Report on an inspection visit to police custody suites in Dorset Police

9–13 November 2009

by

HM Inspectorate of Prisons and

HM Inspectorate of Constabulary

Printed and published by:
Her Majesty's Inspectorate of Prisons
1st Floor, Ashley House
Monck Street
London SW1P 2BQ
England

Her Majesty's Inspectorate of Constabulary
Ground Floor, Ashley House
Monck Street
London SW1P 2BQ
England

Contents

1. Introduction

This report is one in a series of inspections of police custody carried out jointly by our two inspectorates. These inspections form a key part of the joint work programme of the criminal justice inspectorates. They also contribute to the United Kingdom's response to its international obligation to ensure regular and independent inspection of all places of detention.[1] The inspections look at force-wide strategies, treatment and conditions, individual rights and healthcare.

There was a clear management line for the oversight of custody, but there appeared to be some weaknesses at middle management level, which meant that custody staff were not always aware of key policies. We had some concerns about the training of custody officers and the staffing levels in some suites. There were excellent relationships with the Police Authority and independent custody visitors (ICVs), but limited meetings with other strategic partners except healthcare.

At the time of the inspection, there were three main custody suites in Dorset. One was in good condition, but the other two were poor facilities – old, dirty and with cells covered in graffiti. One was due to close shortly after the inspection, but we considered that the other had significant safety issues, which we reported to managers.

There were excellent relationships between staff and detainees, and staff were attentive to individual needs. Procedures to identify and support those at risk of self-harm were good, but personal necessities, such as reading glasses and trouser cords, were removed without any documented risk assessment. There was limited awareness of child protection issues and the specific issues for women, but help was provided to detainees with limited English or learning difficulties. Use of force in custody was not always recorded.

Detainees' rights under the Police and Criminal Evidence Act were observed, and there were arrangements to support the release of vulnerable detainees. However, the appropriate adult scheme did not operate effectively out of hours, and they were not always provided, even for those under 17. A large number of immigration detainees were held, some for over-long periods, though staff tried to support them while in custody. Court cut-off times were very early and this resulted in unnecessarily long, sometimes overnight, stays in custody for juveniles and adults.

Healthcare was commissioned by the primary care trust, on a model in line with, but preceding, the Bradley review into mental health provision in the criminal justice system. Nurses were available 24 hours a day in the three main suites, and doctors called when needed. Detainees were routinely asked whether they wanted to see a healthcare professional, and mental health provision was good. Substance misuse services were however limited and needed urgent review to provide a consistent and comprehensive service across the county.

This inspection found a great deal of good practice in Dorset. Partnership working with the Police Authority and the ICVs was excellent. Healthcare arrangements were among the best we have seen, providing on-site, professional support. Line management was clear, though middle management and staff training and deployment needed to be strengthened. In general, staff treated detainees sensitively and well, though the specific needs of women and juveniles were not always recognised. We had some serious concerns about the state of two of the

[1] Optional Protocol to the United Nations Convention on the Prevention of Torture and Inhuman and Degrading Treatment.

custody suites, and in particular safety issues in one of them. Immigration detainees spent too long in custody, a systemic issue which requires concerted action with the UK Border Agency. We found managers and staff receptive to our concerns, and hope that this report will assist them to improve provision even further.

Denis O'Connor
HM Chief Inspector of Constabulary

Anne Owers
HM Chief Inspector of Prisons

January 2010

2. Background and key findings

2.1 HM Inspectorates of Prisons and Constabulary have a programme of joint inspections of police custody suites, as part of the UK's international obligation to ensure regular independent inspection of places of detention. These inspections look beyond the implementation of the Police and Criminal Evidence Act 1984 (PACE) codes of practice and *Safer Detention and Handling of Persons in Police Custody* 2006 (SDHP) guide, and focus on outcomes for detainees. They are also informed by a set of *Expectations for Police Custody*[2] about the appropriate treatment of detainees and conditions of detention, which have been developed by the two inspectorates to assist best custodial practice..

2.2 At the time of this unannounced inspection, Dorset Police had three main custody suites designated under PACE for the reception of detainees: Bournemouth and Poole in the east and Weymouth in the west of the county. Designated custody facilities were also available and being used in nine small satellite suites situated in police stations around the county. The three main suites operated 24 hours a day and dealt with detainees arrested as a result of mainstream policing. This inspection was largely conducted in the designated custody suites, but visits were made to eight of the nine satellite facilities. A survey of prisoners at HMP Dorchester, who had formerly been detained at custody suites in the force area, was conducted by HM Inspectorate of Prisons researchers to obtain additional evidence (see Appendix III).

2.3 The force cell capacity was 80. Bournemouth had 18 cells, Poole had 16 and Weymouth had 19. In the12 months to October 2009, these cells had been used for 9,139, 5,476 and 5,136 detainees, respectively. The satellite suites were located at Bridport (two cells), Blandford (five), Christchurch (six), Ferndown (two), Shaftesbury (three), Sherborne (three), Swanage (two), Verwood (two) and Wareham (two). In the period from January to October 2009, 1,729 detainees had been held in these suites. These custody suites usually held detainees for a maximum of six hours under PACE, but this could be longer to cope with operational increases in demand and specific circumstances such as Operation Safeguard.

2.4 Comments in this report refer to all suites unless specifically stated otherwise.

Strategic overview

2.5 Custody was managed centrally. There was a clear line management structure from the assistant chief constable through to custody detention officers, although there appeared to be a disconnect between senior and middle managers. In the central department all staff working in custody were permanent, but there were frailties in the staffing model used leading to understaffing against the model. A series of formal meetings was held to manage risks but structures were complex and not well understood by staff.

2.6 The force had a clear custody suite estates strategy for the three designated sites and less formal plans for developments once the ongoing work programme was completed.

2.7 There was good in-house training for new custody sergeants but we were less confident about that for detention officers, which was not nationally accredited. A programme of refresher training was under way.

[2] http://www.justice.gov.uk/inspectorates/hmi-prisons/expectations.htm

2.8 Relationships with the Police Authority and independent custody visitors were excellent but, with the exception of meetings with health service providers, there were limited strategic meetings at the force level with partner organisations.

2.9 External Learning the Lessons information was distributed to staff. A use of force form was usually, but not always, completed and forms were analysed for training purposes and trends.

Treatment and conditions

2.10 Relationships between staff and detainees were excellent. Good use was made of interpreting services and basic religious needs were met. There was limited awareness of relevant child protection issues and the different experience of women in custody, but some work had been done to address the needs of detainees with English language or learning difficulties. Only one suite was suitable for holding detainees with disabilities.

2.11 Risk assessments were carried out and revised as circumstances changed, but the quality was variable. Use of force was monitored, although there was confusion about processes. Fire evacuation drills were carried out on an ad hoc basis.

2.12 Weymouth offered a good environment, but Poole and Bournemouth were poor facilities which were dirty and with cells covered in graffiti. Poole was due to close shortly after the inspection and move to a new building, but the Bournemouth suite was some months away from being moved to a new build site. We considered the latter suite to be particularly unsuitable, with significant safety issues evident. Across the custody estate, there were numerous ligature points in cells, showers and exercise yards.

2.13 Adequate bedding was provided, but mattresses were not always cleaned between uses and the availability of pillows was limited. Showers and exercise were provided when needed, and track suits and footwear for detainees whose clothing was taken. Women's hygiene packs were not routinely offered. Some toilets were dirty and lacked privacy. Catering arrangements were good, with a range of options. A range of reading material was available, but visits were not facilitated.

Individual rights

2.14 Custody sergeants authorised detention appropriately. A large number of immigration detainees were held and there were some long delays before they were collected by the UK Border Agency, but some additional arrangements were in place to meet their needs while in custody. Interpreting services were well used.

2.15 Someone concerned about the welfare of detainees was informed of their whereabouts and detainees were asked about any issues related to dependants. There were arrangements in place for dealing with vulnerable detainees on release.

2.16 Staff in general adhered to PACE and reviews were in accordance with this. Up-to-date copies of PACE were available. Detainees were not interviewed while under the influence of alcohol or drugs. The appropriate adult scheme operated well during the day, but less so out of hours. Appropriate adults were not routinely provided for 17-year-olds and we found an example of one not being provided for a 14-year-old.

2.17 Arrangements for the storing and disposal of DNA and forensics were reasonable, but could still be improved. Court cut-off times were sometimes very early, resulting in bed blocking and unnecessarily long periods spent in custody. There were no video link facilities.

2.18 Staff were clear about the systems for dealing with complaints, which were taken by inspectors. Detainees were not routinely given information on how to complain.

Healthcare

2.19 There were strong strategic links between the force and the healthcare provider. Healthcare provision was commissioned by the primary care trust, in line with the recommendations of the Bradley review,[3] and contracted to a private provider. Nurses were available 24 hours a day in the three main suites, and forensic medical examiners called when needed. Clinical governance arrangements were adequate. Medical rooms were good, defibrillators available and staff trained in their use. The management of medicines was excellent.

2.20 Detainees being booked in were routinely asked if they wanted to see a healthcare professional. The level of patient care provided was good and record keeping appropriate.

2.21 Substance misuse services were limited. Continuity of care was underdeveloped. Needle exchange was provided.

2.22 Services for detainees with mental health issues were good and there were plans for this to be further developed. Community psychiatric nurses visited suites daily and provided a valued service. There were two Section 136[4] place of safety facilities in the county. There were delays in obtaining mental health assessments.

2.23 A full list of recommendations appears as Section 7 of this report, but those regarded by the Inspectorates as of greatest importance are set out below (with references to the relevant paragraphs of the report).

Main recommendations

2.24 All staff working in the custody environment should attend a nationally accredited custody training course. (3.17)

2.25 The levels of staffing in the agreed model should be adhered to in order to ensure the safety of detainees. (3.9-10)

2.26 All cells and detainee areas should be fit for purpose and free of ligature points, which custody staff should be trained to identify. (4.28-31)

2.27 Urgent remedial action to improve safety at the Bournemouth suite should be undertaken. (4.29)

[3] People with mental health problems or learning difficulties in the criminal justice system (30/04/09), Lord Bradley.

[4] Section 136 enables a police officer to remove someone from a public place and take them to a place of safety – for example, a police station. It also states clearly that the purpose of being taken to the place of safety is to enable the person to be examined by a doctor and interviewed by an *approved social worker*, and for the making of any necessary arrangements for treatment or care.

2.28 There should be a review of the provision of substance use arrest referral workers to ensure that a comprehensive service is provided to detainees of all ages across the county. The review should include an analysis of referral data. (6.22-29)

2.29 The UK Border Agency should engage with Dorset Police to improve working relationships at the strategic and operational level to reduce the time that detainees spend in police custody. (5.3)

3. Strategy

Expected outcomes:
There is a strategic focus on custody that drives the development and application of custody specific policies and procedures to protect the wellbeing of detainees.

3.1 An assistant chief constable had portfolio responsibility for custody services. Responsibility for day-to-day management of the three primary custody suites and delivery of services was under the control of the central Criminal Justice Division. Responsibility for the day-to-day management of the nine non 24-hour secondary custody suites was under the control of the County Division. Comprehensive custody policies were in place, incorporating many issues contained within the safer detention and handling of prisoners (SDHP) guidance.

3.2 An assistant chief constable (ACC) was the senior portfolio holder for custody issues. There was evidence of strategic priority being given to custody and there was clear strategic direction of custody in the context of the administration of criminal justice. Work was under way to build two new custody suites at Poole (completion date 16 December 2009) and Bournemouth (completion date summer/autumn 2010). This formed part of an estates strategy which was strongly supported by the Police Authority (PA). There had been a lack of capital investment in the custody estate over a number of years, resulting in concerns that the force was not dealing with the associated risks in the short term.

