary has a clear governance structure to provide safe and respectful custody services, with oversight from senior managers. Since our last inspection, the constabulary has made good progress in improving custody services. However, some areas haven't improved, especially those relating to the use of force and the removal of clothing.

The constabulary generally follows PACE, its codes of practice and other legislation. However, it doesn't do so in all areas, for example when it delays notifying detainees of their rights and entitlements because they are deemed incapable of understanding them, and when reviews of detention are carried out. The constabulary adopted the College of Policing's authorised professional practice (APP), but not all personnel follow it, particularly when managing risk.

The constabulary monitors a range of information about custody services including, for example, waiting times for booking detainees into custody and instances when detention is refused. However, some important information isn't readily available, such as how long detainees wait in custody for Mental Health Act assessments.

Governance and oversight of the use of force isn't sufficiently robust. Since our last inspection, recording of use of force has improved. However, it isn't clear how information is scrutinised to assess whether the use of force in custody is necessary, justified and proportionate.

We have concerns over how some use of force incidents are managed, especially when clothing is removed to manage risk. This sometimes results in using force on a detainee that could potentially have been avoided if the risks had been managed differently. We also found that not enough consideration was given to maintaining detainee dignity when clothing was removed. The use of anti-rip clothing and the associated use of force was an area for improvement in our previous inspection. It is now a cause of concern.

The quality of recording on custody records isn't good enough. There is quality assurance of custody services by dip sampling custody records, but this hasn't identified some of the issues we found.

The constabulary understands its responsibilities under the public sector equality duty. It assesses some custody data for disproportionality.

There is a strong commitment by the constabulary and partner services to keep children out of custody, and good joint working to achieve this. The constabulary also works well with mental health services to support people with mental ill health who come into contact with the police.

Pre-custody – first point of contact

Frontline officers have a good understanding of what makes a person vulnerable, and they take account of this when deciding whether to arrest. Information from call handlers to help officers decide what to do is generally good.

Children are taken to custody only as a last resort. Officers use alternatives such as voluntary attendance interviews instead. The constabulary's early intervention team also helps by working with children to try to prevent them from entering the criminal justice system.

There is good support for officers dealing with people with mental ill health. This is in the form of advice and assistance from the mental health triage service, and a dedicated mental health advice telephone line.

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

Custody personnel treat detainees respectfully and are generally patient and reassuring during their interactions with them. Privacy for detainees is generally well maintained. Detainees are suitably dressed when walking around the suite, but their dignity isn't always protected when clothing is removed.

Custody personnel understand, and do their best to meet, the individual and diverse needs of detainees. There is some good provision in the suites to help them do so, although Blackburn lacks facilities.

The identification of risk is generally good, but it isn't always managed well enough, and some practices don't follow APP guidance. Custody officers (referred to on the fact page as custody sergeants) generally set observation levels for detainees appropriately. Checks on detainees are usually made at the required times, and those under the influence of alcohol or drugs are roused well.

However, custody personnel continue to routinely remove clothing with cords and footwear from detainees rather than making an individual risk assessment to decide this. Anti-rip safety suits continue to be used often and without adequate justification. Sometimes, they are used in response to the behaviour of the detainee rather than the assessed risk the behaviour poses, or they are used because the detainee won't answer the risk assessment questions. Force is sometimes used to remove the clothing; with better risk management, this could be avoided.

Detainees are generally booked into custody promptly and their detention is appropriately authorised. There is generally a good focus on progressing cases as quickly as possible. Custody officers give good explanations to detainees about their rights and entitlements. But if these are delayed because the detainee is drunk or violent, they aren't always then given to detainees at the earliest opportunity.

Reviews of detention don't always comply with the requirements of the PACE codes of practice and aren't always carried out in the best interests of the detainee.

In the custody cell – safeguarding and healthcare

The constabulary has four full-time designated custody suites, at Blackburn, Preston, Blackpool and Lancaster. They are clean and well maintained but there are potential ligature points in all suites.

Custody personnel show a caring attitude towards detainees. Detainees we spoke to were positive about the care they had received in custody. Food and drink are offered and provided regularly. But other care provisions such as showers and exercise aren't. Sometimes there aren't enough personnel to provide them even when a detainee requests them.

Custody personnel have a good understanding of how to safeguard children and vulnerable adults in custody. There are some good arrangements to support this. Custody officers usually secure appropriate adults (AAs) promptly so that early support is provided to most children and vulnerable adults.

Children are detained only when necessary and receive some good care in custody. Custody officers try to keep children's' time in custody as short as possible, but we found that some children spent a long time there. The constabulary seeks to move children charged and remanded to other accommodation but the lack of local authority provision means this rarely happens.

Professional and competent healthcare practitioners carry out prompt clinical assessments and provide good health treatment for detainees. They work well with custody personnel, contributing to decisions regarding risk, fitness to detain or interview, and release.

Dedicated and skilled workers in the liaison and diversion (L&D) service provide good support to vulnerable detainees in custody. This includes help with, for example, mental health or drug and alcohol issues. They also arrange further support in the community after detainees are released, when needed.

We were told Mental Health Act assessments in custody were generally carried out in a timely manner, but there were long wait times if a mental health bed was needed. This leads to detainees being transferred out of custody under section 136 of the Mental Health Act 1983 to wait at a health-based place of safety, usually a hospital. The constabulary doesn't monitor this well enough.

Release and transfer from custody

Custody officers pay good attention to helping detainees get home safely, especially children and vulnerable adults. However, they don't all carry out and record a thorough pre-release risk assessment while the detainee is in their presence.

Custody detention officers complete digital person escort records well for detainees attending court or recalled to prison. But, other than checking these records, custody officers have little involvement in the release of these detainees.

Detainees remanded or arrested on warrant are generally transferred promptly to the next available court. We were told there was a good relationship between court and custody personnel to achieve this and minimise the detainee's time in police custody.

Cause of concern and recommendation

Cause of concern

There has been no improvement in the constabulary's approach to removing clothing from detainees and replacing it with anti-rip safety suits to manage risk, and the use of force to sometimes achieve this. We identified this as an area for improvement in our last inspection. It is now a cause of concern. Our concerns are as follows:

- Anti-rip safety suits are used too often and without sufficient justification. The removal of clothing and replacement with an anti-rip suit is sometimes in response to the behaviour of the detainee rather than the assessed risk the behaviour poses. Sometimes it is solely because the detainee won't answer the risk assessment questions. Little consideration is given to managing the risks in other ways such as increased levels of observations.
- The removal of clothing sometimes leads to force being used to remove it. If the removal of clothing isn't justified, then neither is the use of force to remove it. The use of force could potentially be avoided.
- When clothing is removed, detainee dignity isn't always protected. Although anti-rip clothing is left in the cell with the detainee, some remain naked, and they are given little or no encouragement to put it on.
- There is insufficient governance and oversight over the use of force in custody for Lancashire Constabulary to show that its use is always necessary, justified and proportionate.

Recommendation

The constabulary should make sure that when clothing is removed from detainees and replaced with anti-rip safety suits this is fully justified as the most appropriate way of managing the detainee's risks. It should robustly oversee the use of force in custody to assure itself and others that when force is used it is necessary, justified and proportionate. Custody personnel should take steps to maintain detainee dignity to avoid them remaining naked in their cells.

