INQ. 619/2013

GREATER MANCHESTER POLICE

Sir Peter Fahy Q.P.M., M.A.
Chief Constable

BM

Ms Joanne Kearsley
Area Coroner
The Coroner Court
1 Mount Tabor Street
Stockport
SK1 3AG

04 March 2014

Dear Ms Kearsley,

RE: Mr. Billy SALTON (Deceased)

Thank you for your report dated 6th January 2014. In accordance with the contents of your Regulation 28 report in respect of Billy SALTON, I reply to the matters you have asked me to consider as follows;

1. During the course of the evidence, I heard that Billy Salton had remained in custody overnight and was not progressed as quickly as he could have been whilst in custody as there was no-one available to interview him. This is as a result of GMP policy on how people are progressed through custody. The Prisoner Processing Unit (PPU) is not staffed overnight which leads to people being in custody longer than they should be and bringing GMP "up against the requirements of the Police and Criminal Evidence Act". GMP cannot indicate how many people may have been detained in custody longer than they should have been under their new policy.

Divisional Commanders hold responsibility for staffing their PPUs overnight but the reality is there are very few detainees who can appropriately be interviewed in the night. Indeed many other agencies are not configured to deal with interviews during the night. The Appropriate Adult Scheme, as just one example, will not turn out in night time hours as they believe it is always inappropriate to interview a person who may be tired.

In the case where there are no PPU officers on duty to interview, it is the Custody Sergeant's responsibility to liaise with the Operational Inspector, who acts as Bronze Command for that Division, to agree on resource provision to ensure the effective progress of the investigation. As you observed this often leads to a decision being made to await interview in the morning because the police officers are patrolling and dealing with incidents..

I acknowledge that such delays in custody, whilst waiting for an interviewing officer to be identified, have become increasingly common. I have an ongoing review of divisional policing entitled 'Transforming Divisional Policing' which looks at all aspects of improving the operational service we provide. I have specifically asked it to look at finding ways of processing detainees with greater efficiency in order to reduce their periods of detention.

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2. There was a lack of understanding amongst the custody staff and staff from other agencies as to the level of observations Mr Salton was on and why he was on those observations. It is important that everyone who has care of someone in custody understands what the observations have been, what they should be, when they are to be carried out, whether rousing is required and why the observations are set as they are – i.e. what the medical condition/concern is.

GMP has reviewed its arrangements for communication between custody and clinical staff to negate the practice of MEDACs staff working on two separate records of notes and to improve the continuity of care provided to detainees with health needs.

This has involved the installation of a computerised system for use by MEDACS clinicians, which operates within prescriptive rules requiring MEDACS to type the 708e to overcome issues of illegibility, improve continuity and to seek to ensure the details of the record are directly transcribed into the ICIS custody system.

To improve clarity on levels of observations we have amended the 'drop down' menus accessible to the MEDACs clinicians attending custody suites. Plans are in place to enable MEDACs to directly input their care plans onto our custody system which will further improve communication between custody and clinical practitioners.

A training programme for all clinicians has been agreed which will ensure they are trained and authorised to input onto ICIS by summer 2014.

We accept there continues to be room for improvement in communication in the custody office and have engaged a work programme enabling Custody Sergeants to do more managing in the custody environment and to take a greater overview of the overall working of the office and CDO's. In practice, for example, this would entail the Civilian Detention Officers undertaking specific sections of the 'booking-in' process which facilitates a greater overview of the entire custody environment both front office and back office. This programme is bedding in under the leadership of Chief Superintendent [redacted] *and Superintendent* [redacted]

3. When the detainee is visited and checked all such visits should be accurately recorded on the custody record.

We already have a process that checks custody records to ensure visits are timely and carried out in accordance with the sergeant's risk assessment.

It is though more difficult to check on visits that have been made but not recorded although this sometimes arises when cases are reviewed. It is commonplace for staff to say that there are so many interactions in custody, at some point, they have to take a view on what is worthy of recording.