3.3 Dorset's three primary designated custody suites operated under the control of the central Criminal Justice Division (CJD). The suites were each managed by an inspector, who was the custody site manager (CSM) and managed all Police and Criminal Evidence (PACE) issues and reviews of detention when on duty. When these inspectors were not available, these duties fell to divisional patrol inspectors. The CSMs were line managed by the CJD operations chief inspector, who also had responsibility for the management of custody policies and working practices. The CJD operations chief inspector was line managed by the CJD chief superintendent.

3.4 The force also had nine non 24-hour secondary custody suites with cells. Responsibility for these custody suites rested with managers in the County Division where they were physically sited. The CSMs had line management responsibility for the custody sergeants and detention officers (DOs). The police sergeants in the custody suite were posted into custody roles from patrol teams, the expectation being that they would remain in post for a minimum of two years. Overall, there were 25 custody sergeants within the CJD, supported by 45 DOs.

3.5 All custody sergeants had received specific custody training before their deployment in the custody suites. In the case of DOs this was not always possible, as there were insufficient staff to make the running of a custody course feasible. In these circumstances, they were deployed to shadow an experienced member of staff but were regarded as supernumerary and not counted as part of the core team.

3.6 The training course for sergeants was a 12-day in-force course based on a nationally approved custody training course, which was delivered by dedicated trainers. This covered all aspects of custody duties, including roles and responsibilities, risk assessment, first aid and use of the new computer system, +CUS. On completion of training, custody sergeants had an opportunity to shadow an experienced colleague in the custody environment before working unaccompanied.

3.7 The training course for DOs was a five-day in-force bespoke course, which was not based on a nationally approved custody training course. This involved an induction to policy, procedures and IT systems, and also included first-aid and personal safety training. On completion of this training, the DOs were allocated an experienced DO as a mentor, with whom they worked for 14 working days. During this time they had to complete a number of tasks, which were evidenced in an induction workbook. The tasks had to be signed off by the mentor DO, custody sergeant and CSM before the DO was allowed to work unaccompanied. We were not convinced that this training model reflected the important nature of DO work, particularly as the experienced members of staff being asked to carry out the mentoring role had received no additional training.

3.8 Refresher and ongoing training was carried out for all custody staff every five weeks through the facilitation of a training day rostered into their shift pattern. This approach allowed staff to train together as a team, which was commented on favourably by staff. Recent examples of this had included training in first aid, personal safety, methadone/drug issue, exit risk assessments, mental health issues and drug misuse.

3.9 We had concerns about the current staffing. At Bournemouth, the staffing model was for two custody sergeants to be on duty. On one team, we found a recently trained custody sergeant working unaccompanied and on another team, the custody sergeant was working unaccompanied while also being shadowed by a colleague. We were told that it was common practice for absences not to be routinely backfilled.

3.10 Custody staff worked a nine-hour dayshift, late shift and nightshift. This allowed a rostered handover period for all shifts, except the nightshift to dayshift handover, when the force relied on the goodwill of custody staff to arrive early to complete a handover. Comprehensive custody policies were in place, incorporating many issues contained in the Safer Detention and Handling of Prisoners (SDHP) guidance, and this assisted staff in discharging their duties.

3.11 We were told that attempts had been made at chief officer level to tighten existing protocols with the UK Border Agency, but the agency had failed to engage. This practice had led to cells becoming blocked, which impacted on operational capacity (see paragraph 5.3).

3.12 There were good working relationships with partners across Dorset. The force had been the first in the country to have its primary health services in custody suites commissioned by the NHS, although this project was currently being evaluated.

3.13 The PA was positive about its relationship with the force, which it found to be approachable and responsive on both a formal and informal basis (see section on healthcare). Strategic Crime and Criminal Justice Governance Board (SCCJGB) meetings, chaired by the ACC, took place quarterly and were supported by weekly CJD command team meetings and monthly CJD team strategic planning meetings. In addition, the CJD operations chief inspector held regular bi-monthly meetings with the three CSMs and the CJD project inspector. However, at a practitioner level we found no evidence of any custody users' meetings, to provide a forum for the discussion and resolution of local custody issues.

3.14 While the governance structure was good, with a clear command structure, staff felt that there was a lack of visibility from senior managers. This disconnect appeared to be at middle management level with the CJD, which had led to some staff not being aware of the existence of custody key performance indicators (KPIs), despite these being discussed every quarter at the force performance board meetings and monitored through the SCCJGB and CJD command team meetings.

3.15 There was a PA lead for the independent custody visitors (ICV) scheme, as an independent oversight mechanism. ICVs were scheduled to visit the three primary designated custody suites (Bournemouth, Poole and Weymouth) at least once a week and the non 24-hour secondary sites once every three months, and in most cases these visits were carried out. Feedback forms were submitted after every visit, and resolution of ongoing issues was formally and informally raised with the CSMs or through the ICV chair and PA custody lead. The content of these forms was discussed at ICV panel meetings. These were held quarterly and attended by panel members, the ACC, the CJD chief superintendent, the CJD operations chief inspector, the PA chief executive, the PA vice chair and the PA custody lead, resulting in an open and transparent relationship between all parties. These panel meetings also provided an opportunity for the ICVs to receive input on changes in legislation and working practices in the custody environment.

3.16 Although the central CJD provided policies and procedures for the guidance of staff, both in the CJD and territorial divisions, there were some policy gaps which were required to be underpinned by standard operational procedures to allow staff to deliver the strategic intent of the force. This included guidance on the taking, storage, transportation and subsequent destruction of DNA and forensic samples.

3.17 CSMs did not have a formal quality assurance process to dip sample custody records; however, this was done informally by a CJD support officer, who brought the details of these checks and any findings to the attention of the CJD operations chief inspector. The force was, however, shortly to introduce a formalised process, whereby the CSMs would each dip sample 10 custody records a month from their respective custody suites.

3.18 There was evidence of staff being readily able to access the Independent Police Complaints Commission (IPCC) Learning the Lesson newsletter and other relevant material through the custody section of the force intranet. The CJD also electronically circulated a monthly Custody Managers Update bulletin for the attention of all custody staff; this contained information on force-wide developments, details of good practice, adverse incidents, up-to-date news on custody developments, and changes in working practices and legislation.

3.19 The use of force was recorded in an officer's pocket notebook and through the submission of a use of force report form. However, this was not always well understood or applied by custody staff (see paragraph 4.26). These forms were submitted to the Public Order and Officer Safety Unit, which monitored the content to formulate future training scenarios and identify if staff were in need of any additional training from a personal safety perspective. The use of force was also monitored by the professional standards department and the officer staff safety group, enabling senior managers to identify patterns and monitor trends.

Recommendations

(See also main recommendations 2.24 and 2.25.)

3.20 Shift patterns should be reviewed to ensure that handovers are factored into all shifts.

3.21 A custody users' forum should be introduced to facilitate partnership working at a practitioner level.

3.22 The force meetings structure should be reviewed to streamline processes to ensure that staff are clear about the business model in use and its operation.

3.23 Senior managers in the force should continue efforts to engage effectively with the UK Border Agency to improve working relationships at the strategic level.

4. Treatment and conditions

Expected outcomes:
Detainees are held in a clean and decent environment in which their safety is protected and their multiple and diverse needs are met.

4.1 Detainees were in general treated well and professionally, and individual needs were identified. There was insufficient attention to the needs of diverse groups, such as women and juveniles. Translation services were well used. Staff had safer custody training and there were sound procedures to identify and mitigate self-harm risks, but some generic policies were overly risk-averse. Immigration detainees were routinely strip-searched. W saw evidence of de-escalation, but there was some confusion about the recording of use of force in custody. Weymouth provided a good environment, but Poole and Bournemouth were poor, and the latter had significant safety issues. Some detainees did not know how to use call bells, which they needed to access the toilets in some cells, and on one occasion the bells were muted. Catering arrangements were good. Visits were not facilitated.

Respect

4.2 Cars were normally used to transport detainees, but when there was a doubt about a detainee's potential to be aggressive, a van was used. This was the case even for detainees with a disability and those who were known to be pregnant, and there were no allowances for those with special needs. The vans had compartments which could be described as caged-off metal boxes. This provided cramped and rudimentary conditions for detainees.

4.3 The treatment of detainees at custody suites was generally excellent, particularly in relation to those who were unfamiliar with the surroundings. The booking-in process was carefully explained to first-time detainees and their understanding was checked throughout the process. Detainees were referred to either by their first name or a title with a family name. Detainees known to custody staff were treated with respectful familiarity.

4.4 There was no evidence in policies that the needs of detainees from different backgrounds had been recognised or should be identified. Custody staff did not recognise any differences in the impact of detention on gender, age or race and dealt with detainees according to the Police and Criminal Evidence Act (PACE), their individual needs and the risks they presented with. The needs of detainees were identified through the initial interview process, which followed a standard format, although the staff carrying out these interviews often took time to establish a rapport with the detainee.

4.5 Although there were some designated cells for women, female staff were not always on duty. The risk assessment gave female detainees the opportunity to speak to a female member of staff but in all other ways they were treated the same as male detainees.

4.6 For detainees who were unable to understand English, a telephone interpreting service was used. When necessary, accredited interpreters were also utilised. Apart from a small number of cases where the detainee's first language was uncommon, the services of an interpreter could be obtained rapidly. A daily welfare checklist for immigration detainees was completed. Detainees were not routinely asked if they could read or write.

4.7 There was a range of materials available to aid communication with those with language or learning difficulties. For example, we were shown a pictorial form which showed pictures of what could be accessed by ringing the cell call bell. There was also a leaflet providing additional information in an accessible format for detainees with learning difficulties. Language recognition charts were available at the front desk. Translated notices of entitlement were available and issued, and immigration detainees had the opportunity to contact their consulate.

4.8 All detainees were asked if they had any religious or dietary needs, and copies of religious texts and prayer mats were available on request.

4.9 Despite detainees being asked about any medical, physical or mental health issues, none of the custody suites were properly equipped to meet the needs of detainees using a wheelchair or requiring walking aids. At Weymouth, an arresting officer requested a wheelchair for a distressed Section 136 detainee he had just brought in, but was advised that there was not one available. The custody desks at Poole and Bournemouth, and one of the custody desks at Weymouth, were raised and potentially acted as a barrier, although we saw staff making efforts to maintain some privacy in their interactions with detainees. The suite at Bournemouth was arranged on three different levels, making it poorly suited to cater for the needs of detainees with mobility problems.

4.10 There were portable hearing loops at the custody suite at Bournemouth, and an 'Information for deaf people taken into custody' video. These were not available at Poole and Weymouth, but all suites had access to British Sign Language interpreters. At Poole, we observed a detainee with hearing impairment, who was well known to custody staff, being brought to the custody suite. Care was taken to communicate with him through writing until the interpreter arrived, and the arresting officer waited for the interpreter to arrive before reading the detainee his rights, to ensure that he fully understood.

4.11 Staff did not receive any specific training on child protection awareness, and some but not all were conversant with the process of reporting child protection issues. They had had some input on attention deficit hyperactivity disorder from the Youth Justice Service and training on the role of appropriate adults at one of their training days. Young people were not routinely separated from adults when they were interviewed. We were told that this would be done only if an adult sex offender was being dealt with at the same time. In these circumstances, an auxiliary interview room was utilised at Bournemouth, where there were three designated cells for juveniles, along with an additional holding room. The juvenile cells were located in the basement, at a distance from the staffed area, making them difficult to supervise. The juvenile cells at Weymouth were not covered by closed-circuit television (CCTV). At Poole, staff were aware that, ideally, juveniles should be located in the detention rooms closest to the custody desk. Location in these cells was done on a risk assessment basis, as there was a glass pane in the detention room doors, which staff told us could be shattered if a juvenile detainee was particularly volatile.