Introduction

This report is one in a series of inspections of police custody carried out jointly by HMICFRS and CQC. These inspections are part of the joint work programme of the criminal justice inspectorates and contribute to the UK's response to its international obligations under the United Nations Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).

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

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

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

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

The expectations are grouped under five inspection areas:

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

The inspections also assess compliance with the PACE 1984, its codes of practice and the College of Policing's authorised professional practice – detention and custody.

The methodology for carrying out the inspections is based on:

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

We also analyse a representative sample of custody records from all suites in the force area for the week before the inspection starts. For Lancashire Constabulary, we analysed a sample of 100 records. The methodology for our inspection is set out in full at Appendix I.

Terminology in this report

Our report contains references to 'national' bodies, strategies, policies, systems, responsibilities, processes and data. In some instances, 'national' means applying to England and Wales. In others, it means applying to England and Wales and Scotland, or the whole of the United Kingdom.

Section 1. Leadership, accountability and working with partners

Expected outcomes

Chief officers have a clear priority to protect the safety and well-being of detainees and to divert vulnerable people away from custody.

Leadership

Lancashire Constabulary has a clear governance structure to provide safe and respectful custody services. An assistant chief constable is responsible for custody services, supported by a chief superintendent and a superintendent. A chief inspector oversees day-to-day delivery of custody services.

There are effective arrangements to oversee custody:

- Monthly custody tactical group (CTG) meetings chaired by the chief inspector consider matters such as:
    - training;
    - estate maintenance; and
    - changes to APP.
- Quarterly custody policy management group meetings chaired by the assistant chief constable consider:
    - any matters referred from the CTG;
    - policy decisions;
    - health and safety;
    - adverse incidents; and
    - management of the demand for custody services.

The constabulary has made good progress in improving some custody services since our last inspection. But some concerns haven't been dealt with well enough, especially relating to the use of force and the removal of clothing.

The healthcare service in custody is provided by Castle Rock Group. There are good arrangements to oversee the contract at both force and regional level.

There are four full-time custody suites: at Blackpool and Lancaster in the West area, Blackburn in the East and Preston in the South. The suites at Skelmersdale and Burnley, which we reported on in our last inspection, aren't currently in use. The Blackpool suite is newly built but the other three suites are older, and Blackburn lacks some of the facilities to cater for detainee needs in the way we would expect. There are potential ligature points in all of them. We gave a report to the constabulary detailing these and physical conditions in general. It started to act on some of the concerns straight away.

There are three custody management inspectors, 60 officers (referred to on the fact page as 'custody sergeants') and 10 custody detention officers. Sergeants trained in custody from frontline and neighbourhood policing teams provide custody officer cover when necessary.

We found there weren't always enough personnel on duty in the suites. They were stretched at times and not always able to meet detainee needs. Although there were usually enough custody officers, there weren't always enough custody detention officers to offer detainees showers and exercise, and these weren't always provided even when requested. This was particularly the case at Blackburn, where limitations of the intercom system and the lack of sinks in cells mean more demand on detention officer time.

The constabulary provides custody training through its own training department. Initial training for custody personnel is comprehensive and follows the nationally accredited course. Personnel have a period of mentoring before taking up their duties. Continuous professional development is provided every ten weeks. Recent training days have included topics such as adverse incidents, risk management, changes to bail legislation and neurodiversity awareness. Personnel we spoke to were generally positive about the training they received.

The constabulary has adopted the College of Policing's APP, but not all personnel follow it, particularly when managing risk. For example, clothing with cords is always removed from detainees without an individual risk assessment determining it as necessary, and custody officers don't consistently carry out pre-release risk assessments while the detainee is present.

The constabulary generally follows PACE, its codes of practice and other legislation. Custody officers pay good attention to ensuring PACE code G necessity for arrest criteria are met before detention is authorised. But officers who don't inform a detainee of their rights because the detainee is drunk or violent don't always subsequently inform them as soon as practicable. This doesn't follow paragraph 3.1 of PACE code C. Furthermore, some aspects of detention reviews don't meet the requirements of the PACE codes of practice.

There is a good approach to managing adverse incidents, and learning is shared with personnel through regular newsletters. There have been two deaths in custody in Lancashire since our last inspection, and one detainee committed suicide after being released from custody in 2019. The constabulary referred these incidents to the Independent Office for Police Conduct in line with its guidance.

Area for improvement

The constabulary should make sure there are enough custody personnel on duty to meet detainee needs.

Area for improvement

All custody procedures and practices should consistently comply with PACE and its codes of practice, and follow authorised professional practice guidance.

Accountability

The constabulary monitors custody performance at the monthly CTG meeting. Any concerns are reported to the quarterly custody policy management group meeting. Monitoring includes:

- the number of detainees entering custody;
- waiting times for booking detainees into custody;
- children;
- strip searching;
- refusals of detention; and
- adverse incidents.

However, information isn't readily available or monitored for some important areas. For example, the constabulary doesn't monitor the length of time detainees wait for a Mental Health Act assessment, or the time it takes to move them from custody to a mental health facility if needed. Some information is difficult to extract from the constabulary's computer system, such as the use of restraint equipment in custody.

Governance and oversight of the use of force isn't sufficiently robust and hasn't improved enough since our last inspection. There is a strategic use of powers board and a scrutiny group with members from outside the constabulary, including the independent custody visitors scheme. There is enough information available to help these groups scrutinise the use of force, and they also review cases. But it isn't clear what happens as a result of any scrutiny, or how the constabulary uses this information to show that when force is used in custody, it is necessary, justified and proportionate.

The constabulary has recently introduced quality assurance of incidents, including reviewing CCTV footage. This has identified concerns, similar to those we found in our own review of CCTV footage. But there has been little action to address these.

While there has been improvement in how use of force is recorded, we continue to have concerns over how well it is managed, especially when a detainee's clothing is removed and replaced with an anti-rip safety suit to manage risk. This sometimes results in using force on a detainee that could potentially be avoided if the risks were managed differently. The use of anti-rip clothing and associated use of force was an area for improvement in our previous inspection. It is now a cause of concern.

The quality of recording on custody records isn't good enough. We saw some very detailed entries on detention logs, and there was good recording of level 2 rousal checks for detainees. However, there is a reliance on using standard text without removing the text that doesn't apply or adding further details to describe what actions have been taken. This leads to confusing and contradictory entries on custody records. This is especially the case for cell observation visits and reviews of detention.

There is a comprehensive dip sampling process to quality assure custody services. When themes are identified, they are shared via the staff newsletter or used to inform training. But this quality assurance hasn't identified some of the issues we found.

The constabulary understands its responsibilities under the public sector equality duty. Custody personnel have received training on the Equality Act 2010, and on topics such as mental ill health and neurodiverse conditions. The constabulary monitors some custody data for disproportionality. This has recently included data relating to strip searching. Disproportionality is monitored at the equality, diversity and inclusion board chaired by the chief constable.

The constabulary is open to external scrutiny. Independent custody visitors conduct weekly visits to each suite. They report a good relationship with the constabulary. Issues identified at visits are raised with personnel and generally dealt with at the time or at their regular meetings. The scheme manager is included in custody meetings and has access to performance information.

Area for improvement

The constabulary should improve the standard of recording on custody records, so it is clear what actions have been taken. Quality assurance should be robust and make sure records are completed to the required standard.

