Report on an inspection visit to police custody suites in South Yorkshire

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by

HM Inspectorate of Prisons and

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1. Introduction

This report is one in a series relating to 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 health care.

At the time of this inspection, South Yorkshire Police operated seven primary custody suites designated under the Police and Criminal Evidence Act (PACE) for the reception of detainees, all operated 24 hours a day. The suites were all managed centrally by the Criminal Justice Administration Department (CJAD), with an Assistant Chief Constable having strategic management responsibility.

Staff were well trained, with regular refresher training and adherence to PACE was good. Observed relationships between staff and detainees were good, and risk assessments were detailed, although some computerised information important to completing these was not available to all staff. The needs of many groups were well met but there were limited facilities for detainees with disabilities. The use of force in custody was not subject to clear governance or oversight and information was not collated to allow patterns and trends to be monitored and practice to be improved.

The physical environment of the suites was poor. Some suites were particularly old and ill-maintained, cells were covered in graffiti and cleanliness was poor. Showers were clean but rarely offered. There were ligature points identified in all the suites and, although health and safety checks were carried out, they needed to be improved.

The arrangements for monitoring the health care contract could be tightened, governance arrangements were still being developed, and the inspection identified some deficiencies in cleanliness and adequacy of medical rooms. Substance abuse and mental health diversion schemes were good, although the use of suites as a place of safety under the Mental Health Act needed review. The management of medications required improvement, in particular the safety and security of their storage. There were specific issues with poor flagging of medicines stock and register discrepancies.

In general, this is a positive report. It does, however, raise some systemic issues about the poor physical conditions in most suites and the management of medications. We hope that our recommendations will be helpful to the South Yorkshire Police and the police authority in continuing to improve custodial conditions and treatment.

Sir Denis O'Connor
HM Chief Inspector of Constabulary

Nigel Newcomen
HM Deputy Chief Inspector of Prisons

August 2010

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

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, South Yorkshire Police had seven primary custody suites designated under PACE for the reception of detainees across the county. These were located at Doncaster, Rotherham, Barnsley and in Sheffield at Attercliffe, Ecclesfield, Moss Way and the Charge Office, Bridge Street (known locally as COBS). The suites operated 24 hours a day and dealt with detainees arrested as a result of mainstream policing. All suites were visited during this inspection. A survey of prisoners at HMP Doncaster, who had formerly been detained at custody suites in the force area, was conducted by an HM Inspectorate of Prisons researcher and inspector to obtain additional evidence (see appendix III).

2.3 The force cell capacity was 131. Across all custody suites in the force area, 46,787 detainees had been dealt with in the year from June 2009 to May 2010. Doncaster, the biggest suite with 38 cells, had dealt with 11,791 detainees in the year to May 2010. Rotherham had 18 cells and had dealt with 6,909 detainees in that period, while Barnsley had 24 cells and had dealt with 8,094 detainees. COBS was the largest of the custody suites in Sheffield, with 26 cells dealing with 9,528 detainees. Moss Way had 11 cells and had dealt with 3,022 detainees, while Ecclesfield and Attercliffe both had seven cells and had dealt with 4,034 and 3,409 detainees respectively. In the six months from December 2009 to May 2010, 243 detainees had been detained for immigration matters in the force area.

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

Strategy

2.5 All seven custody suites were managed centrally by the criminal justice administration department (CJAD). There was a need to develop further the strategy of how the estate could be managed and developed, although there were advanced plans to shut the custody suite at Attercliffe. There had been a recent upgrade of facilities at the suites, but conditions in some were poor.

2.6 An assistant chief constable (ACC) had strategic management responsibility, supported by a chief superintendent and a custody lead who was a chief inspector. Staff complained that senior managers did not have a visible presence in custody. Custody sergeants were permanent and managed by inspectors with oversight of the seven suites. Detention officers were managed by custody sergeants. Staff were well trained and refresher training was offered every 10 weeks). Staffing numbers were adequate.

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

2.7 Dip sampling of custody records took place, but was insufficient. The quality and clarity of information on custody records was very poor, reflecting in part the mainly paper-based custody handling system.

2.8 There was a range of meetings where custody could be discussed. The Police Authority indicated good relations with the force and there were three active independent custody visitor (ICV) panels. Relationships with external partner organisations were mostly strong, although further progress needed to be made with regard to mental health.

2.9 There was some monitoring of use of force, but management information on patterns and trends was not being collected.

Treatment and conditions

2.10 Relationships and interactions between staff and detainees were good and the needs of many groups were well met. However, facilities for detainees with disabilities were poor and the needs of female detainees could have been better met. The physical layout of booking in areas allowed little privacy. Risk assessments conducted on arrival were completed in some detail, but limitations with the custody handling system meant police national computer information was not always available. Given the lack of closed-circuit television (CCTV) in suites and poor environments, staff appropriately took a risk-sensitive approach. Ligature points in cells and other detainee areas were found in all the custody suites. Health and safety walk throughs were done, but needed to be improved.

2.11 There was limited governance of use of force, with no consistent means of establishing whether force used was proportionate. There were some informal arrangements to use exercise yards to assist in de-escalation, but no means of establishing the appropriateness of this as a course of action.

2.12 The respectful approach by staff was in stark contrast to the physical environment of the suites. Cells were covered in graffiti, some of it particularly unpleasant, and cleanliness was also poor at some suites. Some suites were particularly old and tired with limited storage facilities. Detainees were given mattresses and blankets, although some we saw being given out were dirty. Showers were rarely offered. Stocks of clothing were available if needed. The use of cell call bells was routinely explained. Awareness of fire evacuation procedures needed to be improved.

2.13 Some food was poor quality, although readily offered. Outside exercise and visits were rarely facilitated, but some reading materials were available.

Individual rights

2.14 Custody sergeants looked critically at the reasons for detention. Detainees were asked if they wanted someone informed they were in custody. There were sometimes delays in immigration detainees being dealt with by the UK Border Agency (UKBA). Interpreting services were good. Custody was not used as a place of safety for children and young people under section 46 of' the Children Act (1989). Dependency obligations were not routinely explored with newly arrived detainees.

2.15 Adherence to PACE was good. The duty solicitor scheme worked well. Defence solicitors were positive about relationships with staff and said they were respectful to detainees. Appropriate adult provision was generally good, but the service was limited at night and staff adhered to

the PACE definition of a child, which meant 17 year olds were not routinely provided with an appropriate adult.[3] Arrangements for managing DNA and forensics were generally good, with only minor issues evident.

2.16 Pre-release risk assessments were carried out with more vulnerable detainees. Court cut-off times were acceptable. Detainees were not told how to make a complaint, and arrangements for doing so varied. While some complainants were dealt with by duty inspectors, others were sent to the police station front office to do so on release.

Health care

2.17 A new private health care provider, Medacs had been in place for several months and governance arrangements were still being developed. Provision included nurse and forensic medical examiner (FME) cover. Treatment rooms were shabby and in some cases inadequate. The management of medications needed to be improved. Defibrillators were available at all suites and staff trained in their use, but checking arrangements were inadequate.

2.18 Detainees were routinely asked on arrival if they wanted to see a health care professional. Response times were monitored by Medacs. Prescribed medication was not always supplied when needed. Symptomatic relief was available for substance users, although Methadone scripts were not always provided. Clinical records were stored on the Medacs IT system.

2.19 Substance use services were good. There was good continuity of care provided by workers and links to community services and issues around alcohol were dealt with. Services for detainees with mental health problems were mixed. There were good mental health diversion services, but too many detainees were brought into police custody under section 136 of the Mental Health Act.

Main recommendations

2.20 The force should collate the use of force and monitor the use of force locally and at force-wide level, for example by ethnicity, location and officer involved.

2.21 Cells should be safe and staff should be trained to identify potential ligature points and other health and safety issues.

2.22 All cells and detainee areas should be clean, adequately heated and free of graffiti.

2.23 All medications should be stored safely, securely and in accordance with current legislation. Discrepancies in stocks of controlled drugs should be thoroughly investigated and reported to the relevant accountable officer at the primary care trust.

[3] Although this met the current requirements of PACE, in all other UK law and international treaty obligations, 17 year olds are treated as juveniles. The UK government has committed to bringing PACE into line as soon as a legislative slot is available.

