STAFFORDSHIRE COMMISSIONER
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# COMMISSIONER'S INDEPENDENT SCRUTINY REPORT

## Custody & Detention – Mental Health Processes
## 21st May 2025

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| **Scrutiny Panel:** | **Custody & Detention** |
| **Members:** | Fred Cox<br>Sue Mather<br>Paul Smith<br>Jennifer Watkins<br>Sue Westwick<br><br>Also present:<br>Insp Barry Greenfield<br>Michelle Ryan – SCO<br>Holly Sproston - SCO |
| **Purpose:** | That the correct procedure has been followed with regard to the detention of detainees with mental health issues. To ensure that the process is compliant with the law and best practice.<br><br>For all aspects, the scrutiny should demonstrate:<br>- Was the action/behaviour justified?<br>- Has it been explained adequately?<br>- Has it been recorded properly? |
| **Panel Findings:** | The panel were offered 5 records where a Mental Health Act Assessment had been undertaken between the period of 1st February 2025 and 15th April 2025. Full Custody Records were provided for the cases. BWV footage was available for one of the incidents.<br><br>**Custody Record C25005718 – Northern Area Custody Facility.**<br>The male detainee was a juvenile on arrest but turned 18 whilst in custody.<br>Detainee was arrested for assault to his father and threats to harm himself. BWV footage was available which showed the arrival at custody and the erratic behaviour of the detainee prior to booking in. The detainee becomes very aggressive. He is officially detained at 17:08. The detainee has to be restrained by 5 officers on arrival. A mental health act assessment is requested at 21:05 and undertaken at 22:51 but detainee is deemed not to require detaining under S2 of the Mental Health Act. The custody record was clear but details were basic. It was not clear from the record who acted as an Appropriate Adult. The panel noted that in the BWV footage, the officers dealing with the detainee were calm in their manner and worked hard to |

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| | de-escalate the situation. However concern was raised with regard to the number of officers talking to the detainee at the same time. They felt this was confusing for the detainee particularly a juvenile who may be distressed, anxious and scared.<br><br>**Custody Record C25001969 –Northern Area Custody Facility.**<br>Male adult detainee was arrested to prevent a breach of the peace. Detainee was aggressive on arrival at 02:40 but refused to answer questions during his medical assessment. It appeared that the detainee had taken monkey dust and the health care professional indicated that a period of rest was required. A mental health act assessment was requested at 21:03 and undertaken at 22:09 and the detainee was detained under S2 of the Mental Health Act. An ambulance was called at 00:13 and arrived at 02:33 to transport the detainee to a mental health unit. The custody log was clear and comprehensive details given of the decisions made and processes followed.<br><br>**Custody Record C25004912 – Northern Area Custody Facility.**<br>Male adult detainee was arrested on release from prison as he made threats to HMP officers that he would kill both his parents. On arrival at 10:57 the detainee was calm and compliant although his record indicated markers for bipolar, schizophrenia and violence. The health care professional requested the attendance of the mental health clinician at 12:30. The mental health act assessment was undertaken at 17:29 w confirmed the detainee was very poorly and should be detained under S2 of the Mental Health Act. The custody log was very detailed and demonstrated the meticulous care of custody officers and the frustration in trying to secure a bed at a mental health unit. A number of calls to various national establishments led to frustrating delays in securing an appropriate bed. Custody staff are to be commended for their persistence in trying to ensure a safe and appropriate environment for the detainee. This was eventually obtained in the Manchester area. |
| **Recommendations and Observations:** | The panel have noted the following:<br><br>**Observations:**<br>• The custody records selected were clear and two out of three had detailed information on the processes and decisions made in helping and supporting these detainees.<br>• In the first incident it was noted that a lead officer should have been nominated to communicate and reassure the detainee rather than a number of officers talking to the distressed detainee at the same time.<br>• The custody records demonstrated the empathy and support officers gave to the vulnerable detainees. This is to be commended.<br>• There were significant delays in finding suitable places at appropriate mental health units. These units are better equipped to deal with these types of issues. The panel recognise that the delays are no fault of the custody staff. |

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| | **Recommendations:**<br>• The Force raise the delay issues with relevant partner agencies. The welfare of the detainee is not best served in custody in these situations.<br>• To remind officers that a lead officer be nominated in custody when communicating with distressed/ aggressive detainees. |
| **Force Lead Response:** | I would like to thank the members of the CISP for their time and dedication. The recommendations and observations of the panel has been fed back to the officers and their supervisors in order to improve our delivery around Mental Health in custody<br><br>Its pleasing to see the use of BWV which shows the level of care provided by the team. I will recirculate advice around a lead officer dealing to act as the spokesperson, although at times this isn't always practical.<br><br>The challenge around beds is a national issue which is reported and tracked though our Custody performance and scrutiny meetings. This is also reviewed by the force lead for Mental Health.<br><br>I recognised that custody is not the right place for persons detained under the MHA, we have an escalation process in place which is shared with the team.<br><br>There is ongoing with updating the force Mental Health policy, which custody are supporting with. |