Working with partners

There is a strong commitment by the constabulary and partner services to keep children out of custody. The constabulary works with the youth justice service to support children and address the causes of offending behaviour. It also works with children's social services to monitor missing children, recognising that early intervention with them will help keep them out of the criminal justice system.

The constabulary also works with its local authorities to move children charged and refused bail from custody to alternative accommodation. However, despite the efforts the constabulary has made, the lack of local authority provision means children aren't moved as they should be.

The constabulary works well with mental health services to support people with mental ill health. There are some good joint working arrangements to help improve outcomes for those with mental ill health who come into contact with the police. An initiative has recently been introduced in the Blackpool area to try and reduce the time police officers spend waiting with people at hospital to hand them over to health professionals.

Section 2. Pre-custody – first point of contact

Expected outcomes

Police officers and staff actively consider alternatives to custody. They effectively identify vulnerabilities that may increase individuals' risk of harm. They divert children and vulnerable adults away from custody when detention may not be appropriate.

Assessment and diversion at first point of contact

Frontline officers have a good understanding of what makes a person vulnerable. They consider, for example, age, alcohol or substance misuse, and mental ill health as influencing vulnerability. They also consider a person's situation, such as their living environment. They take account of any vulnerabilities, and the need to keep a person safe, when deciding what action to take. Officers said they often discussed cases with a custody officer or their supervisor before arrest to decide if it was the right decision, or whether alternative ways of dealing with the incident were more appropriate.

The constabulary provides training on vulnerability. It is usually included in annual officer safety training. Recent training has included recognising the differences between acute behavioural disorder and mental health crisis. Officers told us their knowledge and understanding also came through their experience of policing.

Information to support frontline officers deal with incidents is generally good. Officers told us that call handlers in the constabulary control room scanned police systems and provided as much information as they could to help them. Officers can also get some information directly on their mobile devices. They said they usually had enough information to help them decide what to do.

Children are taken to custody only as a last resort. Frontline officers said they always considered other options to keep children away from custody. These often include arranging attendance interviews or resolving the incident through a community resolution.

The constabulary also has an early intervention team that supports children with offending behaviour. The team works with children to try and prevent them from entering the criminal justice system. It offers diversion activities, such as involving the child in community sport or gym activities. Frontline officers spoke positively about the work of the team and the help it offered when dealing with incidents involving children.

Frontline officers told us they received good support from mental health services when dealing with people with mental ill health. Police officers and mental health professionals working from a car offer a mental health triage service, providing advice and assistance to officers and attending incidents to deal with people directly. The service is available from late afternoon to midnight. Officers spoke highly of it. They said it helped them decide what to do, and it sometimes avoided detaining a person under section 136 of the Mental Health Act 1983 because more appropriate health solutions were provided instead.

When the triage service isn't available, officers ring a dedicated mental health service telephone line. This provides advice and assistance 24 hours a day. Officers told us that, although there were sometimes delays in speaking to someone, the service generally worked well.

When people are detained under section 136, they are usually taken to the A&E department at the local hospital because there are no beds available at the mental health suites. Officers said they usually waited a long time with the person before handing them over to the health service. This is a poor outcome for the person in mental health crisis and poor use of police time. The Blackpool area has recently introduced a trial scheme known as Prometheus, in which the health facility takes responsibility for waiting with the person rather than police officers.

People with suspected mental ill health but who have committed an offence are usually arrested and taken to custody. Once in custody, any mental health concerns are assessed. The investigation of the offence continues until a Mental Health Act assessment determines the person should be transferred to a health-based place of safety. Officers told us they took a case-by-case approach and sometimes asked for information and advice from mental health professionals to help decide whether arrest was appropriate. However, in a few of the cases we examined, it was our view that the person should have been detained under section 136 and taken to a health facility rather than arrested and taken to custody.

Officers carry out a transportation risk assessment for any person they arrest and share this with custody officers. It identifies any vulnerabilities the detainee may have, and concerns that may need to be taken account of when in custody.

Detainees are normally taken to custody in police vans. People detained under section 136 should be transported to a mental health facility or hospital by ambulance. However, because there can be long waits, officers often ask for authority to take the person in a police vehicle. There are no specific arrangements for any detainees with mobility difficulties, but officers said they would make suitable arrangements in discussion with the detainee.

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

Expected outcomes

Detainees are treated respectfully in the custody suite and their individual needs are identified and met. Detainees' risks are identified at the earliest opportunity and managed effectively. Detention is appropriately authorised. Detainees are informed of their legal rights and can freely exercise these rights while in custody.

Respect

Custody personnel treat detainees respectfully and are generally patient and reassuring during their interactions with them.

Privacy for detainees during booking-in is generally well maintained. There are privacy barriers between custody booking-in desks. But poor acoustics at Lancaster, Blackburn and Preston mean conversations are difficult to hear when the suites are busy.

Detainees aren't always offered the opportunity to speak with a member of staff in private when they are booked in. There is a discreet booking-in area at Blackpool for sensitive cases, but no arrangements at the other suites.

There is CCTV coverage in suites and in some cells. Detainees are told about this and that the toilet area in the cell is obscured. CCTV monitoring screens can be seen only by custody personnel and not those in the communal custody areas.

The shower areas don't offer enough privacy. The shower doors at all suites are too low and detainees can be seen from corridors. Personnel try to minimise this by closing corridors and discreetly supervising detainees using them.

Detainee dignity isn't always protected. Detainees are generally properly dressed when walking around the suite or in interviews. But when personnel remove their clothing for safety reasons and give them anti-rip safety suits, detainee dignity isn't always maintained. Although anti-rip clothing is left with the detainee in their cell, some remain naked, and they are given little or no encouragement to put it on. This forms part of our cause of concern about the removal of clothing.

Meeting diverse and individual needs

Custody personnel understand how to meet the individual needs of detainees and those with protected characteristics or from minority groups. They generally do their best to meet these.

The suites have some good provision to help detainees with disabilities. This includes:

- wheelchairs that are in good condition;
- thick mattresses at all suites;
- an adapted toilet at each suite, although, other than at Blackpool, these are used as staff-only toilets;
- hearing loops;
- sight lines on the cell walls (markings to help visually impaired people to judge the position of walls and obstructions); and
- rights and entitlements in easy-to-read formats, including a video shown on a mobile device and a sign language video on the constabulary intranet.

Detainees are routinely asked if they have caring responsibilities for others that need to be considered while they are in custody.

Females are assigned a female member of custody personnel who they can speak with. Menstrual care products are available with handwashing facilities in the cells at three of the suites. At Blackburn there are no sinks in any of the cells, which isn't satisfactory, especially for women. Custody detention officers sometimes give detainees hand gel or wet wipes because they don't have the time to take them to the communal sinks.

Personnel show reasonable knowledge of neurodiversity, how it affects detainees and things that might help, such as distraction activities.

The personnel we spoke to showed a good awareness of how transgender detainees should be treated.

The range of religious items to help detainees to observe their faith is limited. Three suites cater only for Islam and Christianity. Blackburn caters for Judaism as well. The items are stored correctly, and there is guidance for personnel on the handling of the Quran.

Provision for detainees who speak little or no English is generally good. Interpretation is available in most languages. Conversations are conducted over a three-way phone at the booking-in desk to allow for privacy.