4.12 Young women aged under 17 were not always continually supervised by a female member of staff. We were told, however, that there was always a female officer available in or around the stations who could be called on at short notice.

4.13 The custody sergeants were clear that juveniles should not remain in custody any longer than necessary and we saw evidence that young people were being bailed at the earliest opportunity. Custody staff kept all detainees' access to the facilities and exercise yard separate.

Safety

4.14 Custody staff received safer custody training and twice-yearly first-aid refresher training. All custody sergeants had undergone training in risk assessment procedures as part of their initial custody sergeant training. The risk assessment process followed the questioning format prescribed by the new computer system, +CUS. All custody staff carried anti-ligature knives and most custody staff also carried cell keys.

4.15 All detainees were risk assessed regarding potential self-harm. They were asked direct questions about present or historical self-harm and suicide attempts and thoughts. We observed custody sergeants taking into consideration whether detainees were under the influence of alcohol or drugs and checking historical information and markers on the computer database and the Police National Computer (PNC). Custody sergeants also checked with arresting officers if they were not confident about the detainee's answers, particularly in relation to whether they thought that the detainee was under the influence of drugs or alcohol. However, no explicit questions were asked about drug or alcohol dependency. In a case involving a detainee with mental health problems, we noted the sergeant discreetly using background information about a detainee's personal circumstances, supplied by the arresting officer, which aided the overall admission procedure.

4.16 Once the risk assessment had been completed, the level of observation was recorded on the custody record and we saw examples of where this had been increased or lowered, depending on the circumstances. Most of the risk assessments we looked at were completed thoroughly.

4.17 Reading glasses, trouser and jumper cords, and shoes were routinely removed from detainees. We were told that reading glasses were removed to prevent detainees harming themselves with the glass or using it to etch graffiti in the cells. Glasses were returned on a risk assessment basis, but there was no documented evidence of this risk assessment.

4.18 When there were concerns about a detainee, he or she was placed in a cell equipped with CCTV, but there did not appear to be an over-reliance on this as a means of monitoring.

4.19 The level of observations was not predictable during the day, but at night we observed many records showing that detainees who had been placed on level one observation (hourly) had been visited every hour, on the hour. Cells were checked following each occupation to ensure that nothing had been left behind by the previous occupant.

4.20 Although the force policy stated that cells could be shared, this never happened, as this would in reality require an officer to be assigned solely to watch the cell that was being shared. The risk assessment required custody sergeants to assess, through their observations and information on the PNC and +CUS, if the detainee was violent, at risk of absconding or had any history of racially motivated offending, among other indicators. These markers were on the front page of the +CUS, so all staff were aware of the risk factors for each detainee.

4.21 We were told that if a refractory detainee was being brought into the custody suite, staff prepared for his or her arrival by clearing the custody desk area of non-custody staff and ensuring that there were sufficient staff available to manage the situation. Handcuffs were only removed if there was no risk of the detainee being violent. Detainees were strip-searched if they were arrested for drug-related offences and if there was a suspicion that they were concealing a weapon. However, during the inspection, five immigration detainees were arrested and all were strip-searched. We were told that this was done routinely to detainees categorised as 'unknown illegal', without recourse to a risk assessment.

4.22 Custody sergeants and DOs were vigilant and managed detainees being brought into the custody suite, as well as officers and legal representatives, to ensure that there was minimal traffic in the booking in area.

4.23 Staff in the custody suites were expected to carry out daily and weekly checks of their facilities to identify health and safety, maintenance and cleanliness issues. There was no documentation to guide staff on what should be checked and no formal mechanism to record that a check had been completed. In addition, the custody site managers were expected to carry out a monthly health and safety and equipment check of their facilities. We found evidence that these checks were being carried out, but the associated documentation was limited, and in one custody suite (Bournemouth), the responsibility for the monthly checks had been devolved to a custody sergeant.

4.24 A formal health and safety walk through was carried out at the three primary designated custody suites by a health and safety assessor, CJD operations chief inspector and CJD support officer every six months, and at the non 24-hour sites this was carried out annually. We found evidence of these being done but, from documentation supplied and interviews with staff, there was a lack of clarity about whether detainees were moved out of cells to facilitate such a check. Cells that were identified as having possible ligature points were not taken out of service until repaired. Some cells containing ligature points had not been identified, which demonstrated gaps in knowledge.

Use of force

4.25 All custody staff received control and restraint (C&R) training twice a year. We were told by custody staff who had undertaken the training that no C&R techniques had been taught that were specific for use on juveniles. We were told that force was used as a last resort, and we saw an example of de-escalation being used by custody staff; calming a detainee down by speaking to him, locating him in a cell and trying to explore what was causing the problem behaviour.

4.26 Custody sergeants considered the laying of hands on a detainee as a use of force, and we were told by a custody sergeant that when force was used in the custody suite, this was recorded on the detainee's individual custody record. There was some confusion among custody sergeants about when a separate use of force form should be completed, and we were told that not all were doing so when force was used in custody.

4.27 All detainees we observed had handcuffs removed while in secure areas of the custody suite. Detainees were asked about their arrest, if they had been handcuffed and if they had sustained any marks or injuries, and this was recorded on the custody records. When force was used, detainees were not seen by healthcare staff unless it was evident that they had received or complained of an injury.

Physical conditions

4.28 Poole custody suite was old, in a poor state of repair and ingrained with dirt and offensive graffiti, some gang-related and dating back to 1997. Saliva was coated on cell walls and on the CCTV cameras of one of the cells. The exercise yard was similarly poor, with graffiti on the walls and large chunks taken out of the brickwork. A new custody suite had been built and the move was due to take place in December 2009. Despite daily cleaning by contractors, the cells and communal areas were in such a poor decorative state that cleaning did not significantly improve the environment. The tiled cells were in a better decorative state and offered a more

positive environment for detainees. We were told by the custody site manager that ongoing repairs were reported to contractors, and we saw records of this. Trip hazards around the custody suite were identified by black and yellow tape, as opposed to being repaired. Minor spillages were expected to be cleaned up by the DOs but spillage of any body fluids was reported to the cleaning contractor, although staff were unclear if there was an expected response time. Cells which were monitored by CCTV had the toilet area obscured by a small square.

4.29 The suite at Bournemouth was old and badly designed. The accommodation was on three levels and this created serious difficulties for staff trying to maintain supervision of detainees. The overall fabric of the building was run down. The cells were gloomy, with little natural light. They were dank and poorly ventilated but the heating was adequate. There was widespread graffiti on the inside of cell doors. In some cases, the graffiti was decades old and extended to the shower and exercise areas. Although the cells were reasonably clean, many of the communal areas were dirty and the corridor walls were grimy. As this suite was due to be refurbished, little was being invested in maintenance, other than for basic requirements.

4.30 The custody suite at Weymouth was in a much better condition. The cells were clean, mostly free from graffiti and in good decorative order, but some detainees complained of feeling cold and were given extra blankets to compensate. The facility was suitable for dealing with detainees with mobility problems, as the cells were all at ground level. Of the 18 cells, six had CCTV but none of these had the toilets pixelated or blocked out, so detainees occupying these cells were unable to use the toilet in privacy. This custody suite was in a Private Finance Initiative (PFI) building and there was a team to deal with any maintenance work that had been identified.

4.31 We visited all the force custody suites, with the exception of one two-cell site, which was unavailable for operational reasons. In most cases, the cells we inspected contained multiple ligature points, which presented significant safety issues, and we advised the force of these immediately. The condition of the Bournemouth suite was of serious concern, as it was intrinsically unsafe, and we considered the risk to detainees to be unacceptably high, with numerous opportunities for ligatures in cells, showers and exercise yards. The force was responsive and took steps during the inspection to decommission a number of cells and instigate urgent remedial action.

4.32 There was a clear no-smoking policy at all sites, which was rigorously enforced both for staff and detainees. There was no evidence of anyone smoking on the premises and none of the detainees had been offered any replacement aids to cope with not smoking.

4.33 At Bournemouth, we were told that a fire drill was carried out every six months. We were also informed that staff were due to receive fire training the following month. However, staff that we spoke to in the custody suite were unclear about the fire safety arrangements.

4.34 A full evacuation at Poole custody suite had been undertaken in May 2009, although there was no written record of this. A fire safety book was available for visitors to the suite to sign but this was not routinely used. Handcuffs were available in the event of a fire, although staff told us that they were not trained to use them.

4.35 At Weymouth, staff said that they were unaware of any practice evacuations with detainees having taken place. The fire alarms were tested every week and there was an awareness of what to do in the event of a fire, and they had sufficient handcuffs to evacuate the suite safely.

4.36 All cells had call bells. Instructions on how to use them were not always given to detainees and some of those we spoke to were unsure about how to operate the call bells and when it was appropriate to use them. At Bournemouth and Poole, call bells were answered promptly. At Weymouth, on the first day of inspection the call bells were muted. There was a panel by the booking-in desk which indicated which cell occupant wanted attention, as well as larger lights outside the cells, which could be seen from the booking-in desk when the doors to the corridors were open; however, these doors were not always kept open and therefore the needs of detainees could easily be overlooked. Call bells across the custody estate were not routinely checked by staff to ensure that they were in working order.

4.37 There was a sufficient number of blankets and mattresses at all sites, but pillows were not provided at Weymouth and Bournemouth. At Bournemouth, blankets were not issued during the day unless there were 'exceptional circumstances', but they were provided at other sites. The blankets were laundered after each use but it was clear that the mattresses were not regularly cleaned.

Personal comfort and hygiene

4.38 Hygiene packs were available for women but they were not informed of this on entering the suite (see section on respect) and packs were only supplied on request. Seven out of the 16 cells at Poole and seven of the 18 cells at Bournemouth had toilets, but wash basins were located in communal areas. It was therefore particularly important that detainees were aware of the purpose of the cell call bells, if only to access toilets (see section on physical conditions). Most of the cells at Weymouth had internal sanitation. A small amount of toilet paper was given to detainees who occupied cells with toilets; this was sometimes only provided on request at Weymouth.

4.39 The shower at Poole, although old and basic, was reasonably clean. Detainees were routinely offered showers. The showers at Bournemouth and Weymouth were reasonably clean; those at Bournemouth provided adequate privacy, but those at Weymouth less so. In our survey, 44% of detainees, compared with 8% at comparator police custody suites, said that they had been offered a shower. Custody records indicated that detainees were offered showers, and towels and soap were available.

4.40 Although there was a prompt during the risk assessment to ask detainees if they had wet clothing, we observed some custody sergeants ticking the box but not routinely asking the question. Detainees we spoke to who had had their clothes taken away were given track suit tops and bottoms, T-shirts and slippers. Plimsolls were also available at the point of discharge. There was a good stock of these items held in the custody suites, and many of the detainees made use of the slippers. Replacement underwear was not available anywhere other than Weymouth, where paper underwear was offered. Family and friends were permitted to bring in items of clothing.

Catering

4.41 Food was served at set meal times, and detainees were also provided with food on request. There was a relatively wide range of food available, consisting of branded pasties and sandwiches, as well as basic microwavable products. The food was popular with detainees and they seemed to appreciate the choices available. At Weymouth, the canteen was used to provide meals for detainees during opening hours. Hot and cold drinks were provided on request and staff were diligent about responding to these requests. We were told by custody

staff that they would purchase alternative meals for detainees who were being held for a number of days. Subject to risk assessment, visitors could bring in sealed food for detainees.