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 ACC was the senior portfolio holder for custody issues in South Yorkshire Police, but had only recently taken over this portfolio responsibility following a restructuring of management roles. There was no evidence that there was a clear plan to develop the custody estate across the force area. The force and authority accept there has been an underinvestment in the custodial estate in the past and, despite recent work to build an additional nine cells at Doncaster and some refurbishment in six of the seven designated suites, a significant amount of work was still required to upgrade custody capability.

3.2 A proposal to build a new custody suite with 60 to 90 cells to replace the four existing Sheffield designated suites had been shelved due to the wider economic situation. The force had decided to close one of the smaller Sheffield suites at Attercliffe from September 2010, which would release staff and funding for redistribution among the remaining custody suites. The force believed the remaining capacity of its custody estate was adequate to meet demand. However, the age of the estate was compounded by long-standing issues such as heavy graffiti and continuing heating and drainage issues at two of the sites.

3.3 South Yorkshire's seven designated custody suites operated under the control of the central CJAD. Each suite was managed by an inspector who was the custody manager. The custody manager managed all PACE issues and reviews of detention when on duty and, if they were not available, these duties fell to operational inspectors. Custody managers were line managed by a temporary chief inspector (TCI) who was head of custody. She also had responsibility for the management of custody policies and working practices. The TCI was in turn line managed by the chief superintendent CJAD.

3.4 The custody managers had line management responsibility for the custody sergeants, who in turn line managed the detention officers. The sergeants were posted into custody roles from patrol teams with an expectation that they remain in post for a minimum of two years. There were 66 custody sergeants supported by 71 detention officers, with a further 31 funded through a Home Office drug testing programme.[4] Recognising that this external funding could be withdrawn at any time, the force had started to convert these detention officer posts into permanent posts. Seven Home Office-funded posts had been converted and there were plans to convert the rest shortly. There were a few custody sergeant and detention officer vacancies, but these were due to be filled by existing staff following closure of Attercliffe.

3.5 All custody sergeants had received specific nationally approved custody training before deployment in the custody suites. Availability of custody courses meant this was not always possible for detention officers, in which case they shadowed trained colleagues and could not work alone. Their training would be facilitated at the earliest opportunity. The training for custody sergeants covered PACE legal responsibilities for custody officers, the forces' custody system and first aid training tailored to custody staff. The training for detention officers covered the relevant aspects of PACE followed by work placements to ensure their ongoing development and including first aid, personal safety and fire safety modules. Refresher training was carried out for all custody staff every 10 weeks, with a training day built into shift patterns.

[4] Drug testing on arrest. Drugs Act 2005

A comprehensive custody procedures manual incorporated many issues in the SDHP and assisted staff in discharging their duties effectively.

3.6 There were good working relationships with partners across South Yorkshire, extending to good interpersonal networks that assisted in progressing issues. This was reinforced by the Police Authority, which was very positive about its relationship with the force, describing it as approachable and responsive. There were, however, some ongoing frustrations with the level of engagement with mental health services (see section on health care).

3.7 Quarterly performance meetings were chaired by the ACC, supported by monthly CJAD command team meetings chaired by the Chief Superintendent and monthly custody manager meetings chaired by the TCI. Monthly operational district and departmental commanders meetings were also held where the Chief Constable held them to account for issues arising under their command. There were no custody users meetings for practitioners to discuss and resolve local custody issues, although the TCI was looking to reintroduce these.

3.8 Despite a clear command structure, custody staff described a lack of visibility from CJAD senior managers. Management were aware of the complaints process and there was a feedback loop from the Complaints and Professional Standards Department (CPSD). This filtered down to custody managers, allowing them to identify the number and type of complaints made by detainees (see section on individual rights).

3.9 A Police Authority lead for criminal justice was responsible for liaising with the ICV scheme, which the force viewed as an important independent oversight mechanism. There were three ICV panels, each with its own coordinator. ICVs visited the larger custody suites at least twice a week and smaller custody suites once a week. Feedback forms were submitted after every visit, with one copy left with the custody sergeant with whom any issues were raised and another copy left for the information of the custody manager. The relevant panel coordinator and the Police Authority scheme coordinator were also given copies. The feedback given was formally discussed at quarterly panel meetings attended by ICV members and local custody managers.

3.10 Daily quality assurance checks were carried out by the custody managers, who were required to dip sample one custody record per shift when on duty. Any issues identified, positive or negative, were addressed individually. The number of custody records examined was inadequate, representing less than 4% of the annual throughput of detainees. The checks involved a yes/no list and were not robust enough to ensure that all relevant learning points were identified. A custody audit and inspection guidance policy was being drafted as the force had recognised weaknesses around walk through and quality assurance processes (see section on treatment and conditions).

3.11 The force could provide only limited management information from its custody handling system, mainly because it was difficult to extract information from what was largely a paper-based system. Consequently, the force could not access relevant and timely management information to assist with strategic planning, staffing models or performance around investigative decisions. Custody staff had no access to the police national computer (PNC) as there was no direct link between it and the custody system, and we were not confident that the processes in place were robust enough to always ensure relevant safety markers were notified to custody sergeants. It also exposed detainees, staff and the force to unwarranted and needless risk.

3.12 Following any adverse incident in custody, the custody sergeant had to complete a positive intervention form that was emailed to the relevant custody manager and the TCI. Learning

points from such incidents were circulated to staff by custody managers, but details of all these incidents were recorded centrally where staff could access them. Staff also had access to the Independent Police Complaints Commission (IPCC) Learning the Lessons bulletin through an intranet, but staff told us they were not always aware when the intranet was updated.

3.13 The use of force was recorded in an officer's pocket notebook, on a detainee's custody record and through the submission of a use of force monitoring form, but staff did not think all three would be routinely completed. Submitted forms were forwarded to the officer safety training unit, which monitored the contents to formulate future training scenarios and identify any additional staff training needs. The number and nature of incidents were not adequately monitored, information on the nature and location of incidents and ethnicity and age of detainees involved was not collated and reported incidents were not analysed to identify trends or inform any changes in strategy. Use of force records were not properly quality checked and there were no links between the management of use of force and an overarching custody strategy. Use of force was not discussed at senior staff meetings and there was no overall guidance specific to custody officers about the use of force in custody suites. (See main recommendation 2.20.)

Recommendations

3.14 The force should review its custody facilities and its strategic plan to ensure it develops the custody estate to enhance the wellbeing of detainees.

3.15 The force should address the shortcomings of extracting management information from the custody handling system.

3.16 There should be direct access to the police national computer from custody suites.

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.

Respect

4.1 Most detainees had relatively short journeys to custody suites, usually in police cars. Police vans were used for disruptive or violent detainees. Properly completed escort records accompanied detainees transported by private contractors. Although staff were busy and the environment noisy, staff had time for the detainees in their charge and treated them respectfully. First or preferred names were mostly used. Some reception areas were cramped, crowded and unwelcoming and none offered any privacy for detainees being booked in and disclosing personal information. We saw one juvenile at Ecclesfield answering bail for a sexual offence with 13 other people in the booking in area.

4.2 Staff had not had child welfare or development training. Some had a good understanding of the distinct needs of children, but others said children were not treated differently other than using an appropriate adult. Juvenile detainees were usually held in detention rooms closer to the booking in desk. Staff at Moss Way said that, subject to risk assessment, appropriate adults could stay with a detainee in the detention room with the door unlocked. Some custody staff took more time to explain information to juveniles and used less formal language, but we also saw a very young detainee whose needs were not particularly taken into account. He became upset when he could not see his mother and was subsequently placed on constant supervision. Female detainees were not routinely offered the opportunity to speak to a female member of staff and most staff assumed they would ask for anything they needed. One female detainee who said she was pregnant was quickly referred to see a doctor.

4.3 Other than the new cells at Doncaster, there were no facilities for detainees with disabilities. There were no hearing loops or facilities for detainees with visual impairments. In our prison survey, 27% of respondents, against a comparator of 19%, said they had a disability and 12% compared to 3% said they had been victimised because of their disability. Custody staff had received cultural diversity training as part of their initial induction. They treated all detainees consistently and were aware of cultural differences. Religious needs were catered for, with bibles, prayer mats and Qur'ans available.