Area for improvement

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

- having satisfactory washing arrangements at Blackburn for all detainees but especially for women; and
- catering for all the main faiths at each suite.

Risk assessments

The identification of risk is generally good, but it isn't always managed well enough. Some practices are contrary to APP guidance.

Most detainees are booked in promptly. But when the suite is busy there can be long waits in holding rooms before their detention is authorised. Personnel told us that, when this occurred, they prioritised the booking-in of children and vulnerable adults, and detainees who may pose greater risks.

Initial risk assessments are generally thorough and focus appropriately on identifying risk, vulnerability and welfare concerns. Custody officers interact well with detainees when asking risk questions but don't always explain well enough the purpose of carrying out the risk assessment. They also don't always cross-reference information from, for example, the Police National Computer, previous custody records or force intelligence systems, to help with their assessment. They rarely ask arresting officers or escorting officers if they have any other information to contribute. However, custody officers usually involve healthcare practitioners, when required, to help identify and manage risk.

Custody officers mostly set observations for detainees at a level commensurate with presenting risks.

Detainees under the influence of alcohol or drugs are monitored through level 2 rousal checks, as set out by APP guidance. Custody detention officers rouse them at the required time and in the right way, with the details of the checks accurately recorded. However, there is sometimes a lack of continuity in personnel carrying out such checks. Continuity is important as it makes it easier to establish changes in a detainee's behaviour or condition when under the influence of alcohol or drugs.

Checks that don't involve rousing the detainee are sometimes carried out by looking through the cell door spyglass. This isn't an acceptable welfare check and doesn't follow APP guidance. Most detainees are checked at the required frequency. However, the recording of these checks in the detention log is often poor, using copy-and-paste template entries with little or no wording specific to the detainee.

When the risk assessment indicates a higher level of risk, detainees are observed at either level 3 (constant observation by CCTV) or level 4 (physical supervision at close proximity). The custody officer should fully brief the officers responsible for the observations, with accurate recording of the briefing and the observing officers' details in the detention log. However, this doesn't always happen, and the observing

officers aren't always focused properly on the task of observing or completing observation logs. These practices don't follow APP guidance.

Officers carrying out level 3 observations do so in a spacious area free from distractions. Positively, when officers are conducting level 3 or level 4 observations, custody personnel continue to conduct welfare checks, including any rousals when required.

As found in our previous inspection, custody personnel continue to routinely remove clothing with cords and footwear from detainees rather than making an individual risk assessment to determine if this is necessary. They don't always record when clothing has been removed or the justification for this. This doesn't follow APP guidance.

Anti-rip safety suits continue to be used often and without adequate justification. In many cases, clothing is removed as a response to a detainee's behaviour rather than any self-harm risks they might pose, or because they don't comply with the risk assessment. This practice is a disproportionate way of managing risk, and sometimes leads to force being used to remove the clothing that could otherwise have been avoided. The risks could be better managed by increased levels of observation and by talking with detainees. This hasn't improved since our previous inspection and, as reflected in the Leadership section, is now a cause of concern.

There is a comprehensive handover between all incoming personnel and most outgoing personnel to make sure all relevant information is passed on to those taking over responsibility for detainees. Healthcare practitioners are also involved in handovers. However, after the handover, not all custody officers visit the detainees in their care. Those who do, engage with the detainees and assess the risk well.

Cell call bells work through an intercom system, other than at Blackburn, and personnel generally respond to them promptly. All personnel carry anti-ligature knives, which improves their ability to respond should a detainee attempt self-harm.

The management of cell keys in all suites is good, giving custody personnel good control over the movement of detainees and others in the suite.

Area for improvement

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

- custody officers fully explain to detainees the importance of the risk assessment;
- custody officers cross-reference all appropriate available information when carrying out a risk assessment and ask arresting or escorting officers if they have further information to add;
- there is continuity of personnel who carry out cell checks and level 2 rousals;
- level 4 observations are carried out and recorded as per authorised professional practice requirements;
- the removal of cords and footwear is based on an individualised risk assessment and fully justified in the custody record; and
- all custody officers visit and engage with detainees at the beginning of their shifts.

Individual legal rights – detention

Detainees are generally booked into custody promptly. Most are taken straight to the booking-in desk, but some wait if the suite is busy.

Detention is appropriately authorised. Arresting officers generally explain the circumstances surrounding the arrest well. But they don't always explain the grounds for the necessity to detain, as required by PACE code G, in enough detail. So custody officers sometimes need to ask further questions to help them to decide whether to authorise detention. When detention isn't necessary, it is appropriately refused.

The constabulary uses voluntary attendance interviews as an alternative to arrest. Police stations have interview rooms to use for voluntary attendees, so they enter the custody suite only if fingerprinting or other custody processes are necessary.

There is generally a good focus on progressing cases to keep the detainee's time in custody as short as possible. Investigations are usually expeditious, and officers try to conclude the case, where possible, without the need to bail or release the detainee under investigation.

However, we found some detainees spent a long time in custody. The constabulary monitors detention times but it isn't clear how it uses this information to assure itself cases are dealt with as quickly as possible, or to understand the reasons for any delays.

Bail is appropriately authorised. Any conditions or restrictions are well explained to detainees, and commensurate with the offences under investigation. All appropriate paperwork is given to detainees before they leave.

Custody personnel told us there were good working relationships with immigration services to get immigration detainees moved from police custody to immigration detention facilities.

Individual legal rights – detainees' rights and entitlements

Custody officers give good explanations to detainees about their rights and entitlements. These are:

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

Custody officers routinely give detainees a leaflet setting these out. There are copies of the 'easy read' version for children and those who need help in understanding their rights and entitlements. There is also a video explaining them. Officers also routinely offer the most recent edition of PACE code C to detainees.

However, officers who don't inform a detainee of their rights because the detainee is drunk or violent, or has suspected mental ill health, don't always subsequently inform the detainee at the earliest opportunity, or as soon as the detainee is capable of understanding them. In some cases, the detainee wasn't told, despite them showing some understanding of their surroundings by answering the risk assessment questions. It was sometimes several hours into a detainee's detention before they were informed of their rights and entitlements. We found some cases where a review of detention had taken place, but the detainee still hadn't been informed of them.

We expect custody officers to explore the reasons when a detainee declines free legal advice. But not all custody officers do this.

We also expect legal representatives to be encouraged to represent detainees in person. We saw legal representatives attending in person and custody officers told us this was usually the case.

There are posters in all suites in different languages advertising the right to free legal advice.

All custody officers we spoke to were aware of the requirements of Annex M. This states that detainees should receive documents and records on important information about custody processes in a language they can understand. Officers can find these on the constabulary's computer system to print off and give to detainees.

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

When detainees are held incommunicado (delaying their right to have someone informed of their arrest), this is appropriately authorised. The restriction is removed when no longer required, and the detainee can then speak to the person they have requested.

Detainees who are foreign nationals have the right to speak to somebody at their country's embassy, consulate or high commission at any time. Custody officers arrange this if requested. When custody officers are required to notify these bodies because an agreement exists with the relevant country, this is done.

DNA samples are stored in freezers that are locked or freezers that are in locked rooms, to maintain the integrity of the samples. They are regularly collected from the suites for analysis. We saw posters in all the suites explaining the Protection of Freedoms Act 2012 and the retention and destruction of DNA samples. However, we didn't see this explained verbally to all detainees or see the posters being brought to their attention.