Activities

4.42 Although detainees were not routinely offered exercise, if they requested it they were likely to receive it, particularly if they had been held for longer periods. In our survey, 21%, compared with only 6% at comparator suites, said that they had been offered exercise.

4.43 There was a good store of books and some magazines available at each of the suites. The reading material was well organised and contained items in foreign languages, as well as easy-to-read books.

4.44 Visits were not facilitated.

Recommendations

(See also main recommendations 2.26 and 2.27.)

4.45 Detainees should be transported in vehicles which are appropriate to the specific needs of the individual concerned.

4.46 There should be clear policies to meet the needs of female detainees and those with disabilities or mobility issues while they are in custody or being transported.

4.47 Detainees' ability to read and write should be ascertained when being booked into custody.

4.48 Booking-in desks should be of an appropriate height to facilitate effective and private communication between staff and detainees.

4.49 All custody staff should undertake child protection awareness training.

4.50 Juveniles should be located in accommodation which is easy to supervise closely and whenever practicable in a separate area from adult detainees.

4.51 At Poole, the glass panels should be removed from the juvenile detention rooms, so that juveniles can be located in these cells.

4.52 There should be an explicit question in the risk assessment to ascertain a detainee's alcohol or drug dependency.

4.53 Spectacles should only be taken from detainees if the risk assessment indicates the need to do so.

4.54 Night-time observations should not be predictable.

4.55 Strip-searching of immigration detainees should be based on a risk assessment, rather than routine.

4.56 The regular health and safety, maintenance and cleanliness checks should be reviewed and formalised across the custody estate. These checks should be fully recorded and monitored to ensure that identified issues are addressed.

4.57 Repairs should be completed in a timely manner and general maintenance should be managed and carried out expeditiously.

4.58 In those cells at Weymouth with closed-circuit television, the toilet area should be pixelated or blocked out to facilitate privacy.

4.59 Subject to individual needs assessment, nicotine replacement aids should be available to detainees.

4.60 Staff working in the custody suite should all be familiar with the fire safety arrangements; evacuations should be recorded and the fire safety book routinely used.

4.61 The purpose of cell call bells should be explained to all detainees.

4.62 Detainees should be issued with clean mattresses and pillows.

4.63 Female detainees should routinely be offered female hygiene items.

4.64 Replacement underwear should be available at all sites for detainees who need it.

4.65 Detainees remaining in custody for more than 24 hours should be allowed visits.

4.66 Procedures for recording and reporting use of force should be consistently applied when force is used in custody.

Good practice

4.67 *There was a range of materials available to assist detainees with little or no English and with learning difficulties.*

4.68 *Detainees were routinely offered showers.*

5. Individual rights

Expected outcomes:
Detainees are informed of their individual rights on arrival and can freely exercise those rights while in custody.

5.1 The reason for detention was explained to detainees in a language they understood. Detainees were asked if they had dependants and were offered help when necessary. There were some unacceptable delays in the UK Border Agency removing detainees to detention centres. If possible, juveniles were bailed if there were difficulties in securing appropriate adults. Interpreting services were not used during the duty inspector's review for some detainees who could not speak English. Appropriate adults, both for juveniles and vulnerable adults, but not 17-year-olds, were usually accessed; this scheme operated well during office hours, but response times were less reliable out of hours. Detainees were transported to court in a timely manner but the court cut-off times were too early, so that detainees, including minors, could be held overnight. Detainees we interviewed did not know how to make a complaint but inspectors dealt with complaints once made.

Rights relating to detention

5.2 Custody sergeants followed the requirements of the Police and Criminal Evidence Act (PACE). They invited officers to outline the reason for arrest and made a determination as to the appropriateness of detention. All detainees, including immigration detainees, had the reason for their detention explained in a language they understood. Their rights and entitlements, including the opportunity to have someone notified of their whereabouts and to contact a legal representative, were also explained. Subject to risk assessment, detainees, including those who did not speak English, were permitted to make a telephone call to family members or friends, provided that the recipients were in the UK. When telephone calls were disallowed, this was authorised by an inspector and the reasons documented in the custody records and relayed to the detainee.

5.3 In the year to October 2009, records indicated that 221 immigration detainees had been held in the force area. Custody records of immigration detainees being held showed that most cases concerned UK Border Agency (UKBA) operations. We were told by staff that, at the operational level, there were positive working relationships between custody staff and immigration officers. The length of detention ranged from 15 hours to 99 hours, and in the year to October 2009, five had been held in custody for longer than the 72 hours maximum agreed in the working protocol with the UKBA. When further investigation needed to be carried out by the UKBA, IS96 forms were issued and immigration detainees were given reporting instructions and not unnecessarily detained.

5.4 Custody records indicated that, where possible, juveniles were bailed if there were difficulties in securing appropriate adults. In our survey, only 49% of detainees said that they had been held at the police station for over 24 hours, against the 65% comparator for all police areas (see Appendix III for details of methodology).

5.5 The new computer system, +CUS, provided automatic triggers for carrying out reviews. Reviews were completed on time. A few were carried out by telephone; when this occurred, the reason was explained in the custody records and the reviewing inspector spoke to the

detainee by telephone. In some of the records of detainees who could not speak English, the available interpreting services had not been used during the inspector's review or if the review had been conducted over the telephone.

5.6 The custody suites were not used as a place of safety under Section 46 of the Children Act 1989 and staff were aware of the agencies to contact that dealt with securing placements for vulnerable young people.

5.7 All detainees were asked on arrival in custody if they needed help to look after anyone who was dependent on them. Staff were prepared to take reasonable steps to provide assistance.

5.8 We observed simple cautions being used but the implications of accepting them were not fully explained to the individuals concerned until after they had agreed to accept them, despite one detainee stating, 'Yes I'll accept it, whatever that is'.

5.9 A force detainee release policy was in operation and a process was in place to assess the needs of vulnerable detainees on release. However, actions taken as a result mainly concerned the transportation of detainees home, and no list of community agencies was offered to those needing advice or support. The community mental health nurses and substance misuse workers were involved when they could provide assistance on release.

5.10 A professional telephone interpreting service was used whenever a detainee had difficulty communicating in English. Fairly extensive use was also made of interpreters through the National Register of Public Service Interpreters (NRPSI) and a local database of interpreters.

Rights relating to PACE

5.11 Detainees were able to speak to legal representatives in private consultation rooms or over the telephone. We observed custody sergeants advising detainees that if they chose not to have a legal representative, they could change their minds during their detention, and custody records showed that this was facilitated. A duty solicitor scheme was available, which also included some specialist immigration solicitors.

5.12 Immigration detainees held under PACE were asked if they wanted to access legal advice and were encouraged to do so before any immigration warrants were served, as legal advice sought after the serving of warrants was not covered by the duty solicitor scheme. Some of the records showed that specialist immigration solicitors had been accessed, but only in a minority of cases.

5.13 The appropriate adults service for vulnerable adults was provided by the social services department, which provided qualified social workers or trained assistant care managers to attend the custody suite. Custody sergeants told us that this arrangement worked well during office hours but was subject to significant delays out of hours.

5.14 Appropriate adults for juveniles were provided by the youth offending service during office hours and social services during the evenings and weekends. Custody sergeants told us that a parent or carer usually attended. There were no specific checks on the suitability of parents or carers who attended as appropriate adults. If the young person was estranged from the parent or carer or did not want this person to act as an appropriate adult, staff would take this into consideration. Staff adhered to the PACE definition of a child, which meant that appropriate adults were not routinely provided for detainees aged 17 years, who are otherwise deemed to be children by the Children Act 1989.

5.15 During the inspection, we spoke to a 14-year-old girl who had been arrested for failing to appear at court, and for whom an appropriate adult had not been contacted. The custody sergeant believed that this had not been necessary because the girl was well known to staff and had been in custody on many previous occasions. A solicitor present in the suite on other business, who knew the girl, had also briefly been notified of her presence. The girl had been admitted in the early afternoon and held in custody overnight, appearing at the youth court the following morning. Once this had been brought to the attention of managers, instructions were sent out to staff reinforcing the need to ensure that appropriate adults were provided in all cases prescribed by PACE.

5.16 All detainees were told that they could consult a copy of the PACE code of conduct, and up-to-date copies were available. Custody records and our observations indicated that detainees were not interviewed under the influence of drugs or alcohol, and the custody sergeant, with the assistance of healthcare professionals where appropriate, made the decision as to when detainees were fit to be interviewed.

5.17 We observed that interviewing officers did not carry out interviews for over-long periods and that detainees were given breaks during interviews. Custody records showed that eight hours' rest was given during 24-hour periods. Records also showed that detainees who were brought into custody during the night were dealt with in a reasonable time; they were interviewed and charged during the night where appropriate, thereby minimising delays.

5.18 Arrangements for managing and storing DNA and forensic samples were adequate, although recording systems needed to be improved. We found a few forensic samples being inadequately stored in fridges across three sites (Weymouth, Sherborne and Blandford), the oldest dating back to November 2007, and it was unclear whether these should have been sent for analysis, stored elsewhere if still required or disposed of in a suitable manner if no longer required as evidence. Only one site (Weymouth) used a register to record the details of blood and urine samples placed in a fridge. In this case, however, some samples had been removed and the register had not been updated. None of the sites had a system for recording when DNA was taken (other than on +CUS updates), stored or submitted for processing. This practice did not allow for a clear audit trail to show if DNA samples had been taken in appropriate cases.

5.19 Detainees were transported to court in a timely manner but the court cut-off times were too early, at between 12.30pm and 1.30pm, resulting in unnecessarily long stays in custody. We observed a detainee answering a warrant at 9.30am at the custody suite. The matter was being dealt with at Bournemouth court and there was no transport available to get him there. He was held overnight, to be produced at court the next day. The custody sergeant had made significant attempts to have the case heard on the day he had been detained. The cut-off time to produce a detainee at court at Weymouth during the weekend was 10am, which was far too early. At Poole, we observed a vulnerable 14-year-old girl arrive in custody at 1.30pm, coinciding with the court cut-off time. A detention officer attempted to arrange for her to be dealt with at court on the same day, in order to avoid holding her in custody overnight. The officer was unsuccessful and as a result a minor was detained overnight, which we were told was not unusual. No attempt was made to escalate this to the custody sergeant or inspector.

5.20 Solicitors were able to access a copy of the front sheet of the custody record from custody sergeants, and all detainees were asked if they would allow medical information to be disclosed to solicitors. We were told that either solicitors or detainees could submit a request for a copy of their records after release and that these would be accessed from the Civil Disclosure Unit.

Rights relating to treatment

5.21 Detainees we interviewed did not know how to make a complaint. Custody staff told us that if the complaint was related to their arrest or treatment while in custody, detainees could make a complaint to the custody inspector. Detainees also had the opportunity to make a complaint during the inspector's review.

5.22 Custody staff had access to newsletters and information from custody standards officers regarding any trends in complaints or specific complaints relating to that particular suite.

Recommendations

(See also main recommendation 2.29.)

5.23 Interpreting services should be used during the inspector's PACE reviews for detainees for whom English is not their first language.

5.24 Detainees aged 17 and under should be provided with an appropriate adult.

5.25 Detainees should have pre-court disposals, such as cautions, explained to them in full before being asked to make a decision.

5.26 All detainees who are vulnerable on release should be provided with a range of support to meet their needs, including a list of agencies in the community which might assist them.

5.27 Appropriate adults should be readily available 24 hours a day to support juveniles and vulnerable adults in custody.