Safety

4.4 All detainees were risk assessed on arrival using a standard set of questions and the custody sergeant's observations. Custody sergeants relied on other staff to provide relevant detainee information from the PNC and, while this was usually available, it was not always the case. This was borne out by our custody records analysis, which showed that this was the case in only half the custody records we reviewed at Sheffield. Staff also relied on the local custody handling system, which provided quite detailed information on triggers and risk factors, and verbal information from the arresting officer. Most risk assessment interviews we observed were thorough, but some, particularly at Rotherham, were cursory and did not allow enough time for all detainees to explain their circumstances. Records of risk assessments were balanced and mostly proportionate and plans for any detainee with an identified risk were very cautious. Given the lack of CCTV in suites (see paragraph 4.5) and poor environments,

including numbers of ligature points in cells, this approach appeared appropriate. Anyone potentially presenting a risk to other people was dealt with separately and staffing levels were increased if necessary.

4.5 CCTV cameras covered communal areas, but not cells. No cells were shared. Staff routinely roused detainees when appropriate. Each suite had at least two constant observation cells with full glass doors, although in some cases these were next to each other so a detainee in one could see into the other. All observation cells were dirty, most had graffiti on doors and benches and those at Rotherham and Attercliffe were particularly stark and dreary. Detainees at risk of self-harm were usually put in an observation cell on constant watch until they had been reassessed by the custody sergeant. Staff engagement with detainees in observation cells was particularly good.

4.6 Not all shifts had a built in handover period to allow custody sergeants enough time for a comprehensive handover even at busy times. Briefings included sharing good information about detainees, particularly focusing on those who were more vulnerable, such as children or detainees on constant observation.

4.7 Staff had initial and refresher training that covered self-harm and suicide. Staff at Doncaster, Attercliffe and Rotherham did not carry anti-ligature knives, which were kept near the main desks. Most cells contained multiple ligature points and staff did not know what to look for in terms of these. However, the force took action to remove all ligature points identified during the inspection. (See main recommendation 2.21.)

Use of force

4.8 There were no procedures or protocols to manage particularly disturbed detainees safely. We were told that, following the authority of the custody sergeant, detainees at Doncaster, Rotherham, Attercliffe and COBS were put in protective helmets, handcuffed and had their legs bound with Velcro as part of an approved intervention to protect themselves and others. Protocols for this were not known to officers or found at any of the custody suites. Staff said the secure yards at Attercliffe, Rotherham and Doncaster had been used to isolate disruptive detainees until they were calm enough to be placed in an ordinary cell. At Attercliffe, we were told that a detention officer could authorise this practice. There were no governance arrangements or management oversight of these practices.

4.9 All staff had been trained in the approved techniques and received annual refresher training. The staff culture was positive and custody officers were focused on the welfare of detainees. Detainees subject to use of force were not routinely seen by a medical professional unless they had an obvious injury or asked to do so. Most detainees arrived at the custody suite wearing handcuffs and these were removed at the custody sergeant's discretion when the detainee was interviewed at the front desk.

Physical conditions

4.10 Most cells were in a poor condition, with extensive graffiti on doors, benches and walls, some dating back several years and some including offensive or racist language and symbols. The environment at Attercliffe and COBS was particularly poor, with cramped corridors littered with dirty clothes and bedding, dirty cells, stained toilets and poor ventilation. Doncaster was in much better condition, with bright and well decorated communal areas, reasonably clean cells and little graffiti. Staff at Barnsley had no local control over temperatures within the suite and

cited occasions when extreme temperatures had forced the suite to close. (See main recommendation 2.22.)

4.11 Staff described different practices in daily, weekly, monthly and quarterly health and safety, maintenance and cleanliness checks of the custody suites. There was no obvious guidance for staff on what to check and no formal mechanism to record that a check had been completed. Annual health and safety walk throughs took place, but custody managers said they were not involved in these and did not receive any paperwork to confirm one had been completed.

4.12 Detainees were told how to use cell call bells and bells were tested daily. Bells were usually responded to within a minute. The system was occasionally muted for up to 10 minutes if a detainee pressed the bell continually and all custody staff were notified of this in advance. A no smoking policy was strictly enforced across all custody suites. Some staff said nicotine patches were not provided, while staff at Moss Way said health care professionals could supply them. Staff training in, and awareness of, fire evacuation procedures varied and few knew where smoke detectors were or if they worked.

Personal comfort and hygiene

4.13 Each cell contained a plastic-covered mattress. Staff said these were wiped down after use, but not all those we checked were clean. Detainees at some suites were offered a blanket on arrival, while others were offered one only at night. Some blankets were poor quality or dirty. Suites were cleaned daily and a deep cleaning contractor was on 24-hour call to deal with any cells contaminated by body fluids. Detention staff were expected to clean cells generally after use, but did not always do so.

4.14 Showers were reasonably clean, but rarely used and those at Moss Way did not have privacy screens. Detainees were not routinely offered a shower and none of the detainees in our custody record analysis, including four held overnight, had had a shower in custody. Detainees could wash using in-cell sinks and hygiene items such as razors, shower gel, tooth brushes and toothpaste were available. Detainees could use the toilet in private, but those at Barnsley had to ask for toilet paper. Female detainees were not routinely offered a hygiene pack on arrival.

4.15 There were supplies of tracksuit bottoms, T-shirts and plimsolls, but no underwear.

Catering

4.16 More than the comparator in our survey said they had been offered something to eat. Vegetarian and halal diets were catered for, but some meals had low nutritional values or calorific content. Food temperatures were not taken before serving and meals carried through custody suites on open plates. Additional food was provided outside set times if required. Hot and cold drinks were provided on request.

Activities

4.17 Detainees were not routinely offered exercise and only one in our custody record analysis had been given outside exercise (see appendix II). Staff said detainees were usually given exercise on request, particularly if they had been held for longer periods, but detainees we spoke to were unaware they could have exercise. The exercise yard at Attercliffe was stark and completely closed in without natural light.

4.18 There was a reasonable selection of books, magazines and newspapers for detainees at Doncaster, Attercliffe and Rotherham, but at other suites this was limited to what was brought in by staff. Visits were not normally allowed, but could be granted in special circumstances at the custody sergeant's discretion.

Recommendations

4.19 Booking in desks should allow effective and private communication between detainees and staff.

4.20 There should be clear policies and procedures to meet the specific needs of women and children.

4.21 Some cells should be adapted for use by detainees with physical disabilities.

4.22 Risk assessments should take into account all the relevant information available to staff, who should actively engage with detainees when booking them in to custody.

4.23 An overlap period should be built into all shifts to facilitate an effective handover between staff.

4.24 Governance arrangements and management oversight of all interventions dealing with violent detainees should be put in place and details issued to all staff.

4.25 The processes for carrying out health and safety, maintenance and cleanliness checks should be formalised across the custody estate and the results reviewed by managers. Staff should be given appropriate training to allow them to carry out these checks.

4.26 All detainees held overnight and those who require one should be offered a shower, which they should be able to take with an appropriate degree of privacy.

4.27 Food should be of sufficient quality and calorific content to sustain detainees for the duration of their stay.

4.28 Detainees held for over 24 hours should be offered outdoor exercise in exercise yards that should be clean, well maintained and fit for use.

Housekeeping points

4.29 Custody staff should carry ligature knives.

4.30 All staff should be familiar with fire prevention procedures.

4.31 Mattresses should be wiped clean after each use and blankets should be clean.

4.32 All female detainees should be offered a hygiene pack on arrival.

4.33 All cells should contain a supply of toilet paper.

4.34 Replacement underwear should be available if required.

5. Individual rights

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

Rights relating to detention

5.1 Custody sergeants checked that detention was appropriate before authorising it. Those we spoke to described a 'culture of arrest', with alternatives such as voluntary reporting seldom used. Managers told us that the force was seeking to address this and to develop a greater focus on alternatives disposals and restorative justice. Staff described good relationships with the UKBA, although there were some long delays of between three and five days for immigration detainees to be collected. The average wait was just over 26 hours. Police custody was not used as a place of safety for children and young people under Section 46 of the Children Act 1989.

