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COMMISSIONER'S INDEPENDENT SCRUTINY REPORT

Custody & Detention – Mental Health Processes
25th April 2024

Scrutiny Panel:	**Custody & Detention**
Members:	Jim Rowley – Chair Martin Adams George Beech MBE Manny Kang Sue Mather Sue Westwick Also present: Inspector David Hide Michelle Ryan – SCO 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. For all aspects, the scrutiny should demonstrate: - Was the action/behaviour justified? - Has it been explained adequately? - Has it been recorded properly?
Panel Findings:	At the pre-meeting held on 16th April 2024, the panel were offered 8 records where a Mental Health Act Assessment had been undertaken between the period of 1st January 2024 and 31st March 2024. The panel selected 5 records to scrutinise further at the full meeting. Full Custody Records were provided for the selected cases. **Custody Record C24000291 – Northern Area Custody Facility.** Detainee was arrested for threats to kill. He refused to answer any questions on arrival to custody and acted erratically. Previous records indicated possible schizophrenic and alcohol dependent. A Mental Health Act assessment was requested at 09:34 and conducted at 10:30. Detainee was detained under Section 2 of the Mental Health Act and transported to hospital. The detainee was held for 23 hours and 29 minutes.

The custody record was very clear with detailed information on the process and decisions made.

Custody Record C24002228 –Northern Area Custody Facility.
Detainee was arrested for violence against the person. The detainee was under 18. On arrival at custody the detainee was very agitated and indicated he was having thoughts of harming others. It was identified quickly that a Mental Health Act Assessment was required. This was requested at 13:34 took place at 15:10. Detainee was detained under Section 2 of the Mental Health Act. A bed was sought at a suitable hospital and the detainee left custody at 21:07.
The detainee was held for 12 hours and 25 minutes.
The custody record was clear with detailed information on the process and decisions made.

Custody Record C24002288 – Northern Area Custody Facility.
Detainee was arrested for assault and criminal damage. On arrival at custody, records indicated bipolar and detainee indicated he had not taken his medication. During the detention period the Health Care Professional, Solicitor and Appropriate Adult raised concerns with regard to the detainee's mental health. The custody record does indicate the monitoring of this and the decline in the detainee's mental capacity. A Mental Health Act Assessment was requested at 21:17. The Mental Health Act Assessment was undertaken at 00:05. The Detainee was detained under Section 2 of the Mental Health Act at 00:25. The further delay was due to a Psychiatric Intensive Care Unit bed not being available.
The detainee was held for 38 hours and 24 minutes
The custody record was clear with detailed information on the process and decisions made. It was also clear that custody staff made numerous calls to health providers to expedite the transfer to a suitable mental health unit.

Custody Record C24003427 – Southern Area Custody Facility.
Detainee was arrested for stalking, fear of violence. On arrival at custody, intelligence indicated that the detainee was possibly suicidal and had misdiagnosed mental health issues. Detainee was initially calm and compliant on booking in. Later the detainee began to exhibit erratic behaviours indicating he was hearing voices. At 09:10 a request for a Mental Health Act assessment was made. At 14:24 a Mental Health Act Assessment was undertaken. The detainee was detained under section 2 of the Mental Health Act at 15:13. The detainee was transported to a mental health unit at 23:47.
The detainee was held for 25 hours and 04 minutes.
The custody record was clear with detailed information on the process and decisions made. The panel noted again that the detainee was held for eight and a half hours waiting for a bed at a mental health unit and an ambulance.

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Recommendations and Observations:	The panel have noted the following: **Observations:** • The custody records selected were clear and had detailed information on the processes and decisions made in helping and supporting these detainees. • The custody records demonstrated the empathy and support officers gave to the vulnerable detainees. This is to be commended. • 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. **Recommendations:** • The Force raise the delay issues with relevant partner agencies. The welfare of the detainee is not best served in custody in these situations.
Force Lead Response:	As always custody would like to thank the panel of volunteers for taking the time to review and make comment on these records. There is clear reassurance from the panel that the custody staff are effectively identifying incidents of mental health and these are well rationalised on the records. It is also good to note that the team are acting with real compassion. The panel have identified the national problem around the shortage of beds and the delays this causes. To provide reassurance to the panel custody are currently working alongside our early intervention and problem solvers to tackle this area in mental health and are working on a dashboard of performance data to more effectively monitor these delays so a wider strategic understanding of these pressures can be ascertained.