I do agree with this but can see how this can degrade into quite significant events not being accurately recorded. We will, therefore, shortly be giving a series of inputs to staff which will

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focus on recording the rationale behind risk assessments and will also demonstrate to staff the importance of recording their actions as accurately as possible. The Professional Standards Branch will be involved in this programme, which will involve the use of case studies to enhance best practice.

4. Risk assessments carried out whilst in police custody should be recorded when they are done. If there are no changes to a risk assessment then this should be recorded and any rationale noted.

Since the death of Mr Salton, Custody Branch has significantly upgraded its ICIS computer system. This system prompts Custody Sergeants to undertake further reviews linked to specific/significant events affecting the detainees period of detention, including an exit risk assessment.

You are right to point out that all risk assessments, including those where there is no change in the detainee's circumstances, should also be recorded. This requirement has been communicated to custody staff and is currently being monitored by Custody Inspectors undertaking dip sampling of custody records.

5. Handovers between Custody Sergeants were ineffective and there was no handover between the Civilian Detention Staff. Important information was missed or lost in translation. Proper handovers should take place as to the detained person's condition, risk assessment, any medical condition, levels of visits and other important matters.

We have conducted a review of handovers between sergeants. As a result we have made it clear to sergeants that the handover need not be a comprehensive review of each detainee. Rather, they should have completed the Custody Summary Screen so that all the relevant detail is available on the ICIS system and the handover should contain key risk issues, for example medical conditions, medication required and so forth.

It is now our operating policy that this summary screen should be accurate so that staff use the computer to ascertain key information and work from this.

The work programme, mentioned above, also seeks to improve communication channels in custody amongst Custody Sergeants and Custody Detention staff both during handover and during the working day.

6. The Prisoner Escort form (PER) was incorrectly completed. The final Custody Sergeant should ensure that the transferring documentation is accurate.

Since your observations we have put out improved guidance on completion of the PER form to sergeants which include what to record, when it is to be done and how it is to be signed off. This has been extensively checked and has led to improvements in standards.

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7. There were no specific instructions to monitor Mr Salton whilst he was in the CCTV cell. The CCTV screen is situated furthest away from the desk where someone in the back office is more likely to be seated (next to the security controls) meaning that there is less likelihood of them "glancing" at the CCTV screen.

At present we remain satisfied with our current arrangements for CCTV usage. We do use CCTV for constant observations in some cases. However, in the case with Mr Salton, the level of observations was at Level 2.

We see CCTV as something that adds value to the care plan in such situations but would not want to commit to specifically instructing staff to observe the screen at this level of observations. In the way we currently operate, we believe, this may lead to a deterioration in the level of coverage of detainees by CCTV. I also am keen that CCTV use never becomes an alternative to the necessary personal contact between my staff and detainees.

We are currently happy that the CCTV is optimally placed to be viewed by all staff who work in Custody.

The programme of work I described earlier in improving communication and management of the office is looking at every aspect of the roles staff undertake in Custody. The monitoring of CCTV is one of those roles and they will be looking for a system that matches or improves the coverage of CCTV we have and also provide greater accountability.

On a final general point I am concerned that Custody, which is primarily a function to achieve criminal justice outcomes, is increasingly being used to deal with issues and matters that do not lie within the scope of policing. I acknowledge that we should always strive to achieve the best possible care for all detainees. However, we are undoubtedly picking up the gaps in services which should be provided by other agencies. This takes our attention and resources from policing but also places officers, who are not medically trained, in increasingly difficult situations.

As a force we are working with other agencies, particularly the NHS, to reduce the number of those with mental illness or other medical conditions coming into custody. Long term this would ideally include a facility to deal with drunken individuals. In this day and age the concrete rooms of a custody block are not suitable places for sick people.

Yours sincerely

[redacted]

Sir Peter Fahy
Chief Constable