5.2 All detainees were offered a leaflet outlining their rights and entitlements, which were available in languages other than English. This information was also available in Braille at Ecclesfield. Detainees were told they could let someone know where they were, but this was not always recorded in custody records. A professional telephone interpreting service was used when necessary during booking in and risk assessment and to explain detainees' rights. Posters displayed in some suites advertised this service.

5.3 Detainees were not routinely asked about any dependency obligations and there were no formal arrangements with social services to care for dependents. Custody staff said they helped detainees find a carer when necessary and kept time in custody to a minimum where possible. Social services were contacted as a last resort.

5.4 Pre-release risk assessments were completed, but most were basic and at best comprised a simple strategy to transport a detainee home safely. Referrals were made as required to medical services and there were established links with local community mental health teams. Staff gave examples of detainees subject to constant watches who had multi-agency care plans in place before release. Leaflets detailing local support services were given to detainees on release.

Rights relating to PACE

5.5 The procedural requirements of PACE were applied efficiently. Custody reviews were carried out at the specified times and this was confirmed by defence solicitors. Inspectors or, when necessary, superintendants could usually be located to carry out reviews. Detainees were not interviewed if under the influence, or thought to be under the influence, of alcohol or drugs. A medical opinion was always sought if there was any doubt. Detainees were given adequate breaks between formal interviews.

5.6 Detainees could consult a copy of PACE. The duty solicitor scheme worked well and detainees could speak to their legal representative in an adequately equipped interview room. Solicitors were given copies of custody records on request and the detainee could apply for these in writing on release. Staff said it was difficult to get access to solicitors for immigration

detainees. Defence solicitors were positive about relationships with staff and said they were respectful to detainees.

5.7 Juveniles were not interviewed without an appropriate adult present. However, South Yorkshire police adhered to the PACE definition of a child instead of the Children Act (1989) definition, which meant those aged 17 were not provided with an appropriate adult unless otherwise deemed vulnerable. Custody sergeants had clear and realistic criteria for assessing the suitability of proposed appropriate adults. Voluntary appropriate adults were available at all custody suites for both juveniles and vulnerable adults, but each had its own scheme. The service in Sheffield was provided by SOVA and coordinated through Ecclesfield station. It was available between 8am and midnight and any detainee requiring the service after midnight was detained overnight or bailed by the custody sergeant. The service at Doncaster was provided by the local youth offending team and the social services emergency duty team from 8am to midnight. Custody staff we spoke to said the appropriate adult service was efficient, with average response times of around an hour. Appropriate adults also said they and their clients were well treated in the suites.

5.8 A recent force-wide review of forensic exhibits and DNA samples had clearly had a positive impact. A small number of PACE DNA samples were found at Barnsley, Rotherham, Attercliffe and Ecclesfield, but these would have been destroyed if forwarded on as DNA profiles for the detainees concerned were already held on the national DNA database. This suggested that a small number of officers were unclear about the process of taking and submitting PACE DNA samples. A temporary overnight property store at Ecclesfield was not secure, allowing free access to forensic exhibits, and there were a few exhibits dating back to April and May 2010. The force took immediate remedial action when these issues were pointed out.

5.9 Court cut-off times were around 3.30pm. Custody staff had reasonably good working relationships with court staff and could normally arrange for vulnerable detainees to be dealt with rather than being remanded overnight unnecessarily.

Rights relating to treatment

5.10 Detainees were not told how to make a complaint. Staff at most suites said any detainee wanting to complaint would be dealt with by the duty inspector. Staff at Attercliffe said complaints were not dealt with while the detainee was in detention, but said they would preserve evidence if a detainee indicated they intended to complain. At Doncaster, the custody inspector interviewed all complainants, completed written complaint forms and ensured that evidence was preserved. There was no special process for dealing with complaints of racial discrimination.

Recommendations

5.11 Custody staff should ensure that detainee dependency obligations are routinely identified and, where possible, addressed.

5.12 Appropriate adults should be available to support juveniles aged 17 and under and vulnerable adults in custody, including out of hours.

5.13 Detainees should be told how to make a complaint and facilitated to do so before they leave custody, in line with IPCC guidance.[5]

[5] IPCC statutory guidance to the police service and police authorities on the handling of complaints, 2010.

6. Health care

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

Clinical governance

6.1 General health services had been provided by Medacs since September 2009. Mental health services were provided by the relevant local NHS mental health trust and were well embedded with relevant governance arrangements. Substance use services were provided by a range of providers depending on location. We did not see any detainees treated by Medacs staff and were no given access to clinical records. However, 42% of detainees in our prison survey who had been seen by a health care professional rated the quality of care as good or very good. Medacs staff had all been employed in the previous 12 months and had received training for their role on induction. Senior managers said staff could access up-to-date training, but staff we spoke to described gaps in their knowledge and a lack of continuous professional development.

6.2 There were various monitoring arrangements, but some of these did not provide sufficient information to adequately assess performance. Medacs had a target of seeing all detainees within an hour of referral and, according to its own figures, had achieved this in 89% of cases. Police staff met regularly with the contract manager for Medacs and Medacs provided data such as average waiting times by custody suite. Medacs managers said there had been no complaints from detainees about the services provided, although the validity of this was called into question by the fact that detainees were not told how to complain (see section on individual rights). Nevertheless, the force considered current average waiting times, at 37 minutes, as a significant improvement on the previous arrangements.

6.3 Clinical rooms were in various conditions. The room at Barnsley was very small and couches in several suites were damaged. Most rooms were untidy and cluttered. No infection control audit had been carried out and cleaning schedules were limited. Some sharps bins were not signed or dated when first used and some clinical waste sacks contained domestic rubbish. Some rooms had a 'useful information' folder listing pharmacists and GPs in the area and giving details of the Samaritans and places where young people could get free local pregnancy tests and contraceptive advice. Custody staff had easy access to all rooms. The digital lock codes were quickly changed when this was pointed out to senior managers. Two clinical room doors were wide open when we arrived at the suites.

6.4 Most suites had two medication cabinets, one in the clinical room and the other near the custody desk. The key to both was sometimes on the same key ring held by custody staff. Custody desk cupboards were overstocked, particularly with large quantities of controlled drugs. Boxes were often muddled up and there were empty foils for one medication in the box of another medication. At COBS, there were 187 dihydrocodeine tablets in a cupboard when the register indicated only 104 and at Rotherham, we identified potentially 12 diazepam missing from a cupboard in the clinical room. Altogether, there were discrepancies in the registers and stocks of controlled drugs in eight of the 10 cupboards checked. We were told that the stocks were regularly checked by nursing staff and discrepancies reported to Medacs senior managers, but staff did not know what, if any, action was taken. We brought these discrepancies to the attention of the relevant primary care trust accountable officers. (See main recommendation 2.23.)

6.5 Medications prescribed by FMEs were administered by two detention staff, who then signed the relevant prescription. Nurses giving medications used patient group directions for single doses of a specific range of medications. Custody staff appeared unaware of the professional accountability and legal framework within which nurses worked, complaining that nurses did not prescribe medications for them to give and returned to suites to administer further doses. It was unclear whether return visits were booked by the nurse as such or whether custody staff had to log a new call with the Medacs call centre.

6.6 Each suite had a defibrillator by the custody sergeants' desks and oxygen was kept in the clinical rooms. Checks of the equipment were carried out by Medacs staff, who sent all related records to their head office so these were not available to custody staff. Custody staff we spoke to said they had been trained to use the equipment and some Medacs staff said their training was due to be updated, but no dates had been set.

Patient care

6.7 In our prison survey, 28% of respondents said their entitlement to see a health care professional in custody had been explained to them. In our custody record analysis, seven detainees had been seen by a health care professional, with the longest wait being about two hours 55 minutes (see appendix II). Otherwise, the wait for a health care professional ranged from seven minutes to one hour 14 minutes. Custody staff telephoned a central call centre if a detainee needed to see a health care professional and were given a unique patient number. A clinical record was created on the clinical IT system at the same time. COBS and Doncaster had a nurse based at the suite, but otherwise custody staff relied on a nurse travelling to them. All staff worked 12-hour shifts and provided cover 24 hours a day.