Area for improvement

Detainees who aren't informed of their rights and entitlements, because they are deemed incapable of understanding them, must be given this information at the earliest opportunity.

Area for improvement

Custody officers should ask a detainee why they are declining free legal advice, and record the reasons given.

Reviews of detention

Reviews of detention don't always comply with the requirements of the PACE codes of practice. They aren't always carried out well enough, or in the best interests of the detainee.

Not all reviews are carried out at the due time. Many reviews are carried out in the early hours of the morning when they aren't due for a further two or three hours. This is to fit in with reviewing inspectors' availability on the day shift when they have early morning meetings to attend This isn't in the interests of the detainee as the review is often carried out when they are asleep. If the review had been done at the due time, they would have been awake and could have been spoken to. There is little explanation recorded about the reasons for any early or late reviews, as required. During our inspection, the position improved with more reviews done at the correct time.

When reviews are carried out while the detainee is asleep, the detainee isn't routinely reminded of this at the earliest opportunity, as required by PACE code C paragraph 15.7. When custody officers inform the detainee of a sleeping review, they don't always go through it in detail, and sometimes just tell the detainee of the decision to further authorise detention. This hasn't improved since our last inspection.

However, we observed some good reviews. These included good explanations of how the investigation was progressing and consideration of the detainee's welfare, including the offer of washing facilities, exercise and reading material.

Recording of reviews isn't good enough. Some are recorded using templates that aren't tailored to the detainee, with copy-and-paste information, leading to confusing records.

Area for improvement

The constabulary should carry out reviews of detention in the best interests of the detainee, and consistently comply with PACE and its codes of practice.

Complaints

Notices outlining how detainees can make a complaint are displayed at all custody suites. Information about the Independent Office for Police Conduct (IOPC) is included in the notices but there are no separate IOPC leaflets.

Custody personnel are aware they should take any complaints before a detainee leaves custody, but don't always do this. Instead, the detainee is sometimes directed to the front counter of the police station. This hasn't improved since our last inspection.

Area for improvement

The constabulary should give detainees the opportunity to make a complaint before they leave custody.

Section 4. In the custody cell – safeguarding and healthcare

Expected outcomes

Detainees are held in a safe and clean environment, which protects their safety during custody. If force is used on a detainee this is as a last resort. Their care needs are met, and children and vulnerable adults are protected from harm. They have their physical and mental health, and any substance misuse, needs met.

Physical environment

The constabulary has four full-time designated custody suites, at Blackburn, Preston, Blackpool and Lancaster. They are owned and managed by Lancashire Constabulary. All have been built since 2000. Blackpool was built in 2017 and has modern facilities.

There are potential ligature points across the custody estate, although Lancaster has fewer than the other suites. They are mainly around cell hatches, benches, door frames, some sinks and drain covers for showers, and in exercise yards. During the inspection, we gave the constabulary a comprehensive report detailing these as well as general conditions.

Overall, cleanliness in the suites is good, although there is staining on floors, particularly in corners of cells and around some cell toilets. There is good natural light in most cells, and little graffiti.

Most cells have sinks, apart from Blackburn. Detainees in this suite are taken to one of the two communal sinks to wash their hands. There are communal showers and sinks at all suites. There is a disabled toilet for detainees at Blackpool but the disabled toilets at the other suites are for staff use only.

Several cell doors are glass fronted, which assists, for example, detainees who suffer from claustrophobia. There is a dedicated discreet booking-in facility at Blackpool but no such facilities at the other suites.

CCTV monitors are well positioned to help custody personnel watch detainees on CCTV, without others in the communal areas of the suite able to see. There is a suitable place for officers to sit when carrying out level 3 constant observations.

Other than Blackpool, not all cells are covered by CCTV, which limits the ability to manage risks. When the suites are busy, detainees must sometimes be moved to different cells, so that the CCTV cells can be used for those with higher risks.

The quality of CCTV footage is generally good. Notices that CCTV is in operation are displayed at all suites. However, more notices at booking-in desks, and in van dock areas and holding rooms, would be an improvement.

Daily and weekly safety and maintenance checks of the suites are carried out and recorded well. We were told that repairs were generally completed quickly.

Custody personnel have a good awareness of emergency evacuation procedures. All the personnel we spoke to had taken part in annual evacuation training, but few had taken part in a physical evacuation practice in the past year. There are enough handcuffs in case all cells need to be evacuated, but some evacuation bags lacked torches and tabards.

Area for improvement

The constabulary should address issues involving potential ligature points and, where resources don't allow them to be dealt with immediately, the risks should be managed to make sure that custody is provided safely.

Area for improvement

The constabulary should increase the number of cells covered by CCTV to better manage detainee risks.

Use of force

When force is used in custody it is usually proportionate to the risks posed. But this isn't always the case when force is used to remove clothing.

We reviewed 19 cases of use of force on CCTV. We saw some good communication and negotiation by officers, which de-escalated some situations well, avoiding the need to use force. However, in many of the cases involving the removal of clothing for replacement with an anti-rip safety suit, it wasn't clear from custody records, or our observations of CCTV, that the removal was necessary and justified. In our view, it led to using force that could potentially have been avoided; if the removal of clothing isn't justified, neither is the use of force. In addition, officers didn't always maintain the detainee's dignity well when removing the clothing. This hasn't improved since our previous inspection and, as reflected in the Leadership section, it is now a cause of concern.

In most cases when force was used, it was proportionate to the incident. But custody officers don't always oversee and direct the use of force well enough, and incidents aren't always managed well. We found restraint techniques weren't always deployed in the best way and sometimes officers failed to appropriately control the situation. This resulted in the incident escalating and further force being used, increasing the risk of injury to the detainee and the officers involved. We also saw restraint controls removed too quickly from non-compliant or riskier detainees, resulting in the need to use force.

However, more positively, we found that when force was used, officers often recognised the potential risks to detainees and took action to mitigate them. For example, they protected the detainee's head.

We referred five cases to the constabulary for learning. In three cases, we asked it to review the assessment and monitoring of the detainee's risk and the subsequent use of force. One case involved the use of techniques that in our opinion could have resulted in injury to the detainee, and one case involved the use of incapacitant spray. In four of the five cases, we also had concerns about how the detainee's dignity had been considered.

The use of force in custody is generally well recorded on the custody record, often including the details and role of those involved, and the type of force used. But we found some incidents where force had been used but not recorded on the custody record.

Officers who use force on detainees in custody usually submit individual use of force forms as required by National Police Chiefs' Council guidance. Notices are clearly displayed in some custody suites reminding them to do so, and custody officers also remind them. We asked for use of force forms for the incidents we reviewed, and we received forms for most of them.

Designated sergeants review use of force incidents on custody records and CCTV footage to quality assure and learn from them. This quality assurance has identified some of the concerns we are raising. But it isn't clear what has been done as a result.

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

We found the necessity and justification for a strip search weren't always clearly recorded on custody records. In the cases we reviewed, strip searches were generally conducted appropriately but the dignity of the detainee wasn't always considered. On occasion it was incorrectly recorded that a strip search had been authorised when in fact the detainee's clothing had been removed for replacement with alternative clothing.

Most custody officers and all custody detention officers are up to date with their officer safety training. Training is planned for those who aren't.

