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COMMISSIONER'S INDEPENDENT SCRUTINY REPORT

Custody & Detention – Mental Health Process
18 July 2023

Scrutiny Panel:	**Custody & Detention**
Members:	Jim Rowley – Chair George Beech MBE Samantha Couzens Sue Mather Sophia Norrington Joshua Whitehurst 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:	The panel were offered a selection of 30 records from the time period 1st December 2022 to 31st May 2023 where it had been recorded that detainees had been subject to a Mental Health Assessment under the Mental Health Act. At the pre-meeting on 5th July 2023, the panel chose 6 records to scrutinise. Custody Records and CCTV were requested from the Force. At the scrutiny meeting Custody Records for each detainee were provided. However, for four instances CCTV was not available due to the incident being more than 3 months old. The panel were initially unaware that CCTV is overwritten every 3 months if not required for evidential purposes. For the two other incidents the CCTV was available but operational issues meant that it was unable to be downloaded in time for the scrutiny meeting. It was agreed that in future meetings only incidents / records less than 3 months old would be scrutinised and prepared in good time.

Custody Record C22015710 – Southern Custody Facility

- No CCTV available as the incident occurred on 6th December 2022.
- Detained Person (DP) was Red Carded and rights and entitlements were unable to be given.
- The custody record indicates clearly the aggressive nature and violent nature of the DP.
- The panel noted that the processes were thorough and comprehensive.
- The panel noted that the whole process was very swift and the DP was transported to a place of safety quickly.

Custody Record C23000332 – Southern Custody Facility

- No CCTV available as the incident occurred on 6th January 2023.
- It appears the DP was triaged by Health Care Professional (HCP) from Northern Custody Facility. The panel would like clarity on why this occurred.
- DP was assessed but found not to require being detained under the Mental Health Act and that the criminal justice route should be continued.
- The panel noted that that the process was thorough and comprehensive.

Custody Record CC23000402 – Northern Custody Facility

- No CCTV available as the incident occurred on 8th January 2023.
- No Mental Health Assessment under the Mental Health Act took place, this was deemed as not required.
- The panel noted that that the process was thorough and comprehensive.

Custody Record 23000651 – Northern Custody Facility

- No CCTV available as incident occurred on 13th January 2023.
- DP was heavily impaired by substance abuse.
- DP did not have a Mental Health Assessment under the Mental Health Act until some three days later due to him being unfit to assess.
- DP was then detained under S2 of the Mental Health Act and transported to a place of safety.
- The panel noted that that the process was thorough and comprehensive. In particular this DP presented significant issues and panel members noted the care and consideration given to the DP by all in Custody.
- It appears from the custody record that the DP returns to Custody on 6th April 2023 for failing to attend bail and is subsequently sectioned under s136 of Mental Health Act and transferred to a place of safety. Panel members

questioned whether this was acceptable within the Mental Health Act codes of practice.

Custody Record C23003473 – Northern Custody Facility

- CCTV was available for this incident but due to operational requirements was not downloaded in time for the scrutiny.
- The CCTV was viewed prior to the meeting and shows that the DP was brought straight in to the cell where a cell abstraction takes place. There is no sound on camera cells.
- DP was extremely violent on arrival and taken to a cell immediately.
- A Mental Health Assessment under the Mental Health Act was conducted some 24 hours later due to the aggressive nature of the DP.
- The local place of safety was unable to provide a bed and it was determined that the DP required a Psychiatric Intensive Care Unit bed.
- The panel noted that the custody staff have strongly indicated that Custody is 'not the right and safest place for this patient' to the Hospital and the Mental Health Care professionals.
- Concern was raised by the panel that the DP was unable to transfer to a place of safety for 3 days due to a lack of beds in both local and national facilities.
- The panel felt that custody is not the right place for DPs to be detained for a significant length of time once sectioned under the Mental Health Act.
- The panel noted that that the process was thorough and comprehensive. The DP had significant issues and panel members noted the care and consideration given to the DP by all in Custody. In addition, the panel noted the pressure on custody staff exacerbated by the lack of NHS resources.

Custody Record 23006063 – Northern Custody Facility

- CCTV was available for this incident but due to operational requirements was not downloaded in time for the scrutiny.
- The CCTV was viewed separately prior to the scrutiny and shows a male being brought in and being booked in. The male appears co-operative but affected by a substance. DP is a known Monkey Dust user.
- Mental Health Assessment was undertaken some 20 hours later. Due to ambulance strike an ambulance would not be available for another 6-7 hours. DP was transported to place of safety by officers.
- The panel noted that the processes were thorough and comprehensive.

Update from Previous Scrutiny – June 2022

A scrutiny was undertaken by the panel in 2022 in the same subject area. As part of that previous report the following recommendations were noted.

	• There should be a better way of recording on NICHE where a Mental Health Act Assessment has been requested which will enable a swift method of identifying these types of cases for future review. The Force indicated that there is no specific field and cases are identified by 'Text Search' which isn't always accurate. **Panel Response:** It was noted that the incidents provided for the scrutiny in July 2023 was a better selection. • Sound quality on CCTV footage to be improved. Concern was raised that the poor quality would hamper any future investigations of incidents in custody and future scrutiny reviews. **Panel Response**: Unable to comment as no CCTV was provided. • The panel would review various stages of the booking in process rather than view the whole process on CCTV **Panel Response:** To note for future scrutiny.
Recommendations and Observations:	The panel have noted the following: Recommendations: • That a representative from the Force attends future scrutiny meetings to enable clarification on issues raised during the scrutiny. • For future scrutiny, incidents within Custody are selected within a three-month timeline to ensure the availability of CCTV. Observations: • The panel were impressed with the care and consideration given to detainees which was demonstrated through the custody logs. • The panel recognised the frustration and pressure that officers experienced in dealing with individuals who needed specialist mental healthcare which, at times, was not forthcoming from partnership agencies.

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Force Lead Response - Chief Inspector Lucy Maskew :	I have reviewed the comments made by the panel and it is reassuring to see that it was consistent around the detainees being treated with care and consideration. In order to explore more detail around the HCP triage this will be sent to the thematic lead for custody, Tim Heap, to query the process. In force the Vulnerability Manager is currently working with Annette Powell, Problem Solver Mental Health, to deliver an escalation policy to share with partners to reduce the lengthy waits in custody. It is accepted it is not a place of safety and not the best location for detainees to be whilst assessed. NACF due to acoustics does continue to have issues with sound quality and this has been escalated to Estates. Due to the new operational justice model it has proved increasingly difficult to get a representative to attend these meetings but this has now been placed on the origin system to improve attendance. I will be sharing this document with Tracey Brookes, Force Vulnerability manager and Annette Powell, as there is current ongoing work for a Terms of Reference to be built for force wide mental health scrutiny and this is relevant to this piece of work.