6.8 In our custody record analysis, nine detainees were on medication on arrival in custody and only five of these had been seen by a health care professional. One risk assessment stated the detainee had 'epilepsy' with no indication of what medication was required or when. One detainee with schizophrenia did not have his medication with him so an alternative was prescribed. Another FME assessment stated that a detainee would need further medication if detained beyond his next due dose, although the risk assessment said medication was required 'as and when'.

6.9 We were given different answers when we asked whether detainees could receive Methadone in custody. Senior Medacs managers said it was at the FME's discretion, although patient need was paramount. Minutes of the Medacs contract meetings said FMEs would give half the prescribed dose in custody. Substance use workers and custody staff said it was rare for Methadone to be prescribed or administered in custody. In our survey, 44% of respondents with drug or alcohol problems said they had been offered relief medication.

6.10 Detainee clinical records were computerised and saved on a remote server. We were not given access to these so could not ascertain the quality of the records or whether they conformed to professional guidance from regulatory bodies. The IT system also gave staff access to clinical protocols and NMC guidance. Detainees could ask for, and receive, a full copy of their clinical records, but no one could recall this ever happening.

6.11 Following an assessment, the health professional gave custody staff a summary of the consultation and a care plan. Those we looked at indicated some disputes between nursing staff about whether certain detainees needed an appropriate adult with them. In one case, one nurse had said a detainee arrested on a unit for people with learning disabilities required an appropriate adult, while another nurse who saw the detainee the following morning disagreed.

Neither nurse made any attempt to ensure that the detainee received his medications, even though a copy of his medication chart had been sent with him to custody. He was seen by the mental health nurse, who also acted as his appropriate adult when he was interviewed.

Substance use

6.12 Substance use services were provided by different agencies in different parts of the force area. In our survey, 41% of respondents said they had a drug or alcohol problem and 50% of these had been offered or seen by a substance use worker. Force statistics showed 116 positive drug tests in the previous three months, of which 92 had been seen and assessed in custody and 24 had been 'away from custody'.

6.13 Services in Sheffield were provided by Addaction, whose staff were based in three of the four custody suites (not Moss Way, although a service was still provided) from 7.30am to 7pm and until 9pm at COBS. They saw detainees who tested positive for drugs and undertook daily 'cell sweeps' as they were not confident that custody staff routinely referred all drug users. They also saw detainees with alcohol problems and provided a brief assessment, information and referral to appropriate alcohol support services. They said detainees could wait up to 12 weeks for an assessment by the alcohol support services. A court worker was also part of the drug intervention programme team and went to court to offer support and explain the process.

6.14 Rotherham, Doncaster and South Humber Mental Health Trust (RDASH) provided the services in Doncaster and Rotherham from Clearways substance use team. Staff were based in each custody suite from 7am to 10pm on weekdays and to 3pm at weekends. They saw detainees who tested positive to drugs following a trigger offence, as well as those with alcohol issues and other voluntary clients. They could provide follow-up appointments for detainees with drug issues within a couple of days and out-of-hours custody staff were able to make appointments to detainees leaving the suite. Detainees requiring support with alcohol issues were referred to local services.

6.15 In Barnsley, Phoenix Futures had recently secured the contract to provide substance use services. There was a worker in the custody suite from 7.30am to 8.30pm each weekday, with reduced hours at weekends covering what were considered the busier times. They saw detainees with drug or alcohol issues and followed them up in the community, with appointments within a couple of days.

6.16 All three services were good schemes that could signpost juvenile detainees if required.

6.17 Needle exchange schemes were available at each suite, but staff said they were rarely used. It was not clear whether this was because they were not well promoted or because detainees were aware of existing local needle exchange schemes.

Mental health

6.18 There were good and well embedded liaison and diversion schemes across the force area. A South Yorkshire multi-agency information-sharing policy (mental health) had been signed by all relevant agencies and there were various meetings between the force and Yorkshire and Humber Offender Health and Social Care, including a Section 136 regional meeting. Mental health policies were being reviewed and updated in line with new National Policing Improvement Agency guidance.

6.19 In Sheffield, two nurses worked in the courts as part of a wider forensic team, employed by Sheffield Mental Health Foundation Trust. They liaised with all four custody suites daily, but were most closely associated with COBS. They were available every day the court was open. They had access to the Trust clinical information system and could obtain collateral information about previously known patients. Rotherham and Doncaster suites were served by a member of RDASH on weekdays who visited in the early morning before going on to court. They could divert detainees who had committed low-level offences to an NHS ward or crisis bed, but had no means of diversion for more serious crimes. The team in Barnsley, employed by Barnsley Mental Health Trust, was part of a wider team in the community, but also visited the custody suite daily. Out of normal working hours, the police relied on the relevant mental health crisis team or social worker emergency duty teams.

6.20 In 2009, the team at Sheffield had seen 185 patients as a result of arrest. In Rotherham in 2009/10, the criminal justice liaison team had seen 213 new assessments, of which 64% had been referred by the police, with others referred by Medacs staff, solicitors and probation staff. Nearly 66% of all referrals had been seen at the police station.

6.21 In our custody record analysis, nine detainees reported a mental health problem. One detainee whose behaviour caused some concern waited almost three hours for a health care assessment before being diagnosed with acute psychosis and further professional support requested. It was another five hours before a consultant psychiatrist was able to section the detainee under the Mental Health Act. The detainee left the custody suite for the hospital 12 hours after arrival. The doctor prescribed medication to be administered at 3.45pm, but the log indicated that it was given at 6.55pm.

6.22 All the teams we spoke to had good links with local mental health community services and local prison mental health teams. The team at Sheffield provided induction training for new custody staff, but this was not repeated as update training. Most of the custody staff valued the services provided by their mental health colleagues, but some were unclear about the role of the mental health liaison/diversion teams. Relationships with Medacs staff varied, with good communication at Doncaster, while Medacs staff at Sheffield said they had never met the mental health nurses. This lack of engagement risked hampering patient care.

6.23 Arrangements for Section 136 detainees were not good. We were told that detainees were often taken to the custody suites, particularly if they were intoxicated despite efforts made by the force and policies being in place. In Rotherham, the Section 136 facility was on a general ward rather than a separate suite. Medacs indicated that 15 Section 136 detainees had been taken in to custody suites in June 2010, the monthly average being about 10. We were told that detainees were often moved back to the Section 136 facility once sober. A group was assessing the provision of Section 136 places of safety. The intention was to have one place of safety in each primary care trust area, with tighter protocols for use of the suites.

Recommendations

6.24 Health care staff should receive ongoing training, supervision and support to maintain their professional registration and development so that they have the necessary competencies and skills to meet detainees' needs.

6.25 All clinical rooms should be fit for purpose, subject to infection control measures and free of clutter.

6.26 Detainees with any ongoing prescribed medications should continue to receive them while in custody.

6.27 Detainees requiring relief from the symptoms of drug or alcohol withdrawal should be provided with the relevant medications.

6.28 Police custody should be used as a place of safety for section 136 assessments only in extreme cases.

Housekeeping points

6.29 Sharps bins should be signed and dated when first used.

6.30 There should be a clear procedure for booking a visit when a nurse is required to attend a custody suite solely to administer medications and these should be made known to all staff.