Area for improvement

The constabulary should improve its approach when using force on detainees by making sure:

- custody officers direct and oversee incidents to manage them appropriately and prevent any further escalation of force; and
- restraint techniques are deployed in a way that minimises risks of injuries to detainees and officers.

Detainee care

Custody personnel show a caring attitude towards detainees. Detainees we spoke to were positive about the care they had received in custody. However, when detainees are booked into custody, they aren't routinely told about their entitlement to food and drink, exercise, showers and reading material.

The range of food and drink is good, and all reasonable dietary requirements are catered for. Kitchen areas are generally clean although some microwaves need cleaning. Hot drinks, such as tea, coffee and hot chocolate, are offered and provided regularly, as is food, including microwave meals and cereal bars. Guidance regarding meal ingredients is displayed in each kitchen.

There are distraction materials, such as foam balls, colouring books and fidget poppers, in all suites, but we found they weren't often offered or given to detainees.

The range of reading material is good but isn't routinely offered or provided. There are some children's books, usually stored with the distraction materials, and foreign language titles in Urdu, German, French, Swedish, Danish, Polish, Spanish, Norwegian and Finnish. There are coloured sheets at each suite to assist dyslexic readers.

Constabulary policy is not to provide toilet paper to detainees when they go to their cell. Detainees must ask for it. It is our expectation that it is provided. Some custody detention officers told us they did give it routinely, but this is an inconsistent approach.

There is a range of toiletries, including shower gel and combs, but no shaving equipment. All suites have a range of female sanitary products. All suites have exercise yards, but none have partial cover for inclement weather. Our observations found that offers of showers and exercise were limited because there weren't always enough personnel on duty to facilitate them, especially at Blackburn. Even when requested, they aren't always provided.

There is a good supply of replacement clothing, including footwear, in all sizes for detainees who need it. However, there is limited underwear for either sex.

The quality, condition and cleanliness of mattresses is generally good, but some of the thin mattresses provide little support. Pillows are provided as standard, and all suites have extra-thick mattresses.

The blankets are all safety blankets, providing little warmth. Personnel told us the supply of clean blankets ran low on occasion.

Area for improvement

The constabulary should strengthen its approach to detainee care by:

- informing detainees of the care provisions available when they are booked in;
- giving detainees toilet paper when they go to a cell; and
- routinely offering and providing showers and exercise for detainees.

Safeguarding children and vulnerable people

Custody personnel have a good understanding of how to safeguard children and vulnerable adults in custody. They receive regular training and guidance to improve their awareness and on how to respond to some of the different vulnerabilities presented by those entering police custody. Topics have included mental ill health and child sexual or criminal exploitation.

There are arrangements in place that are understood by everyone to safeguard detained children and vulnerable adults. Arresting and investigating officers make referrals (using PVP forms) to the local multi-agency safeguarding hub for assessment. They are also expected to make direct contact with other agencies, such as local authority social services, to discuss cases that require immediate attention. Custody officers check that safeguarding steps have been taken when releasing detainees, which provides additional assurance concerning the safeguarding arrangements.

Children in custody are routinely seen by the L&D team when it is on duty. In the cases we examined, we found this happened consistently, with children spoken to and their needs discussed. When necessary, referrals are made to other agencies to provide support for children after they leave custody.

A female member of custody personnel is assigned to care for girls in custody, as required by the Children and Young Persons Act 1933. Positively, in Lancashire, boys and women are also assigned a same-sex staff member. In the cases we reviewed, and during our observations, we saw detainees were told about this and were usually spoken to by the assigned member of staff. These roles are re-allocated at shift changes, making sure the assigned responsibility continues.

Custody officers make sure children and vulnerable adults get home safely when they are released.

Appropriate adults

Children and vulnerable adults are usually supported by AAs from early in their detention.

Family or carers are considered to act as AAs first and, when possible, arresting officers arrange these at the time of arrest. When this isn't possible, the constabulary uses a contracted AA scheme. Child Action Northwest (CANW) provides AAs for vulnerable adults 24 hours a day across all the suites in Lancashire. For children in the Blackburn, Preston and Lancaster suites, it provides AAs between 9am and midnight. CANW AAs are expected to arrive within three hours. If an AA is required for a child at night, custody officers said they did their best to arrange one. For children in Blackpool, the local youth justice service provides AAs instead.

Custody officers are expected to request an AA within one hour of the detainee entering custody and to arrange for them to attend promptly. In the cases we examined, we found this normally happened, with AAs providing support to help detainees understand their rights and entitlements, and other custody processes, from early on in their detention. We found a few cases where there were long waits for an AA but, overall, the arrangements work well.

Custody officers consider whether vulnerable adults require an AA. However, we examined a few cases where an AA hadn't been considered when there was information to suggest one might be needed.

The constabulary and the PCC's office monitor CANW's performance. They have quarterly review meetings that consider, for example, how quickly AAs attend when called.

Children

Children are detained in custody only when absolutely necessary. Custody officers robustly assess this and refuse detention if it can't be justified. We saw detention appropriately refused in one of the cases we reviewed.

Custody officers try to keep the time children spend in custody to as short as possible. We found some good examples of 'released under investigation' or bail being used to release a child and avoid detention overnight. However, we also found some long detention times, with cases perhaps not dealt with as quickly as they could have been.

Since our last inspection, the constabulary has increased its focus on understanding the needs of children. This has included the promotion of the See the Child campaign, intended to encourage officers to see children as potential victims as well as offenders.

There is some good care of children in custody. A child-friendly video provides tailored content explaining the detainee's rights, entitlements and likely journey through police custody. Other care provisions, including foam balls and other distraction items, and a large collection of books, are also available. However, we didn't see these routinely offered.

The constabulary monitors children in custody, including the numbers entering and how long they spend there. In addition, a custody management inspector reviews all children in custody to assess how well they have been dealt with.

There are also quarterly, well-represented and attended, multi-agency meetings to discuss children in custody, and each agency's role in supporting them. This discussion includes outcomes for children charged and remanded in custody.

However, outcomes for these children remain poor and haven't improved since our last inspection. In the year to 28 February 2023, information provided by the constabulary shows 70 children were remanded, with 69 requests made for alternative accommodation. But no children were transferred. The constabulary is working with its local authority partners (which have a statutory responsibility to provide alternative accommodation) to try and improve the position. But the constabulary could also improve its own approach by considering earlier whether alternative accommodation might be needed and making earlier requests. This would give the local authorities more opportunity to explore what might be available.

Healthcare

Castle Rock Group (CRG) is contracted to provide physical healthcare to detainees and carry out forensic testing in custody. There is good oversight of CRG and good joint working between CRG and the constabulary, with monthly performance reporting and contract management meetings.

Healthcare practitioners (HCPs) aren't embedded in every suite. There are 3 HCPs and 1 forensic medical examiner (FME) on shift 24 hours a day. The HCPs usually start their shifts at Blackburn, Preston and Blackpool with either an HCP or FME covering Lancaster when required. The contract requires that HCPs see 90 percent of detainees within either 1 or 2 hours of being called, depending on the urgency of the request. CRG meets these response times most months. Some detainees experience longer waits if HCPs have to travel between custody suites. Increases in staffing and ongoing recruitment are helping to provide better service coverage by HCPs.