5.28 The force should review how it takes, stores, tracks and submits all DNA and forensic samples taken from detainees. The review should identify gaps in policies, training, storage facilities and audit trails. The review should have a senior officer responsible for delivery of an action plan which addresses the issues.

5.29 When there is a risk of overnight detention and the courts refuse to deal with vulnerable detainees, the case should immediately be passed to a senior police officer to raise with the court.

5.30 The force should instigate discussions with the court service to extend court cut-off times.

5.31 Detainees should be told how to make a complaint.

6. Healthcare

Expected outcomes:
Detainees have access to competent healthcare professionals who meet their physical health, mental health and substance use needs in a timely way.

6.1 Dorset Police was the first force in the country to work with the NHS to commission health services for detainees. Primary healthcare was commissioned from, and provided by a private provider. Detainees had access to competent health professionals, who met their physical health, mental health and substance use needs, although some improvements needed to be made. Steps had been taken to ensure that the primary care provider had a robust clinical governance framework, although not all staff had received appraisals, and development and training had been limited. Clinical rooms varied, but were clean and had appropriate equipment. Resuscitation equipment was limited. Medications were stored safely and securely. Detainees could continue to receive prescribed medications, and a policy for the administration of methadone was being piloted. Record keeping was good, but detainees did not sign the records to consent to the sharing of information. Links to custody records were reasonable. Substance misuse services needed urgently to be reviewed. Mental health services were reasonable. There were Section 136 suites available and some audit of their usage.

Clinical governance

6.2 There was a formal agreement that specified that NHS Dorset assumed responsibility for the commissioning and provision of all custody and forensic healthcare services to Dorset Police. The agreement set out the scope of services, the requirements and responsibilities of both parties and the cost of the service.

6.3 NHS Dorset had commissioned a private provider, Harmoni forHealth; the contract had been in place for 16 months at the time of the inspection and was being extended for rolling periods of three months. This caused concerns for the provider, which had had difficulty in recruiting and retaining staff and providing suitable training and professional development as a consequence.

6.4 The service was nurse led. A nurse was based in the custody suite at Weymouth and another at Bournemouth, and the latter also travelled to Poole. Each nurse worked a 12-hour shift, so there was 24-hour cover. One doctor was also on call for the whole county, providing services both to the custody suites and sexual assault victims. This could mean that detainees were subject to delays. It was usually possible for detainees to see a health professional of their own gender, but we were not confident that this was explained to them. In our survey of male prisoners, only 14% said that they had been able to see a health professional of their own gender, which was significantly lower than the 29% comparator.

6.5 Health professionals used a telephone interpreting service for detainees who could not speak English, although not all the clinical rooms had a telephone, so we had concerns about the confidentially of such consultations.

6.6 Senior staff from the police and NHS Dorset chaired a Dorset Police Health Services Partnership Board, which met quarterly. It was attended by representatives from the police, the NHS commissioners, the local authority, mental health services, drug services, the independent custody visitors and a representative from Harmoni forHealth. Contract monitoring

data were presented by the provider at the meeting, as well as various other reports. We had concerns about the robustness of the data presented, which were not verified by either the NHS or the police force. Harmoni forHealth reported that in the three months before the inspection, nurses had seen 1,782 patients, which was around a third of all those held in suites during the period of time in question.

6.7 The provider had developed a clinical governance action plan. The timescales for actions to be completed were all some time in the future. A skills log was being developed and a training needs analysis was planned. Staff we spoke to had not all had annual appraisals, and training opportunities had been hampered by the uncertainty of the contract, although some staff told us that they had received training in the protection of vulnerable adults (POVA). There was no formal clinical supervision.

6.8 The clinical room in each of the custody suites facilitated private consultations. The rooms provided conditions that maintained decency, privacy and dignity. They were clean and the healthcare team had access to infection control policies covering issues such as communicable diseases. Sharps bins were signed and dated, in line with good practice. However, at Poole the clinical waste bin was broken and unusable. There were adequate hand hygiene facilities and materials available at this suite. In the other suites, we were not confident that there were any arrangements for maintaining the rooms for use; for example, we found empty hand gel and soap containers. At Christchurch, there were bags of rubbish in the room and there was no examination couch.

6.9 There was an agreed list of medications stored at each of the three main custody suites, and these were checked daily. Stock levels were low and there was good medicines management. All medicines were securely stored in appropriate metal cabinets. Nursing staff told us that out-of-date medicines were taken to the local pharmacy for disposal. However, we found discarded medicines in a sharps container in the Poole clinical room. This was contrary to hazardous waste management regulations and presented an unnecessary risk of tampering with sharps containers and diversion. We found some inappropriate medications in the Wareham clinical room, but not in any of the other clinical rooms.

6.10 Medicines were only administered by nursing staff against a written prescription faxed to the custody suite by the forensic medical examiner (FME). In order to comply with the Medicines Act, the original prescription was later matched and checked against the fax. A copy of each record of administration was also attached to the custody record. Police staff we spoke to were clear that they should not administer medications except in emergency situations, such as a detainee having an asthma attack or with severe chest pain. To this end, the police held a small stock of salbutamol inhalers and glyceryl trinitrate sprays, so that they could administer them following a telephone call to a health professional while waiting for further assistance.

6.11 Detainees' own medications were stored with their other personal belongings in a locked cupboard and returned on release, except when there was a suspicion that the medicines had been obtained illicitly; for example, a plastic bag of diazepam had been seized from a detainee expressing suicidal thoughts.

6.12 Equipment (including Guedel Airways) was stored in grab bags at the three main custody suites. Defibrillators were provided by the police but, although detention officers said that these were checked at each shift, there was no documentary evidence to support this. Most equipment was found to be in date and ready for use, although we found some out-of-date defibrillator pads in the defibrillator bag at Bournemouth. There was no oxygen or suction available.

6.13 Custody staff said that they received resuscitation training, including use of the defibrillator, every six months. Healthcare staff mandatory training included immediate life support (ILS).

Patient care

6.14 Detainees were generally offered the opportunity to see a healthcare professional on arrival and on request. They could also be seen by a healthcare professional at the discretion of the custody sergeant if there were any health concerns. We witnessed one occasion when, because the nurse had left the suite at the end of her shift before her colleague had arrived, there was no nurse available. During this time, staff called an ambulance for a detainee who had struggled with police and repeatedly head-butted the wall.

6.15 We witnessed some excellent care for detainees. For example, one detainee had arrived at the Bournemouth suite in an unkempt condition. This detainee was well known to police and healthcare staff. The nurse obtained head lice treatment and other lotions and arranged for the detainee to have a shower. Later in the week, the same detainee was re-arrested and taken to Poole; arrangements were made for his medication and treatment lotions to be collected from Bournemouth and taken to Poole, so that further treatment could be administered.

6.16 If a detainee complained about healthcare while in custody, the complaint was sent to NHS Dorset for investigation and resolution.

6.17 Detainees could continue to receive prescribed medication for any clinical condition, although nicotine replacement therapy was not provided (see recommendation 4.59). When a detainee required medicines not stocked at the custody suite, they were prescribed by the FME, obtained from a local pharmacy and then administered by nursing staff. All administrations of medicines were recorded on the custody prescription form and a record made in the custody record. If it was not possible to obtain a prescription, alternative sources for medication were explored, such as collecting the medicine from the detainee's home, with his or her permission.

6.18 The force was piloting a policy for the administration of maintenance medication (methadone or Subutex) in police custody, for known users. The policy included taking a urine sample from the detainee and only providing methadone or Subutex if the sample indicated that no other medications had been taken apart from the maintenance medication. The result was confidential between the detainee and the health professional. The methadone or Subutex was then obtained from the detainee's named pharmacy by the police if the detainee did not have it on arrest, and it was administered by nurses. The policy was due for review a month after the inspection. Any detainee who was not prescribed methadone or Subutex as a result of failing the urine test was offered symptomatic relief in line with a clinical opiate withdrawal scale. Both the drug intervention programme (DIP) team and nursing staff told us that this protocol had led to considerable discontent from detainees. In the preceding three months, an FME had prescribed methadone on only two occasions. While it was positive that detainees had the opportunity to receive their medications in line with safe clinical practice, there were concerns that the policy did not comply with PACE Code C in relation to who could administer controlled drugs to a detainee in a custody suite.

6.19 Each detainee seen by a health professional had a clinical record containing an up-to-date assessment. Staff used a pro-forma clinical assessment/record for each patient, which was completed and kept in a folder in the clinical room. However, we were told that not all the FMEs left their notes in the clinical room, despite this being the stated policy. A separate self-carbonated form was completed after the assessment, for the custody record. The duplicate was stored with the assessment/record. Records were kept on site and then archived each

month at Harmoni forHealth offices. Although ethnicity was recorded in the custody record, healthcare professionals did not record it. Staff were able to refer back to colleagues' notes if the detainee had been seen previously, although a new record was started for each period of detention.

6.20 Detainees were asked for their consent to have their clinical details shared with other agencies, although this was usually only verbal consent, which was then recorded by the nurse. When we questioned this practice, we were told that it was because of security concerns, as detainees could use a pen as a weapon; this seemed to be excessively risk averse. Staff we spoke to were unclear about what they would do if a detainee asked for a copy of his or her clinical records.

6.21 An electronic clinical information system was shortly to be introduced to the custody suites. This would eventually provide better sharing of information between health professionals in the custody suites and those working in prisons, who would use the same system. However, it was not clear how staff would maintain records in a detainee's custody record of interventions by healthcare staff, nor how consent would be recorded.

Substance use

6.22 Substance use services were provided by different third-sector agencies across the county, which were coordinated by the Dorset DIP. Services were provided by Crime Reduction Initiative (CRI) at Bournemouth, and Poole Addiction Services at Poole. At Weymouth, Turning Point provided an arrest referral service to those with drug issues, while EDP assisted those with alcohol issues, although they did not visit the custody suites. Workers from these organisations did not provide a specific service for juvenile detainees, but would signpost them to relevant organisations.

6.23 Health professionals told us that despite their contact with the DIP teams in relation to individuals on a methadone or Subutex programme, they were not permitted to refer detainees directly to the DIP teams; the referral had to be made by police staff.

6.24 At Bournemouth, the substance use workers visited on an ad hoc basis and took referrals from custody staff. We were told that they tended only to see detainees from the Bournemouth area.

6.25 At Poole, a drugs worker visited the suite twice a day from Monday to Friday. He prioritised Poole residents and took details for them to be referred to relevant services. We were told that waiting lists for criminal justice system clients were three weeks or more.

6.26 At Weymouth, the drugs workers visited the custody cells every morning, and sometimes in the afternoon as well. There were no such arrangements for detainees with alcohol issues. The DIP workers prioritised their work with detainees by focusing on those most likely to offend, although the workers also tried to reach all detainees identified as having potential substance misuse problems through brief interventions and the use of leaflets. The DIP team provided a 24-hour telephone service for advice and referrals, to allow custody sergeants to book detainees' appointments before release. The team worked closely with the DIP nurse prescriber, the community drug and alcohol service and the community mental health team. The community mental health out-reach team was contacted about clients who lost touch with the DIP service.

6.27 We were told that the police service drugs team alerted the DIP team when they intended to carry out specific drug-related operations, so that the DIP team could arrange for its workers to be at the custody suite in anticipation of the additional support required.

6.28 In the six months before the inspection, the Dorset DIP had received 421 referrals from custody suites, while the police records indicated that 12,746 detainees had been through custody. This represented only 3.3% of all detainees. In our survey, 54% (26 respondents) of detainees who had been in custody suites in Dorset stated that they had a drug or alcohol problem; of this group, only four said that they had been seen or had been offered the services of a drug or alcohol support worker.