6.31 Documented checks of resuscitation equipment should be available to custody staff in custody suites.

6.32 The needle exchange schemes in custody should be positively promoted to detainees and custody staff.

6.33 Custody staff should receive mental health awareness training as part of their custody refresher training.

6.34 Relations between Medacs staff and all mental health teams should be improved to ensure good care for detainees.

Good practice

6.35 *The range of information held in some clinical rooms assisted staff in providing pertinent information to detainees.*

7. Summary of recommendations

Main recommendations

7.1 The force should collate the use of force and monitor the use of force locally and at force-wide level, for example by ethnicity, location and officer involved. (2.20, see paragraph 2.9)

7.2 Cells should be safe and staff should be trained to identify potential ligature points and other health and safety issues. (2.21, see paragraph 2.10)

7.3 All cells and detainee areas should be clean, adequately heated and free of graffiti. (2.22, see paragraph 2.12)

7.4 All medications should be stored safely, securely and in accordance with current legislation. Discrepancies in stocks of controlled drugs should be thoroughly investigated and reported to the relevant accountable officer at the primary care trust. (2.23, see paragraph 2.17)

Strategy

7.5 The force should review its custody facilities and its strategic plan to ensure it develops the custody estate to enhance the wellbeing of detainees. (3.14, see paragraph 3.2)

7.6 The force should address the shortcomings of extracting management information from the custody handling system. (3.15. see paragraph 3.11)

7.7 There should be direct access to the police national computer from custody suites. (3.16, see paragraph 3.11)

Treatment and conditions

7.8 Booking in desks should allow effective and private communication between detainees and staff. (4.19, see paragraph 4.1)

7.9 There should be clear policies and procedures to meet the specific needs of women and children. (4.20, see paragraph 4.2)

7.10 Some cells should be adapted for use by detainees with physical disabilities. (4.21, see paragraph 4.3)

7.11 Risk assessments should take into account all the relevant information available to staff, who should actively engage with detainees when booking them in to custody. (4.22, see paragraph 4.4)

7.12 An overlap period should be built into all shifts to facilitate an effective handover between staff. (4.23, see paragraph 4.6)

7.13 Governance arrangements and management oversight of all interventions dealing with violent detainees should be put in place and details issued to all staff. (4.24, see paragraph 4.8)

7.14 The processes for carrying out health and safety, maintenance and cleanliness checks should be formalised across the custody estate and the results reviewed by managers. Staff should be given appropriate training to allow them to carry out these checks. (4.25, see paragraph 4.11)

7.15 All detainees held overnight and those who require one should be offered a shower, which they should be able to take with an appropriate degree of privacy. (4.26, see paragraph 4.14)

7.16 Food should be of sufficient quality and calorific content to sustain detainees for the duration of their stay. (4.27, see paragraph 4.16)

7.17 Detainees held for over 24 hours should be offered outdoor exercise in exercise yards that should be clean, well maintained and fit for use. (4.28, see paragraph 4.17)

Individual rights

7.18 Custody staff should ensure that detainee dependency obligations are routinely identified and, where possible, addressed. (5.11, see paragraph 5.3)

7.19 Appropriate adults should be available to support juveniles aged 17 and under and vulnerable adults in custody, including out of hours. (5.12, see paragraph 5.7)

7.20 Detainees should be told how to make a complaint and facilitated to do so before they leave custody, in line with IPCC guidance. (5.13, see paragraph 5.10)

Health care

7.21 Health care staff should receive ongoing training, supervision and support to maintain their professional registration and development so that they have the necessary competencies and skills to meet detainees' needs. (6.24, see paragraph 6.1)

7.22 All clinical rooms should be fit for purpose, subject to infection control measures and free of clutter. (6.25, see paragraph 6.3)

7.23 Detainees with any ongoing prescribed medications should continue to receive them while in custody. (6.26, see paragraph 6.9)

7.24 Detainees requiring relief from the symptoms of drug or alcohol withdrawal should be provided with the relevant medications. (6.27, see paragraph 6.9)

7.25 Police custody should be used as a place of safety for section 136 assessments only in extreme cases. (6.28, see paragraph 6.23)

Housekeeping points

Treatment and conditions

7.26 Custody staff should carry ligature knives. (4.29, see paragraph 4.7)

7.27 All staff should be familiar with fire prevention procedures. (4.30, see paragraph 4.12)

7.28 Mattresses should be wiped clean after each use and blankets should be clean. (4.31, see paragraph 4.13)

7.29 All female detainees should be offered a hygiene pack on arrival. (4.32, see paragraph 4.14)

7.30 All cells should contain a supply of toilet paper. (4.33, see paragraph 4.14)

7.31 Replacement underwear should be available if required. (4.34, see paragraph 4.15)

Health care

7.32 Sharps bins should be signed and dated when first used. (6.29, see paragraph 6.3)

7.33 There should be a clear procedure for booking a visit when a nurse is required to attend a custody suite solely to administer medications and these should be made known to all staff. (6.30, see paragraph 6.5)

7.34 Documented checks of resuscitation equipment should be available to custody staff in custody suites. (6.31, see paragraph 6.6)

7.35 The needle exchange schemes in custody should be positively promoted to detainees and custody staff. (6.32, see paragraph 6.17)

7.36 Custody staff should receive mental health awareness training as part of their custody refresher training. (6.33, see paragraph 6.22)

7.37 Relations between Medacs staff and all mental health teams should be improved to ensure good care for detainees. (6.34, see paragraph 6.22)

Good practice

Health care

7.38 The range of information held in some clinical rooms assisted staff in providing pertinent information to detainees. (6.35, see paragraph 6.3)

Appendix I: Inspection team

Sean Sullivan	HMIP team leader
Gordon Riach	HMIP inspector
Andrew Rooke	HMIP inspector
Angela Johnson	HMIP inspector
Ian Macfadyen	HMIP inspector
Vinnett Pearcy	HMIP inspector
Fiona Shearlaw	HMIC inspector
Paddy Craig	HMIC inspector
Elizabeth Tysoe	HMIP health care inspector
Anne McAffrey	Care Quality Commission inspector
Amy Summerfield	HMIP researcher

Appendix II: Custody record analysis

Background

As part of the inspection of South Yorkshire police custody, a sample of the custody records of detainees held at Barnsley, Doncaster, Rotherham and four Sheffield police stations in May 2010 were analysed. Custody records were held on paper files at each custody suite. A total sample of 30 records were analysed from across South Yorkshire:

Custody suite	Number of records analysed
Bridge Street, Sheffield (HQ)	5
Moss Way, Sheffield	4
Ecclesfield, Sheffield	4
Attercliffe, Sheffield	4
Doncaster	5
Rotherham	4
Barnsley	4
TOTAL	30

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

Demographic information

- Five (17%) of the detainees were female and 25 were male.
- One (3%) person aged under 17 was included in the sample.
- Twenty eight (93%) people in our sample were from a White British/other ethnic background and two (7%) were from a black or ethnic minority background.
- Three (10%) detainees had been held for more than 24 hours. Thirteen (43%) had been in custody overnight, including those who had arrived during the night (before 3am) and were not released until the morning. Twelve (40%) detainees had been held for less than six hours.

Risk Assessments

Initial risk assessment statements were included in all police custody files. These included a standard list of generic questions with some space for additional comments.

- Eleven detainees (37%) were recorded as having consumed alcohol in the 24 hours before arriving in to custody. Two of these were seen by a health care professional. The custody files indicate that all detainees identified as intoxicated on the risk assessment were checked and roused every 30 minutes.
- Three detainees (10%) had current thoughts of self-harm and four (13%) had previous self-harm or suicide attempts recorded on the risk assessment. This identification was mentioned in the custody log, but no specific arrangements in response were recorded for these detainees.
- Nine (30%) detainees in our sample had reported mental health problems.
- Nine (30%) detainees in our sample reported being on medication on arrival in custody. Six of these detainees were seen by a health care professional.
- Two detainees (7%) came into custody with superficial injures.

Removal of clothing

None of the detainees in the sample had had clothing removed.

Foreign nationals

There was only one foreign national in the sample; an immigration detainee under IS91 papers. The file reports that the rights and entitlements under PACE were read to him, even though he was not subject to PACE. The detainee was being held in the custody suite until space was available at an immigration removal centre.

Young people

There was one person under the age of 17 in the sample who had an appropriate adult present when rights and entitlements were read and during the interview.

Women

There were five women in the sample. None of their custody records indicated that they had been offered the chance to speak alone with a female member of staff. With the exception of one log that stated sanitary products had been provided, there was no indication that the specific needs of women detainees were acknowledged or addressed.

Interpreters

None of the custody records indicated that a detainee required the assistance of an interpreter.

Inspector reviews

Inspector reviews were infrequent and rather generic, usually stating that the inspector has reminded the detainee of their right to independent legal advice. The reviews were generally prompted after a detainee had been charged and had been refused bail, or to extend the period of detention for evidence gathering purposes.