Lancashire and South Cumbria NHS Foundation Trust (LSCFT) is commissioned by NHS England to provide L&D services across the Lancashire custody suites. Both NHS England and the constabulary monitor the service. Staff from CRG and LSCFT work well together, and with custody personnel, to share information appropriately and manage detainees' risks.

HCPs and L&D workers receive relevant training for their roles. This includes safeguarding training to help them identify detainees' vulnerabilities and how to report concerns appropriately. Staff receive an annual appraisal of their performance and told us they felt well supported by managers. They receive regular supervision and attend regular team meetings.

Some of the medical rooms are tired and require redecoration and installation of appropriate handwashing sinks. Infection prevention and control standards are good, and the rooms are kept clean and tidy. Forensic sampling is carried out in medical rooms, which isn't ideal, but the rooms are forensically cleaned before and after examinations. Emergency equipment is well maintained and checked on a regular basis.

Governance systems include regular audits to improve the quality and safety of care provided. These cover infection control, medicines and record keeping. Incidents are reported through the providers' online systems and investigated by managers. Learning is shared with staff during team meetings and individual supervision sessions.

Healthcare staff arrange interpreters for those detainees whose first language isn't English, to aid communication in any healthcare assessment.

Both providers have a confidential complaints process and information about these is clearly displayed for detainees to see.

Physical health

Professional and competent HCPs carry out prompt clinical assessments and provide good health treatment for detainees. Assessments are usually within the agreed target response times, although in cases we examined we found some detainees waited longer. Some tasks can be carried out only by an FME, such as supervising a detainee taking methadone. This means some detainees experience waits if the FME is busy elsewhere. CRG is planning to train the HCPs to carry out these tasks.

Custody personnel are positive about the HCPs and value their advice and support. Our observations found HCPs worked well with custody and L&D workers. HCPs contribute to decisions regarding risk, fitness to detain or interview, and release.

HCPs risk assess whether they see a detainee in private with the door closed or whether it would be safer to have a custody staff member close by. They request consent from detainees to carry out assessments of their physical and mental health, including their mental capacity, and keep detailed records on the electronic patient record.

The clinical lead audits records and takes appropriate action to support staff should their assessment or record keeping not meet required standards. HCPs don't currently have access to detainees' community healthcare records, but plans are advanced to implement this. In the meantime, L&D workers can obtain and share this information with HCPs.

Health staff also record a summary of the interventions on the custody record so that custody personnel are aware of the detainee's healthcare needs.

Mental health

The L&D service provided by LSCFT offers support to detainees of any age or with any type of vulnerability. Dedicated and skilled L&D workers provide good support to vulnerable detainees in custody. This includes help with mental health and drug and alcohol issues, as well as housing and social problems.

L&D workers are in the suites 7 days a week, 8am to 8pm, with community engagement teams supporting the service Monday to Friday, 8am to 4pm. Outside these hours, the HCPs provide acute mental health support as part of their role. There is a rich skill mix in the L&D team, including dedicated children and young people practitioners, social workers, mental health nurses, speech and language therapists, and peer mentors.

Custody officers refer detainees for L&D assessment via the custody computer system or verbally to L&D workers. L&D assessments are carried out promptly once referrals are received. Throughout their working hours, L&D workers also screen those entering custody to identify anyone who may benefit from their support. All children are referred to L&D and seen by specialist children and young people practitioners.

At Blackburn, L&D workers see detainees at their cell door because there isn't a room they can use. This isn't confidential.

L&D workers refer detainees to community engagement workers if they feel they may benefit from additional support on release from custody. The L&D team can work with them for up to 12 weeks to help them access the services they need in the community and offer support from peer mentors.

Every detainee seen by an L&D worker is provided with an information leaflet and a summary of the support they have received and any ongoing support to be provided in the community. Detainees are given a direct contact number for the L&D team, should they require additional help.

L&D workers work closely with custody personnel and HCPs, and attend the daily handover meetings. They said this helped improve working relationships.

Clinical records are held on the LSCFT's electronic system, which all health staff can access. L&D workers record interventions with detainees on both the Trust's system and the custody system, so information is shared. L&D workers can also access a detainee's community mental health records with their consent. The records we reviewed were comprehensive and showed relevant referrals and where there was ongoing support.

The constabulary doesn't use custody as a place of safety for those detained under section 136 of the Mental Health Act 1983, other than in exceptional circumstances.

However, when Mental Health Act assessments are needed in custody, we were told advanced mental health practitioners attended in a timely manner to carry these out. But the constabulary has no data to monitor this.

If onward transfer to a mental health bed is needed, bed shortages mean detainees can't be moved quickly. This results in them being moved out of custody under section 136 to await admission in hospital. Section 136 was used in custody on 146 occasions in the 12 months to 28 February 2023, according to information provided by the constabulary. This may indicate that some detainees with mental ill health are arrested and taken to custody rather than to a health-based place of safety.

When police officers detain people under section 136 in a public place, they usually take them to A&E as a place of safety because of a lack of section 136 suites. In Blackpool, a trial has been introduced to hand over detainees to an external agency while awaiting assessment in A&E. This allows officers to return to duty and leave the detainee in the safe care of others.

Police officers can telephone for advice and information from mental health professionals on a 24-hour basis. This helps them decide the best action to take when dealing with an incident involving someone with mental ill health. Street triage services also operate across the county and officers spoke positively about these.

There are strong working relationships between the constabulary mental health lead and mental health service partners. They work well together to manage the joint working arrangements and improve outcomes for people with mental ill health.

Area for improvement

The constabulary should collect information and monitor how quickly detainees receive mental health act assessments in custody and how quickly they are transferred from custody to a health-based place of safety. This should include the use of section 136 in custody.

Substance misuse

HCPs assess and provide treatment for detainees withdrawing from drugs and alcohol while in custody. They use clinical tools to inform their decision-making and monitor detainees' treatment needs while in custody. When clinically indicated, medicines are administered by staff to relieve withdrawal symptoms.

If detainees are already in opiate substitution treatment in the community, this is continued while they are in custody. HCPs aren't currently trained or authorised to issue prescribed methadone and must contact an FME to do this. CRG plans to train HCPs to administer this medication without the need for an FME to attend.

There is no dedicated substance misuse service in the custody suites. L&D workers refer any detainees who require support from drug and alcohol services to community services. Community engagement workers can support them in attending appointments.

Medicines management

HCPs follow national guidance and provide medicines for detainees following assessment, and in line with the patient group directions (PGDs) provided by CRG. PGDs provide a framework that allows some registered health professionals to administer specified medicines to a pre-defined group of patients, without the patients having to see a prescriber. There are several PGDs available in order to support staff with decision-making for a range of health issues, including acute withdrawal from alcohol and drugs, and pain relief.

Custody personnel provide nicotine replacement therapy on request.

CRG has robust governance arrangements to manage medicines. HCPs use systems and processes to safely administer, record and store medicines. They receive regular training to keep them up to date.

Controlled drugs are managed appropriately, and staff complete regular audits of medicines to identify any potential errors. Medicine errors are reported through CRG's electronic reporting system and managers investigate these promptly. Custody personnel store detainees' own labelled medicines in the property lockers. With support from HCPs, these are provided to detainees at scheduled times.