6.29 Dorset Police ran a needle exchange scheme, although we were unable to obtain details on the take-up of the scheme.

Mental health

6.30 Mental health service provision was split across the county between two NHS providers. Dorset Healthcare NHS Foundation Trust provided services in the Bournemouth, Poole and Purbeck area. In the west and north of the county, services were provided by Dorset Community Health NHS Trust, which was the provider arm of the primary care trust, NHS Dorset. The two NHS trusts worked together to provide consistent arrangements across the county, despite different mental health service configurations. All the main custody suites had a dedicated community psychiatric nurse, who made daily visits to the custody suites from Monday to Friday and was available to call during normal office hours. Custody officers told us that there could be delays in obtaining a mental health team for the purposes of mental health assessment under the provisions of the Mental Health Act. Out of hours, the community mental health team could be contacted. All the main custody suites kept a record of on-call duty rotas and contact telephone numbers for the on-call community mental health teams. Mental health teams took referrals only from a doctor, rather than a nurse, which caused unnecessary delays.

6.31 We saw good liaison work between a custody suite and the local mental health services. A detention officer contacted the Forston Clinic, the local mental health acute unit, to obtain further information about a man in custody who was known to the mental health service. By sharing and using information effectively, the custody sergeant was able to make an informed decision about the man, who also had physical health issues. As a result, he was bailed to return a week later, having spent less than an hour in custody.

6.32 The different service configurations between Dorset Healthcare NHS Foundation Trust (where services were concentrated on one acute site at St Anne's Hospital in Bournemouth) and Dorset Community Health NHS Trust (which distributed community-based services) led to some differences in their approach to detainees arrested under Section 136 (S136) of the Mental Health Act. At St Anne's Hospital, detainees were accepted immediately into nursing care, and withdrawal of police officers was by mutual agreement of the staff involved. There were escalation procedures in place to resolve any disagreements. There was a regular monthly integrated management meeting between the police and the health management teams to review recent S136 admissions for de-brief and learning purposes. The joint working assisted in improving the management of detainees with mental health care needs. By contrast, the S136 room based at Forston Clinic was not able to provide nursing care supervision for detainees because the staffing complement based at the clinic site was relatively small. Police officers had to remain at the clinic until the mental health team arrived to carry out an assessment. Despite this disincentive to take detainees to the Forston Clinic,

there had been a significant increase in admissions there during the previous 12 months. The healthcare team considered this to be due to an increased awareness of mental health needs, and also to inappropriate transfer to the S136 health facility.

6.33 An annual audit of assessments under S136 of the Mental Health Act had been carried out in 2008 and another was in the process of being undertaken. Comparative data from the previous five years were used. Between October 2007 and September 2008, 68% of detainees detained under S136 had been taken to St Anne's hospital, and 29% to Forston Clinic, with the remaining 3% being detained in police custody, showing a year-on-year improvement. Ethnic monitoring had been undertaken as part of the audit, as had analysis of area of residence, age and gender. Performance measures relating to attendance times of health professionals had also been examined. Outcome data revealed that, of the 207 cases audited, 91 (45%) had been released, 17% formally admitted under the Mental Health Act, 35% informally admitted and the remaining 3% were 'not stated'.

6.34 A county-wide Mental Health Act working group had reviewed the S136 protocol with the aim of standardising admissions procedures across the county. It was due to be signed by all parties involved within weeks of the inspection. There were also plans for a training programme for the police, to improve their understanding of mental health issues and appropriate admission to S136 facilities.

Recommendations

(See also main recommendation 2.28.)

6.35 Sufficient medical staff should be provided to ensure separation of duties between the requirements of detainees in custody and the victims of sexual assault.

6.36 There should be a telephone in each clinical room, so that healthcare professionals can make calls about patients and conduct consultations requiring a telephone interpreting service in private.

6.37 The contract should be monitored by the commissioners, rather than relying solely on information from the provider.

6.38 All staff should be able to access clinical supervision.

6.39 All clinical rooms should be fit for purpose and ready for use at all times.

6.40 Resuscitation equipment should include suction and oxygen.

6.41 All parties involved should seek legal advice to ensure that the pilot policy for the administration of controlled drugs by nurses meets current legislation.

6.42 All clinical records should be stored in accordance with Caldicott guidelines and the Data Protection Act.

6.43 Detainees should be able to sign to state that they give consent to clinical information being shared; verbal consent should only be used if a risk assessment has identified a concern about the detainee using a pen.

6.44 There should be a policy to define how, with the introduction of the electronic clinical information system, staff will maintain records of interventions by healthcare staff in detainees' custody records.

Housekeeping points

6.45 Sharps bins should not be used for the disposal of unwanted medications.

6.46 There should be documented evidence to prove that resuscitation equipment has been checked, and the evidence should be available to all staff.

Good practice

6.47 *The arrangements for medicines management were excellent.*

6.48 *The annual audit of the use of Section 136 suites was a useful tool for identifying trends.*

7. Summary of recommendations

Main recommendations

7.1 All staff working in the custody environment should attend a nationally accredited custody training course. (2.24)

7.2 The levels of staffing in the agreed model should be adhered to in order to ensure the safety of detainees. (2.25)

7.3 All cells and detainee areas should be fit for purpose and free of ligature points, which custody staff should be trained to identify. (2.26)

7.4 Urgent remedial action to improve safety at the Bournemouth suite should be undertaken. (2.27)

7.5 There should be a review of the provision of substance use arrest referral workers to ensure that a comprehensive service is provided to detainees of all ages across the county. The review should include an analysis of referral data. (2.28)

7.6 The UK Border Agency should engage with Dorset Police to improve working relationships at the strategic and operational level to reduce the time that detainees spend in police custody. (2.29)

Strategy

7.7 Shift patterns should be reviewed to ensure that handovers are factored into all shifts. (3.20)

7.8 A custody users' forum should be introduced to facilitate partnership working at a practitioner level. (3.21)

7.9 The force meetings structure should be reviewed to streamline processes to ensure that staff are clear about the business model in use and its operation. (3.22)

7.10 Senior managers in the force should continue efforts to engage effectively with the UK Border Agency to improve working relationships at the strategic level. (3.23)

Treatment and conditions

7.11 Detainees should be transported in vehicles which are appropriate to the specific needs of the individual concerned. (4.45)

7.12 There should be clear policies to meet the needs of female detainees and those with disabilities or mobility issues while they are in custody or being transported. (4.46)

7.13 Detainees' ability to read and write should be ascertained when being booked into custody. (4.47)

7.14 Booking-in desks should be of an appropriate height to facilitate effective and private communication between staff and detainees. (4.48)

7.15 All custody staff should undertake child protection awareness training. (4.49)

7.16 Juveniles should be located in accommodation which is easy to supervise closely and whenever practicable in a separate area from adult detainees. (4.50)

7.17 At Poole, the glass panels should be removed from the juvenile detention rooms, so that juveniles can be located in these cells. (4.51)

7.18 There should be an explicit question in the risk assessment to ascertain a detainee's alcohol or drug dependency. (4.52)

7.19 Spectacles should only be taken from detainees if the risk assessment indicates the need to do so. (4.53)

7.20 Night-time observations should not be predictable. (4.54)

7.21 Strip-searching of immigration detainees should be based on a risk assessment, rather than routine. (4.55)

7.22 The regular health and safety, maintenance and cleanliness checks should be reviewed and formalised across the custody estate. These checks should be fully recorded and monitored to ensure that identified issues are addressed. (4.56)

7.23 Repairs should be completed in a timely manner and general maintenance should be managed and carried out expeditiously. (4.57)

7.24 In those cells at Weymouth with closed-circuit television, the toilet area should be pixelated or blocked out to facilitate privacy. (4.58)

7.25 Subject to individual needs assessment, nicotine replacement aids should be available to detainees. (4.59)

7.26 Staff working in the custody suite should all be familiar with the fire safety arrangements; evacuations should be recorded and the fire safety book routinely used. (4.60)

7.27 The purpose of cell call bells should be explained to all detainees. (4.61)

7.28 Detainees should be issued with clean mattresses and pillows. (4.62)

7.29 Female detainees should routinely be offered female hygiene items. (4.63)

7.30 Replacement underwear should be available at all sites for detainees who need it. (4.64)

7.31 Detainees remaining in custody for more than 24 hours should be allowed visits. (4.65)

7.32 Procedures for recording and reporting use of force should be consistently applied when force is used in custody. (4.66)

Individual rights

7.33 Interpreting services should be used during the inspector's PACE reviews for detainees for whom English is not their first language. (5.23)

7.34 Detainees aged 17 and under should be provided with an appropriate adult. (5.24)

7.35 Detainees should have pre-court disposals, such as cautions, explained to them in full before being asked to make a decision. (5.25)

7.36 All detainees who are vulnerable on release should be provided with a range of support to meet their needs, including a list of agencies in the community which might assist them. (5.26)

7.37 Appropriate adults should be readily available 24 hours a day to support juveniles and vulnerable adults in custody. (5.27)

7.38 The force should review how it takes, stores, tracks and submits all DNA and forensic samples taken from detainees. The review should identify gaps in policies, training, storage facilities and audit trails. The review should have a senior officer responsible for delivery of an action plan which addresses the issues. (5.28)

7.39 When there is a risk of overnight detention and the courts refuse to deal with vulnerable detainees, the case should immediately be passed to a senior police officer to raise with the court. (5.29)

7.40 The force should instigate discussions with the court service to extend court cut-off times. (5.30)

7.41 Detainees should be told how to make a complaint. (5.31)

Healthcare

7.42 Sufficient medical staff should be provided to ensure separation of duties between the requirements of detainees in custody and the victims of sexual assault. (6.35)

7.43 There should be a telephone in each clinical room, so that healthcare professionals can make calls about patients and conduct consultations requiring a telephone interpreting service in private. (6.36)

7.44 The contract should be monitored by the commissioners, rather than relying solely on information from the provider. (6.37)

7.45 All staff should be able to access clinical supervision. (6.38)

7.46 All clinical rooms should be fit for purpose and ready for use at all times. (6.39)

7.47 Resuscitation equipment should include suction and oxygen. (6.40)

7.48 All parties involved should seek legal advice to ensure that the pilot policy for the administration of controlled drugs by nurses meets current legislation. (6.41)

7.49 All clinical records should be stored in accordance with Caldicott guidelines and the Data Protection Act. (6.42)

7.50 Detainees should be able to sign to state that they give consent to clinical information being shared; verbal consent should only be used if a risk assessment has identified a concern about the detainee using a pen. (6.43)

7.51 There should be a policy to define how, with the introduction of the electronic clinical information system, staff will maintain records of interventions by healthcare staff in detainees' custody records. (6.44)

Housekeeping points

Healthcare

7.52 Sharps bins should not be used for the disposal of unwanted medications. (6.45)

7.53 There should be documented evidence to prove that resuscitation equipment has been checked, and the evidence should be available to all staff. (6.46)

Good practice

Treatment and conditions

7.54 There was a range of materials available to assist detainees with little or no English and with learning difficulties. (4.67)

7.55 Detainees were routinely offered showers. (4.68)

Healthcare

7.56 The arrangements for medicines management were excellent. (6.47)

7.57 The annual audit of the use of Section 136 suites was a useful tool for identifying trends. (6.48)

Appendix I: Inspection team

Sean Sullivan	HMIP team leader
Anita Saigal	HMIP inspector
Ian Mc Fadyen	HMIP inspector
Vinnett Pearcy	HMIP inspector
Paddy Craig	HMIC inspector
Fiona Shearlaw	HMIC inspector
Elizabeth Tysoe	HMIP healthcare inspector
Karen Taylor	Healthcare inspector
Catherine Nichols	HMIP researcher

Appendix II: Custody record analysis

Background

As part of the inspection of Dorset police custody cells, a sample of the custody records of detainees held between 4 and 8 November 2009 were analysed. Custody records were held electronically on CUS. A total sample of 30 records were analysed from across the Dorset area:

Custody suite	Number of records analysed
Bournemouth	14
Weymouth	8
Poole	8
Total	30

The analysis looked at the level of care and access to services such as showers, exercise and telephone calls. Any additional information of note was also recorded.