Services

- All custody files had a standard option for the 'notification of arrest' section to be completed. In the majority of files, this was not completed or signed and there was generally no record of whether detainees were being asked if they wanted someone notified of their arrest.
- Four (13%) detainees had made a telephone call during their time in custody. One detainee's request for a telephone call was denied, with no reason given in the custody record.
- All custody files had a standard 'legal advice requested/ declined' section to be completed. In two cases, this was not completed, making it unclear whether rights were read and the option for legal advice offered. When legal advice was offered, eight (29%) detainees accepted it.
- Seven (23%) detainees were seen by a health care professional.
    - ❖ The longest wait was approximately two hours 55 minutes.

    - ❖ Discounting this, the time waiting for a health care professional ranged from seven to 74 minutes.
- Fourteen (47%) detainees in our sample were offered at least one meal while in custody. One detainee who refused four meals was held for almost 30 hours without having a meal. Sixteen (53%) detainees were not offered a meal while in custody. Twelve of these detainees had been held for less than six hours and four had been held for over six hours, including three who were held for over 12 hours.
- One detainee in the custody sample had been given outside exercise.
- No detainees had a shower while in custody. This included four detainees who had been held overnight and been discharged to court without a shower. One detainee was held for almost 48 hours and taken to court without being offered a shower.
- Four (13%) detainees had been provided with reading materials.
- No evidence of cell sharing was found.

Additional points of note

- There was no evidence of detainees being asked whether they had any dependents who would be affected by them being in custody noted in the custody records.
- There was no evidence of pre-release risk assessments in the custody records.

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 South Yorkshire, 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 June 2010. A list of potential respondents to have passed through Barnsley, Doncaster, Rotherham or Sheffield police stations was created, listing all those who had arrived from Barnsley, Doncaster, Rotherham or Sheffield Magistrates courts within the past two months.

Selecting the sample

In total, 55 respondents were approached. One respondent reported being held in a police station longer than two months previously. On the day, the questionnaire was offered to 54 respondents; there were four refusals and two questionnaires were not returned. All of those sampled had been in custody within the last two months.

Completion of the questionnaire was voluntary. Interviews were carried out with any respondents with literacy difficulties. In total, one respondent was interviewed.

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.

Response rates

In total, 48 (89%) 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 30 police areas since April 2008.

In the comparator document, statistical significance is used to indicate whether there is a real difference between the figures, i.e. 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?
Sheffield (14), Doncaster (12), Rotherham (14) and Barnsley (8)

Q3 What type of detainee were you?

Police detainee	40 (85%)
Prison lock-out (i.e. you were in custody in a prison before coming here)	3 (6%)
Immigration detainee	1 (2%)
I don't know	3 (6%)

Q4 How old are you?

16 years or younger	0 (0%)	*40-49 years*	7 (15%)
17-21 years	8 (17%)	*50-59 years*	0 (0%)
22-29 years	19 (40%)	*60 years or older*	2 (4%)
30-39 years	12 (25%)		

Q5 Are you:

Male	48 (100%)
Female	0 (0%)
Transgender/transsexual	0 (0%)

Q6 What is your ethnic origin?

White - British	38 (79%)
White - Irish	1 (2%)
White - other	1 (2%)
Black or black British - Caribbean	0 (0%)
Black or black British - African	1 (2%)
Black or black British - other	1 (2%)
Asian or Asian British - Indian	1 (2%)
Asian or Asian British - Pakistani	1 (2%)
Asian or Asian British - Bangladeshi	0 (0%)
Asian or Asian British - other	1 (2%)
Mixed heritage - white and black Caribbean	2 (4%)
Mixed heritage - white and black African	0 (0%)
Mixed heritage- white and Asian	0 (0%)
Mixed heritage - other	0 (0%)
Chinese	0 (0%)
Other ethnic group	1 (2%)

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

Yes	3 (7%)
No	41 (93%)

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

None	12 (27%)
Church of England	23 (51%)
Catholic	4 (9%)
Protestant	0 (0%)
Other Christian denomination	1 (2%)
Buddhist	2 (4%)

Hindu 0 (0%)
Jewish 0 (0%)
Muslim 2 (4%)
Sikh 1 (2%)

Q9 How would you describe your sexual orientation?

Straight/heterosexual 43 (100%)
Gay/lesbian/homosexual 0 (0%)
Bisexual 0 (0%)

Q10 Do you consider yourself to have a disability?

Yes 12 (27%)
No 31 (70%)
Don't know 1 (2%)

Q11 Have you ever been held in police custody before?

Yes 41 (91%)
No 4 (9%)

Section 2: Your experience of this custody suite

Q12 How long were you held at the police station?

1 hour or less 0 (0%)
More than 1 hour, but less than 6 hours 1 (2%)
More than 6 hours, but less than 12 hours 1 (2%)
More than 12 hours, but less than 24 hours 12 (26%)
More than 24 hours, but less than 48 hours (2 days) 19 (41%)
More than 48 hours (2 days), but less than 72 hours (3 days) 9 (20%)
72 hours (3 days) or more 4 (9%)

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

Yes 32 (70%)
No 10 (22%)
Don't know/can't remember 4 (9%)

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

Yes 22 (49%)
No 16 (36%)
I don't know what this is/I don't remember 7 (16%)

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

My clothes were not taken 20 (50%)
I was offered a tracksuit to wear 11 (28%)
I was offered an evidence suit to wear 0 (0%)
I was offered a blanket 9 (23%)

Q16 Could you use a toilet when you needed to?

Yes 40 (91%)
No 4 (9%)
Don't know 0 (0%)

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

	Yes	*No*
Toilet paper	16 (36%)	28 (64%)
Sanitary protection	*1 (4%)*	*22 (96%)*

Q18 Did you share a cell at the police station?

Yes	2 (4%)
No	44 (96%)

Q19 How would you rate the condition of your cell:

	Good	*Neither*	*Bad*
Cleanliness	10 (23%)	14 (32%)	20 (45%)
Ventilation/air quality	6 (14%)	10 (23%)	28 (64%)
Temperature	2 (5%)	14 (32%)	28 (64%)
Lighting	17 (43%)	11 (28%)	12 (30%)

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

Yes	33 (73%)
No	12 (27%)

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

Yes	13 (28%)
No	33 (72%)

Q22 Were you held overnight?

Yes	42 (91%)
No	4 (9%)

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

Not held overnight	4 (9%)
Pillow	0 (0%)
Blanket	30 (64%)
Nothing	13 (28%)

Q24 Were you offered a shower at the police station?

Yes	4 (9%)
No	41 (91%)

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

Yes	3 (7%)
No	42 (93%)

Q26 Were you offered anything to:

	Yes	*No*
Eat?	38 (83%)	8 (17%)
Drink?	38 (86%)	6 (14%)

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

I did not have any food or drink	5 (13%)
Yes	16 (40%)
No	19 (48%)

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

I do not smoke	11 (24%)
I was allowed to smoke	1 (2%)
I was not offered anything to cope with not smoking	33 (73%)

I was offered nicotine gum 0 (0%)
I was offered nicotine patches 0 (0%)
I was offered nicotine lozenges 0 (0%)

Q29 Were you offered anything to read?
Yes 8 (18%)
No 37 (82%)

Q30 Was someone informed of your arrest?
Yes 20 (44%)
No 17 (38%)
I don't know 4 (9%)
I didn't want to inform anyone 4 (9%)

Q31 Were you offered a free telephone call?
Yes 19 (41%)
No 27 (59%)

Q32 If you were denied a free phone call, was a reason for this offered?
My telephone call was not denied 19 (51%)
Yes 5 (14%)
No 13 (35%)

Q33 Did you have any concerns about the following, while you were in police custody?