Detainees' own medicines are transferred to court with them. Detainees who don't have their own supply of medicines are given any required medicine before leaving custody to go to court.

Section 5. Release and transfer from custody

Expected outcomes

Detainees are released or transferred from custody safely. Those due to appear in court in person or by video do so promptly.

Safe release and transfer arrangements

Most custody officers focus on helping detainees get home safely.

However, not all custody officers carry out and record a thorough pre-release risk assessment while the detainee is in their presence. Any risks from the initial risk assessment when the detainee entered custody, or concerns that may have become apparent in custody or been identified by HCPs or L&D, aren't always considered or recorded.

Custody officers explain bail conditions or being released under investigation well. But sometimes the consequences of breaching bail conditions, or the offences that those released under investigation may possibly commit if they interfere with victims or witnesses while the investigation is ongoing, aren't always fully explained.

There is good support agency information available, and leaflets are offered to most detainees on release.

Custody officers have limited ways of helping detainees without means to get home. This leads to a reliance on using police vehicles to transport them. They told us they always made sure children and vulnerable detainees got home safely.

Custody detention officers complete digital person escort records and arrange transport for detainees who are attending court or recalled to prison. These records are completed well, containing relevant risk, health and medication information. Custody officers check the records but, other than this, custody officers don't have much involvement with, or oversight of, the release of detainees to court. They rarely speak with detainees to complete a pre-release risk assessment with them. These practices don't follow APP guidance.

Area for improvement

The constabulary should improve how it releases detainees by making sure:

- custody officers carry out a good quality pre-release risk assessment in the presence of the detainee, identifying all risks and vulnerability and recording these accurately; and
- custody officers oversee, and engage with, detainees transferring to court or prison.

Courts

When detainees are remanded, they are generally transferred promptly to the next available court. Detainees appear before a local court in person, although virtual facilities are available if needed. Sometimes the escorting agency doesn't have the capacity to transfer all detainees attending court at the same time. This results in some detainees being transferred later in the day, lengthening their stay in police custody.

Detainees remanded or arrested on warrant later in the day are sometimes able to appear before the court later the same day. We were told there was a good relationship between court and custody personnel to achieve this and minimise detainees' time in police custody.

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

Causes of concern and recommendations

Cause of concern

There has been no improvement in the constabulary's approach to removing clothing from detainees and replacing it with anti-rip safety suits to manage risk, and the use of force to sometimes achieve this. We identified this as an area for improvement in our last inspection. It is now a cause of concern. Our concerns are as follows:

- Anti-rip safety suits are used too often and without sufficient justification. The removal of clothing and replacement with an anti-rip suit is sometimes in response to the behaviour of the detainee rather than the assessed risk the behaviour poses. Sometimes it is solely because the detainee won't answer the risk assessment questions. Little consideration is given to managing the risks in other ways such as increased levels of observations.
- The removal of clothing sometimes leads to force being used to remove it. If the removal of clothing isn't justified, then neither is the use of force to remove it. The use of force could potentially be avoided.
- When clothing is removed, detainee dignity isn't always protected. Although anti-rip clothing is left in the cell with the detainee, some remain naked, and they are given little or no encouragement to put it on.
- There is insufficient governance and oversight over the use of force in custody for Lancashire Constabulary to show that its use is always necessary, justified and proportionate.

Recommendation

The constabulary should make sure that when clothing is removed from detainees and replaced with anti-rip safety suits this is fully justified as the most appropriate way of managing the detainee's risks. It should robustly oversee the use of force in custody to assure itself and others that when force is used it is necessary, justified and proportionate. Custody personnel should take steps to maintain detainee dignity to avoid them remaining naked in their cells.

Areas for improvement

Leadership, accountability and partnerships

The constabulary should make sure there are enough custody personnel on duty to meet detainee needs.

All custody procedures and practices should consistently comply with PACE and its codes of practice, and follow authorised professional practice guidance.

The constabulary should improve the standard of recording on custody records, so it is clear what actions have been taken. Quality assurance should be robust and make sure records are completed to the required standard.

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

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

- having satisfactory washing arrangements at Blackburn for all detainees but especially for women; and
- catering for all the main faiths at each suite.

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

- custody officers fully explain to detainees the importance of the risk assessment;
- custody officers cross-reference all appropriate available information when carrying out a risk assessment and ask arresting or escorting officers if they have further information to add;
- there is continuity of personnel who carry out cell checks and level 2 rousals;
- level 4 observations are carried out and recorded as per authorised professional practice requirements;
- the removal of cords and footwear is based on an individualised risk assessment and fully justified in the custody record; and
- all custody officers visit and engage with detainees at the beginning of their shifts.

Detainees who aren't informed of their rights and entitlements, because they are deemed incapable of understanding them, must be given this information at the earliest opportunity.

Custody officers should ask a detainee why they are declining free legal advice, and record the reasons given.

The constabulary should carry out reviews of detention in the best interests of the detainee, and consistently comply with PACE and its codes of practice.

The constabulary should give detainees the opportunity to make a complaint before they leave custody.

In the custody cell – safeguarding and healthcare

The constabulary should address issues involving potential ligature points and, where resources don't allow them to be dealt with immediately, the risks should be managed to make sure that custody is provided safely.

The constabulary should increase the number of cells covered by CCTV to better manage detainee risks.

The constabulary should improve its approach when using force on detainees by making sure:

- custody officers direct and oversee incidents to manage them appropriately and prevent any further escalation of force; and
- restraint techniques are deployed in a way that minimises risks of injuries to detainees and officers.

The constabulary should strengthen its approach to detainee care by:

- informing detainees of the care provisions available when they are booked in;
- giving detainees toilet paper when they go to a cell; and
- routinely offering and providing showers and exercise for detainees.

The constabulary should collect information and monitor how quickly detainees receive mental health act assessments in custody and how quickly they are transferred from custody to a health-based place of safety. This should include the use of section 136 in custody.

Release and transfer from custody

The constabulary should improve how it releases detainees by making sure:

- custody officers carry out a good quality pre-release risk assessment in the presence of the detainee, identifying all risks and vulnerability and recording these accurately; and
- custody officers oversee, and engage with, detainees transferring to court or prison.

Section 7. Appendices

Appendix I – Methodology

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

Document review

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

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

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

Data review

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

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

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

Custody record analysis

We analyse a sample of custody records drawn from all detainees entering custody over a one-week period prior to the start of our inspection. The records are stratified to reflect throughput at each custody suite and are then picked at random. Our analysis focuses on the legal rights and treatment and conditions of the detainee.

Case audits

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

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

Observations in custody suites

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

Interviews with personnel

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

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

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

Focus groups

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

Feedback to force

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

Appendix II – Inspection team

- Norma Collicott: HMICFRS inspection lead
- Patricia Nixon: HMICFRS inspection officer
- Anthony Davies: HMICFRS inspection officer
- Ian Smith: HMICFRS inspection officer
- Emmanuelle Versmessen: HMICFRS inspection officer
- Nicola Duffy: HMICFRS inspection officer
- Marc Callaghan: HMICFRS inspection officer
- Vijay Singh: HMICFRS inspection officer
- Mark Calland: HMICFRS inspection officer
- Andy Reed: HMICFRS inspection officer
- Stephen Matthews: HMICFRS inspection officer
- Mathew Tedstone: CQC inspector
- Dayni Turney: CQC inspector

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