Demographic information

- Three (10%) of the detainees were female and 27 were male.
- Three people (10%) under the age of 17 were included in the sample.
- All of the detainees sampled were white, 29 (97%) detainees were white British and one was white other.
- Nineteen (63%) detainees had been held overnight, including those who had arrived during the night and were not released until the morning. One (3%) had been held for more than 24 hours. Seven (23%) detainees had been held for less than six hours.
- Seven (23%) detainees had indication of self-harm or suicidal ideation. There was routine strip-searching of those at risk of self-harm or suicide and those on whom the detention staff could not complete a risk assessment. There was also routine allocation of detainees to cells with closed-circuit television (CCTV) coverage, and in one case regular visits from a healthcare professional.
- Five (17%) detainees had disclosed mental health problems. None of the detainees disclosed learning difficulties.
- All of the detainees had been in police custody before.
- Twenty (66%) detainees arrived under the influence of drugs or alcohol. A full rousing routine was detailed on the custody record and their level of intoxication monitored; frequently, the detainees would be released as soon as they were sober.
- On leaving custody, four (13%) went to court, three (10%) straight to prison and the remaining 23 (77%) could return home.

Removal of clothing

Three detainees had had clothing removed from them, in all cases because the clothing was wet; all of these were in Bournemouth. There was no indication about the type of clothing it was replaced with, although it was described as ‘warm clothing’ and ‘alternative clothing’ within the text of the record. It is notable that in one record, a man was strip-searched and his trousers removed in the presence of a female member of staff, due to a lack of staff.

Young people

- None of the young people in the sample were interviewed, although in all cases appropriate adults had been sought. For two of the young people, their parents acted as appropriate adults.
    - One young person did not require an interview. Two young people were released before interview; in one case this was because the duty solicitor could not attend in a reasonable time and the young person's mother, who was acting as an appropriate adult, was not feeling well. The second young person was released before interview because there was a difficulty in obtaining an appropriate adult, after the young person's mother was unable to attend, and there were severe delays in social services attending, so the interview was delayed.
- There was clear consideration for the age of the young people; the delaying of the interviews was often because of the detained person's age and the time of day that the young person was being detained. Thought had gone into avoiding custody, as one young person was initially invited to a non-custodial interview. All of the young people's parents were informed and one young person was allowed to speak to his mother on the telephone. There was also evidence of cell location being changed to reflect the young person's situation. The only young person not to have a parent present in the station was taken home by officers. Even those aged 17 and over had some consideration given; for example, it was noted on one custody record of a 17-year-old female that her age warranted organisation of transport home.
- All three young people had force used on them.
    - One was forcibly stripped, as a metal detector indicated metal in his genital area. This was done without an appropriate adult being present, as he had been arrested for a weapons offence and the risk posed was thought to be high.
    - Arm locks had been used on one, to move him from one cell to another, as he was disturbing other detainees.
    - Leg restraints and quick cuffs were used on one young person, as he became violent.

Interpreters

One (3%) detainee in the sample could not understand English and required an interpreter. Interpreters were requested and attended. Language Line was used to give the detainee his rights, as his first language was Polish. In addition, because he was a Polish national, foreign national rights were given, as a result of which a fax and an email were sent to the Polish embassy. Interpreters were present both for legal advice and for the inspector's review.

Inspector reviews

Inspector reviews were held in line with requirements. One review was conducted late, in order to allow an interpreter to be present.

Services

- All detainees had been asked whether they wanted someone informed of their arrest. Two (6%) detainees had made additional telephone calls in person.
- All detainees had been asked if they wanted a solicitor. Fifteen (50%) detainees had spoken to/seen either their solicitor or a duty solicitor.
- No detainees shared a cell while in custody.

- Six (20%) detainees had requested to see a healthcare professional. The longest wait was two hours, where the healthcare professional had arrived via another station. One detainee, who had already seen a healthcare professional once, was released before he was able to see a healthcare professional for a second time.
- Five (17%) detainees had seen a drugs worker: two detainees at Weymouth and three in Poole. CUS automatically prompted staff to ask whether detainees would like contact with the drug intervention programme team, and details could and would be taken to be passed on after their release.
- Twelve (40%) detainees had eaten at least one meal while in custody. Ten (33%) detainees had been offered food but refused. Eight (27%) detainees had not received any meals, and there was no record of them having refused a meal; three of these had stayed six hours or more, the longest staying for 13 hours.
- Three (10%) detainees had taken a shower and another three had been offered but refused a shower.
- One (3%) detainee had received outside exercise.
- Three (10%) detainees had been provided with reading materials.

Additional points of note

- Pre-release risk assessments were automatically prompted on CUS. This most often led to transportation home, but at times led to more assessments. In one case, where a detainee had been arrested for a domestic violence offence, the victim was contacted, informing her of his imminent release, and he was reminded of his bail conditions.
- The initial risk assessment, although asking a range of important questions, was sometimes scantily completed for compulsory additional information fields, and these were bypassed at times.
- There were some examples of impressive care for detainees, and on occasion tenderness was shown. This ranged from individual care – taking the time to speak to distressed detainees, covering a cold detainee with a blanket – to ensuring that people were contacted if there were dependants and noting and ensuring that rights were given again, if young, non-English-speaking or intoxicated.
- Staff responded to changing risk levels – for example, by moving a detainee to a closer cell with CCTV coverage or a more appropriate cell type, depending on their behaviour.
- One detainee, who arrived at noon, arrived too late for court in Poole.

Appendix III: Summary of detainee questionnaires and interviews

Prisoner survey methodology

A voluntary, confidential and anonymous survey of the prisoner population who had been through a police station in Dorset was carried out for this inspection. The results of this survey formed part of the evidence base for the inspection.

Choosing the sample size

The survey was conducted on 28 October 2009. A list of potential respondents to have passed through Weymouth, Bournemouth and Poole police stations was created, listing all those who had arrived from Blandford, Bournemouth, Bridport, Poole, Sherborne, Wareham, Weymouth or Wimborne magistrates courts within the past month.

Selecting the sample

In total, 61 respondents were approached. A further four were in court that day and so could not be located. Five respondents reported being held in a police station outside of Dorset, or being held longer than two months ago.

On the day, the questionnaire was offered to 56 respondents. There were five refusals, two non-returns and one questionnaire was returned blank. All of those sampled had been in custody within the past two months.

Completion of the questionnaire was voluntary. An interview was conducted with a prisoner who had literacy difficulties.

Methodology

Every questionnaire was distributed to each respondent individually. This gave researchers an opportunity to explain the independence of the Inspectorate and the purpose of the questionnaire, as well as to answer questions.

All completed questionnaires were confidential – only members of the Inspectorate saw them. In order to ensure confidentiality, respondents were asked to do one of the following:

- fill out the questionnaire immediately and hand it straight back to a member of the research team
- have their questionnaire ready to hand back to a member of the research team at a specified time
- seal the questionnaire in the envelope provided and leave it in their room for collection

Respondents were given a choice about putting their names on their questionnaire.

Response rates

In total, 48 (86%) respondents completed and returned their questionnaires.

Comparisons

The following details the results from the survey. Data from each police area have been weighted, in order to mimic a consistent percentage sampled in each establishment.

Some questions have been filtered according to the response to a previous question. Filtered questions are clearly indented and preceded by an explanation as to which respondents are included in the filtered questions. Otherwise, percentages provided refer to the entire sample. All missing responses are excluded from the analysis.

The current survey responses were analysed against comparator figures for all prisoners surveyed in other police areas. This comparator is based on all responses from prisoner surveys carried out in 16 police areas since April 2008.

In the comparator document, statistical significance is used to indicate whether there is a real difference between the figures – that is, the difference is not due to chance alone. Results that are significantly better are indicated by green shading, results that are significantly worse are indicated by blue shading and where there is no significant difference, there is no shading. Orange shading has been used to show a significant difference in prisoners' background details.

Summary

In addition, a summary of the survey results is attached. This shows a breakdown of responses for each question. Percentages have been rounded and therefore may not add up to 100%.

No questions have been filtered within the summary so all percentages refer to responses from the entire sample. The percentages to certain responses within the summary, for example 'not held over night' options across questions, may differ slightly. This is due to different response rates across questions, meaning that the percentages have been calculated out of different totals (all missing data are excluded). The actual numbers will match up, as the data are cleaned to be consistent.

Percentages shown in the summary may differ by 1% or 2 % from that shown in the comparison data, as the comparator data have been weighted for comparison purposes.

Police Custody Survey

Section 1: About You

Q2 **What police station were you last held at?**

24 Bournemouth; 13 Poole; 10 Weymouth; 1 Not recorded

Q3 **What type of detainee were you?**

Police detainee	88%
Prison lock-out (i.e. you were in custody in a prison before coming here)	8%
Immigration detainee	0%
I don't know	4%

Q4 **How old are you?**

16 years or younger	0%	*40-49 years*	8%
17-21 years	19%	*50-59 years*	4%
22-29 years	31%	*60 years or older*	6%
30-39 years	31%		

Q5 **Are you:**

Male	100%
Female	0%
Transgender/transsexual	0%

Q6 **What is your ethnic origin?**

White - British	79%
White - Irish	0%
White - Other	4%
Black or Black British - Caribbean	4%
Black or Black British - African	4%
Black or Black British - Other	0%
Asian or Asian British - Indian	0%
Asian or Asian British - Pakistani	0%
Asian or Asian British - Bangladeshi	0%
Asian or Asian British - Other	4%
Mixed Race - White and Black Caribbean	2%
Mixed Race - White and Black African	0%
Mixed Race - White and Asian	0%
Mixed Race - Other	0%
Chinese	0%
Other ethnic group	2%
Please specify:	100%

Q7 **Are you a foreign national** (i.e. you do not hold a British passport, or you are not eligible for one)**?**

Yes	11%
No	89%

Q8 What, if any, would you classify as your religious group?

None	28%
Church of England	50%
Catholic	13%
Protestant	0%
Other Christian denomination	4%
Buddhist	2%
Hindu	0%
Jewish	0%
Muslim	2%
Sikh	0%
Any other religion, please specify	100%

Q9 How would you describe your sexual orientation?

Straight/heterosexual	98%
Gay/lesbian/homosexual	2%
Bisexual	0%
Other (please specify):	

Q10 Do you consider yourself to have a disability?

Yes	25%
No	75%
Don't know	0%

Q11 Have you ever been held in police custody before?

Yes	98%
No	2%

Section 2: Your experience of this custody suite

If you were a *'prison-lock out'* **some** of the following questions may not apply to you. If a question does not apply to you, please leave it blank.

Q12 How long were you held at the police station?

1 hour or less	0%
More than 1 hour, but less than 6 hours	15%
More than 6 hours, but less than 12 hours	11%
More than 12 hours, but less than 24 hours	26%
More than 24 hours, but less than 48 hours (2 days)	28%
More than 48 hours (2 days), but less than 72 hours (3 days)	15%
72 hours (3 days) or more	6%

Q13 Were you given information about your arrest and your entitlements when you arrived there?