	Yes	*No*
Who was taking care of your children	6 (19%)	25 (81%)
Contacting your partner, relative or friend	25 (63%)	15 (38%)
Contacting your employer	5 (17%)	24 (83%)
Where you were going once released	9 (29%)	22 (71%)

Q34 Were you interviewed by police officials about your case?
Yes 42 (93%)
No ..... 3 (7%) If No, go to Q36

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

	Yes	*No*	*Not needed*
Solicitor	29 (71%)	7 (17%)	5 (12%)
Appropriate adult	1 (5%)	8 (40%)	11 (55%)
Interpreter	4 (21%)	7 (37%)	8 (42%)

Q36 How long did you have to wait for your solicitor?
I did not requested a solicitor 10 (23%)
2 hours or less 4 (9%)
Over 2 hours but less than 4 hours 8 (18%)
4 hours or more 22 (50%)

Q37 Were you officially charged?
Yes 43 (98%)
No 1 (2%)
Don't know 0 (0%)

Q38 How long were you in police custody *after* being charged?
I have not been charged yet 1 (2%)
1 hour or less 1 (2%)

More than 1 hour, but less than 6 hours 10 (24%)
More than 6 hours, but less than 12 hours 10 (24%)
12 hours or more 20 (48%)

Section 3: Safety

Q40 Did you feel safe there?
Yes 28 (64%)
No 16 (36%)

Q41 Had another detainee or a member of staff victimised (insulted or assaulted) you there?
Yes 18 (41%)
No 26 (59%)

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

I have not been victimised	26 (41%)	*Because of your crime*	11 (17%)
Insulting remarks (about you, your family or friends)	8 (13%)	*Because of your sexuality*	1 (2%)
Physical abuse (being hit, kicked or assaulted)	3 (5%)	*Because you have a disability*	5 (8%)
Sexual abuse	0 (0%)	*Because of your religion/religious beliefs* ...	2 (3%)
Your race or ethnic origin	1 (2%)	*Because you are from a different part of the country than others*	1 (2%)
Drugs	6 (9%)		

Q43 Were you handcuffed or restrained while in the police custody suite?
Yes 17 (39%)
No 27 (61%)

Q44 Were you injured while in police custody, in a way that you feel was not your fault?
Yes 9 (21%)
No 34 (79%)

Q45 Were you told how to make a complaint about your treatment here if you needed to?
Yes 5 (12%)
No 38 (88%)

Section 4: Health care

Q47 When you were in police custody were you on any medication?
Yes 21 (48%)
No 23 (52%)

Q48 Were you able to continue taking your medication while there?
Not taking medication 23 (52%)
Yes 9 (20%)
No 12 (27%)

Q49 Did someone explain your entitlements to see a health care professional if you needed to?
Yes 12 (29%)
No 28 (67%)
Don't know 2 (5%)

Q50 Were you seen by the following health care professionals during your time there?

	Yes	*No*
Doctor	10 (26%)	29 (74%)
Nurse	10 (27%)	27 (73%)
Paramedic	0 (0%)	30 (100%)
Psychiatrist	0 (0%)	30 (100%)

Q51 Were you able to see a health care professional of your own gender?

Yes	5 (12%)
No	28 (68%)
Don't know	8 (20%)

Q52 Did you have any drug or alcohol problems?

Yes	18 (41%)
No	26 (59%)

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	26 (59%)
Yes	9 (20%)
No	9 (20%)

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

I didn't have any drug/alcohol problems	26 (59%)
Yes	8 (18%)
No	10 (23%)

Q55 Please rate the quality of your health care while in police custody:

	I was not seen by health care	*Very good*	*Good*	*Neither*	*Bad*	*Very bad*
Quality of health care	25 (57%)	3 (7%)	5 (11%)	5 (11%)	3 (7%)	3 (7%)

Q56 Did you have any specific <u>physical</u> health care needs?

No	29 (67%)
Yes	14 (33%)

Q57 Did you have any specific <u>mental</u> health care needs?

No	34 (79%)
Yes	9 (21%)

Prisoner survey responses for South Yorkshire 2010

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

		South Yorkshire Police	Police custody comparator
	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		
Number of completed questionnaires returned		48	963
SECTION 1: General information			
2	Are you a police detainee?	**86%**	**89%**
3	Are you under 21 years of age?	**16%**	**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%**	**36%**
6	Are you a foreign national?	**7%**	**16%**
7	Are you Muslim?	**4%**	**12%**
8	Are you homosexual/gay or bisexual?	**0%**	**2%**
9	Do you consider yourself to have a disability?	**27%**	**19%**
10	Have you been in police custody before?	**92%**	**90%**
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?	**69%**	**65%**
12	Were you given information about your arrest and entitlements when you arrived?	**69%**	**73%**
13	Were you told about PACE?	**49%**	**51%**
14	If your clothes were taken away, were you given a tracksuit to wear?	**55%**	**45%**
15	Could you use a toilet when you needed to?	**91%**	**90%**
16	If you did use the toilet, was toilet paper provided?	**37%**	**51%**
17	Did you share a cell at the station?	**4%**	**3%**
18	Would you rate the condition of your cell, as 'good' for:		
18a	Cleanliness?	**22%**	**29%**
18b	Ventilation/air quality?	**13%**	**20%**
18c	Temperature?	**4%**	**14%**
18d	Lighting?	**43%**	**43%**
19	Was there any graffiti in your cell when you arrived?	**74%**	**56%**
20	Did staff explain the correct use of the cell bell?	**29%**	**22%**
21	Were you held overnight?	**92%**	**91%**
22	If you were held overnight, were you given **no** clean items of bedding?	**29%**	**31%**
23	Were you offered a shower?	**9%**	**9%**
24	Were you offered a period of outside exercise?	**6%**	**6%**
25a	Were you offered anything to eat?	**83%**	**79%**
25b	Were you offered anything to drink?	**87%**	**81%**
26	Was the food/drink you received suitable for your dietary requirements?	**46%**	**44%**
27	For those who smoke: were you offered **nothing** to help you cope with the ban there?	**74%**	**77%**
28	Were you offered anything to read?	**17%**	**13%**
29	Was someone informed of your arrest?	**45%**	**44%**
30	Were you offered a free telephone call?	**42%**	**53%**

Key to tables

		South Yorkshire Police	Police custody comparator
	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		
31	If you were denied a free call, was a reason given?	**26%**	**14%**
32	Did you have any concerns about:		
32a	Who was taking care of your children?	**19%**	**16%**
32b	Contacting your partner, relative or friend?	**62%**	**53%**
32c	Contacting your employer?	**17%**	**21%**
32d	Where you were going once released?	**28%**	**32%**
34	If you were interviewed were the following people present:		
34a	Solicitor	**71%**	**73%**
34b	Appropriate adult	**5%**	**8%**
34c	Interpreter	**20%**	**7%**
35	Did you wait over four hours for your solicitor?	**66%**	**65%**
37	Were you held 12 hours or more in custody after being charged?	**49%**	**62%**
SECTION 3: Safety			
39	Did you feel unsafe?	**37%**	**41%**
40	Has another detainee or a member of staff victimised you?	**41%**	**42%**
41	If you have felt victimised, what did the incident involve?		
41a	Insulting remarks (about you, your family or friends)	**19%**	**21%**
41b	Physical abuse (being hit, kicked or assaulted)	**7%**	**14%**
41c	Sexual abuse	**0%**	**2%**
41d	Your race or ethnic origin	**2%**	**6%**
41e	Drugs	**14%**	**15%**
41f	Because of your crime	**26%**	**17%**
41g	Because of your sexuality	**2%**	**1%**
41h	Because you have a disability	**12%**	**3%**
41i	Because of your religion/religious beliefs	**5%**	**3%**
41j	Because you are from a different part of the country than others	**2%**	**5%**
42	Were you handcuffed or restrained while in the police custody suite?	**39%**	**47%**
43	Were you injured while in police custody, in a way that you feel is not your fault?	**21%**	**26%**
44	Were you told how to make a complaint about your treatment?	**11%**	**13%**
SECTION 4: Health care			
46	Were you on any medication?	**48%**	**44%**
47	For those who were on medication: were you able to continue taking your medication?	**43%**	**39%**
48	Did someone explain your entitlement to see a health care professional if you needed to?	**28%**	**35%**
49	Were you seen by the following health care professionals during your time in police custody:		
49a	Doctor	**25%**	**50%**
49b	Nurse	**26%**	**14%**
49c	Paramedic	**0%**	**5%**
49d	Psychiatrist	**0%**	**4%**
50	Were you able to see a health care professional of your own gender?	**12%**	**29%**
51	Did you have any drug or alcohol problems?	**41%**	**54%**
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%**	**41%**
53	Were you offered relief medication for your immediate symptoms?	**44%**	**32%**
54	For those who had been seen by health care, would you rate the quality as good/very good?	**42%**	**28%**
55	Do you have any specific physical health care needs?	**33%**	**33%**
56	Do you have any specific mental health care needs?	**21%**	**24%**