Yes	71%
No	15%
Don't know/can't remember	15%

Q14 **Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')?**

Yes	62%
No	21%
I don't know what this is/I don't remember	17%

Q15 **If your clothes were taken away, were you offered different clothing to wear?**

My clothes were not taken	42%
I was offered a tracksuit to wear	47%
I was offered an evidence suit to wear	2%
I was offered a blanket	9%

Q16 **Could you use a toilet when you needed to?**

Yes	91%
No	9%
Don't Know	0%

Q17 **If you have used the toilet there, were these things provided?**

	Yes	*No*
Toilet paper	58%	42%

Q18 **Did you share a cell at the police station?**

Yes	0%
No	100%

Q19 **How would you rate the condition of your cell:**

	Good	*Neither*	*Bad*
Cleanliness	43%	28%	30%
Ventilation/air quality	30%	20%	50%
Temperature	21%	26%	53%
Lighting	58%	23%	19%

Q20 **Was there any graffiti in your cell when you arrived?**

Yes	69%
No	31%

Q21 **Did staff explain to you the correct use of the cell bell?**

Yes	27%
No	73%

Q22 **Were you held overnight?**

Yes	79%
No	21%

Q23 **If you were held overnight, which items of clean bedding were you given?**

Not held overnight	18%
Pillow	16%
Blanket	56%
Nothing	9%

Q24 **Were you offered a shower at the police station?**

Yes	44%
No	56%

Q25 Were you offered any period of outside exercise whilst there?

Yes	21%
No	79%

Q26 Were you offered anything to:

	Yes	*No*
Eat?	91%	9%
Drink?	98%	2%

Q27 Was the food/drink you received suitable for your dietary requirements?

I did not have any food or drink	4%
Yes	60%
No	36%

Q28 If you smoke, were you offered anything to help you cope with the smoking ban there?

I do not smoke	9%
I was allowed to smoke	0%
I was not offered anything to cope with not smoking	91%
I was offered nicotine gum	0%
I was offered nicotine patches	0%
I was offered nicotine lozenges	0%

Q29 Were you offered anything to read?

Yes	22%
No	78%

Q30 Was someone informed of your arrest?

Yes	30%
No	34%
I don't know	9%
I didn't want to inform anyone	28%

Q31 Were you offered a free telephone call?

Yes	36%
No	64%

Q32 If you were denied a free phone call, was a reason for this offered?

My phone call was not denied	42%
Yes	5%
No	53%

Q33 Did you have any concerns about the following, whilst you were in police custody:

	Yes	*No*
Who was taking care of your children	0%	100%
Contacting your partner, relative or friend	54%	46%
Contacting your employer	3%	97%
Where you were going once released	21%	79%

Q34 Were you interviewed by police officials about your case?

Yes 74%

No ..... 26% If No, go to Q36

Q35 Were any of the following people present when you were interviewed?

	Yes	*No*	*Not needed*
Solicitor	53%	32%	15%
Appropriate Adult	8%	42%	50%
Interpreter	4%	39%	57%

Q36 How long did you have to wait for your solicitor?

I did not requested a solicitor 49%

2 hours or less 10%

Over 2 hours but less than 4 hours 13%

4 hours or more 28%

Q37 Were you officially charged?

Yes 80%

No 16%

Don't Know 5%

Q38 How long were you in police custody *after* being charged?

I have not been charged yet 17%

1 hour or less 17%

More than 1 hour, but less than 6 hours 12%

More than 6 hours, but less than 12 hours 10%

12 hours or more 44%

Section 3: Safety

Q40 Did you feel safe there?

Yes 72%

No 28%

Q41 Had another detainee or a member of staff victimised (insulted or assaulted) you there?

Yes 39%

No 61%

Q42 If you have felt victimised, what did the incident involve? (Please tick all that apply to you.)

I have not been victimised 38%

Insulting remarks (about you, your family or friends) 13%

Physical abuse (being hit, kicked or assaulted) .. 7%

Sexual abuse 1%

Your race or ethnic origin 4%

Drugs 14%

Because of your crime 14%

Because of your sexuality 1%

Because you have a disability 1%

Because of your religion/religious beliefs 1%

Because you are from a different part of the country than others 4%

Please describe:

Q43 **Were you handcuffed or restrained whilst in the police custody suite?**

Yes 49%

No 51%

Q44 **Were you injured whilst in police custody, in a way that you feel was not your fault?**

Yes 25%

No 75%

Q45 **Were you told how to make a complaint about your treatment here, if you needed to?**

Yes 16%

No 84%

Section 4: Healthcare

Q47 **When you were in police custody were you on any medication?**

Yes 34%

No 66%

Q48 **Were you able to continue taking your medication whilst there?**

Not taking medication 67%

Yes 7%

No 26%

Q49 **Did someone explain your entitlements to see a healthcare professional, if you needed to?**

Yes 37%

No 53%

Don't know 9%

Q50 **Were you seen by the following healthcare professionals during your time there?**

	Yes	*No*
Doctor	14%	86%
Nurse	41%	59%
Paramedic	10%	90%
Psychiatrist	0%	100%

Q51 **Were you able to see a healthcare professional of your own gender?**

Yes 14%

No 44%

Don't know 42%

Q52 **Did you have any drug or alcohol problems?**

Yes 55%

No 45%

Q53 **Did you see, or were offered the chance to see a drug or alcohol support worker?**

I didn't have any drug/alcohol problems 48%

Yes 26%

No 26%

Q54 **Were you offered relief or medication for your immediate symptoms?**

I didn't have any drug/alcohol problems 45%

Yes 9%

No 45%

Q55 **Please rate the quality of your healthcare whilst in police custody:**

	I was not seen by health-care	*Very Good*	*Good*	*Neither*	*Bad*	*Very Bad*
Quality of healthcare	48%	5%	9%	9%	2%	27%

Q56 **Did you have any specific <u>physical</u> healthcare needs?**

No 69%

Yes 31%

Please specify:

Q57 **Did you have any specific <u>mental</u> healthcare needs?**

No 73%

Yes 27%

Please specify:

Prisoner survey responses for Dorset Police 2009

Prisoner survey responses (missing data has been excluded for each question). Please note: Where there are apparently large differences, which are not indicated as statistically significant, this is likely to be due to chance.

Key to tables

	Any percent highlighted in green is significantly better.	Dorset Police 2009	Police custody comparator
	Any percent highlighted in blue is significantly worse.		
	Any percent highlighted in orange shows a significant difference in prisoners' background details.		
	Percentages which are not highlighted show there is no significant difference.		
Number of completed questionnaires returned		48	567
SECTION 1: General information			
2	Are you a police detainee?	**88%**	**87%**
3	Are you under 21 years of age?	**18%**	**9%**
4	Are you transgender/transsexual?	**0%**	**1%**
5	Are you from a minority ethnic group (including all those who did not tick White British, White Irish or White other categories)?	**16%**	**35%**
6	Are you a foreign national?	**10%**	**15%**
7	Are you Muslim?	**2%**	**12%**
8	Are you homosexual/gay or bisexual?	**2%**	**1%**
9	Do you consider yourself to have a disability?	**25%**	**18%**
10	Have you been in police custody before?	**98%**	**91%**
SECTION 2: Your experience of this custody suite			
For the most recent journey you have made either to or from court or between prisons:			
11	Were you held at the police station for over 24 hours?	**49%**	**65%**
12	Were you given information about your arrest and entitlements when you arrived?	**70%**	**74%**
13	Were you told about PACE?	**61%**	**53%**
14	If your clothes were taken away, were you given a tracksuit to wear?	**81%**	**39%**
15	Could you use a toilet when you needed to?	**92%**	**89%**
16	If you did use the toilet, was toilet paper provided?	**58%**	**53%**
17	Did you share a cell at the station?	**0%**	**3%**
18	Would you rate the condition of your cell, as 'good' for:		
18a	Cleanliness?	**43%**	**30%**
18b	Ventilation/air quality?	**30%**	**19%**
18c	Temperature?	**21%**	**14%**
18d	Lighting?	**58%**	**44%**
19	Was there any graffiti in your cell when you arrived?	**68%**	**56%**
20	Did staff explain the correct use of the cell bell?	**28%**	**22%**
21	Were you held overnight?	**79%**	**91%**
22	If you were held overnight, were you given **no** clean items of bedding?	**10%**	**31%**
23	Were you offered a shower?	**44%**	**8%**
24	Were you offered a period of outside exercise?	**21%**	**6%**
25a	Were you offered anything to eat?	**92%**	**79%**
25b	Were you offered anything to drink?	**98%**	**82%**
26	Was the food/drink you received suitable for your dietary requirements?	**62%**	**41%**
27	For those who smoke: were you offered **nothing** to help you cope with the ban there?	**92%**	**77%**
28	Were you offered anything to read?	**21%**	**14%**
29	Was someone informed of your arrest?	**31%**	**43%**
30	Were you offered a free telephone call?	**37%**	**51%**

Key to tables

	Any percent highlighted in green is significantly better. Any percent highlighted in blue is significantly worse. Any percent highlighted in orange shows a significant difference in prisoners' background details. Percentages which are not highlighted show there is no significant difference.	Dorset Police 2009	Police custody comparator
31	If you were denied a free call, was a reason given?	8%	15%
32	Did you have any concerns about:		
32a	Who was taking care of your children?	0%	17%
32b	Contacting your partner, relative or friend?	54%	53%
32c	Contacting your employer?	3%	21%
32d	Where you were going once released?	20%	35%
34	If you were interviewed were the following people present:		
34a	Solicitor	53%	75%
34b	Appropriate adult	8%	8%
34c	Interpreter	4%	8%
35	Did you wait over four hours for your solicitor?	55%	64%
37	Were you held 12 hours or more in custody after being charged?	53%	64%
SECTION 3: Safety			
39	Did you feel unsafe?	27%	39%
40	Has another detainee or a member of staff victimised you?	39%	44%
41	If you have felt victimised, what did the incident involve?		
41a	Insulting remarks (about you, your family or friends)	20%	25%
41b	Physical abuse (being hit, kicked or assaulted)	11%	15%
41c	Sexual abuse	2%	2%
41d	Your race or ethnic origin	7%	6%
41e	Drugs	22%	17%
41f	Because of your crime	22%	19%
41g	Because of your sexuality	2%	0%
41h	Because you have a disability	2%	3%
41i	Because of your religion/religious beliefs	2%	4%
41j	Because you are from a different part of the country than others	7%	5%
42	Were you handcuffed or restrained whilst in the police custody suite?	49%	47%
43	Were you injured whilst in police custody, in a way that you feel is not your fault?	24%	27%
44	Were you told how to make a complaint about your treatment?	16%	14%
SECTION 4: Healthcare			
46	Were you on any medication?	35%	46%
47	For those who were on medication: were you able to continue taking your medication?	21%	39%
48	Did someone explain your entitlement to see a healthcare professional, if you needed to?	38%	36%
49	Were you seen by the following healthcare professionals during your time in police custody:		
49a	Doctor	14%	50%
49b	Nurse	42%	19%
49c	Paramedic	9%	2%
49d	Psychiatrist	0%	4%
50	Were you able to see a healthcare professional of your own gender?	14%	29%
51	Did you have any drug or alcohol problems?	54%	58%
For those who had drug or alcohol problems:			
52	Did you see, or were offered the chance to see a drug or alcohol support worker?	50%	42%
53	Were you offered relief medication for your immediate symptoms?	16%	37%
54	For those who had been seen by healthcare, would you rate the quality as good/very good?	25%	31%
55	Do you have any specific physical healthcare needs?	32%	36%
56	Do you have any specific mental healthcare needs?	27%	25%