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

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by

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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.

At the time of the inspection, Warwickshire Police had three main custody suites designated for the reception of detainees under the Police and Criminal Evidence Act, 1984 (PACE): Nuneaton, Leamington Spa and Rugby. There were also a number of other decommissioned suites. There were a total of 47 cells in the three designated suites, which operated 24 hours a day. All designated and some decommissioned suites were visited.

Strategic management was good, with clear lines of accountability from the assistant chief constable to custody sergeants. Custody detention assistants were contracted staff from Reliance and there were some concerns about their security clearance. We also had some concerns about the resilience of the staffing model and the level of sick leave. However, staff training arrangements were sound and there was some excellent management information available to inform practice. The Police Authority took an active interest in this area, supported by an effective team of independent custody visitors. Partnership working was generally strong but underdeveloped with health service providers.

Relationships between staff and detainees were generally good. Effective use was made of interpreting services and basic religious needs were met. However, there was limited specific provision for juveniles, women and vulnerable adults. Some cells and communal areas were dirty and we found a number of ligature points. Showers were rarely offered. Neither toilet paper nor women's hygiene packs were routinely provided. Catering was adequate and reading materials were usually provided.

Staff adhered to PACE and ensured detainees received their entitlements. The appropriate adult scheme operated well during the day but less well at night, and was generally not applied to 17 year olds. Immigration detainees tended to be held for lengthy periods because the United Kingdom Border Agency was slow to collect them. The lack of video links and early court cut-off times meant that some detainees were held in custody longer than necessary. Complaint systems needed to be improved, as did the management of forensic samples.

Healthcare provision was inhibited by some conflicts with contracted GPs' surgery hours, together with insufficient monitoring of the contract by police managers. Female doctors were not always available and some clinicians did not have access to computerised custody record. Good quality services were available for substance abusers but services for those with mental health issues were mixed, particularly out of hours. There were no place of safety beds available in the county, so all those detained under the Mental Health Act had to be held in police custody.

This inspection of police custody suites in Warwickshire provides an important degree of public assurance that, in most respects, detention is well managed. A number of areas for

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

improvement are identified in this report, which we hope will assist the Chief Constable and the Police Authority to improve provision further.

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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, Warwickshire Police had three main custody suites designated under the PACE for the reception of detainees: Nuneaton in the north of the county, Leamington Spa in the middle and Rugby in the east. Custody facilities in several other stations in the force area had been decommissioned or were no longer used by the force (see section on treatment and conditions). 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 other sites with custody facilities in the force area. A survey of prisoners at HMP Hewell, 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 47. Nuneaton had 24 cells, Leamington Spa had 14 and Rugby had nine. In the previous 12 months, these cells had been used for 5,531, 4,883 and 2,802 detainees respectively. Of these, 11,057 were male and 2,159 were female, 1,209 were under 17 years and 185 were immigration detainees.

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 to custody sergeants. Custody detention assistants were contracted workers who were responsible to sergeants, but line managed by the contractor (Reliance). Security clearance arrangements for these staff were unclear. All staff working in custody were permanent. A series of formal meetings were held to manage risks.

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

2.7 We had concerns about the staffing model used, including the number of detention officers deployed. There was good in-house training for new custody staff and a programme of refresher training was under way.

2.8 There was very good partnership work with a range of external organisations, other criminal justice organisations and police forces. Relationships with the Police Authority and independent custody visitors were excellent, but those with health service providers were underdeveloped.

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

2.9 Custody managers carried out regular dip sampling of custody records. Some excellent management information was collected and analysed and learning the lessons information was disseminated to front line staff.

2.10 A use of force form was completed and analysed for training purposes, but not for trends.

Treatment and conditions

2.11 Relationships between staff and detainees were generally good. Good use was made of interpreting services and basic religious needs were met. There was limited awareness of child protection issues, the needs of detainees with learning difficulties and the different experience of women in custody. Only one suite was suitable for holding detainees with disabilities.

2.12 Risk assessments were carried out and revised as circumstances changed, but some lacked depth. There was no closed-circuit television coverage in cells. Force was not over-used and good de-escalation techniques were used. Fire evacuation drills took place.

2.13 Some cells and communal areas were dirty and covered in graffiti. Nuneaton offered a good environment, but Leamington Spa and Rugby were in need of refurbishment. There were ligature points in some cells, showers and exercise yards. Adequate bedding was provided, but not always cleaned between uses. Showers were rarely provided and most detainees whose clothing was taken were given paper suits to wear. Toilet paper and women's hygiene packs were not routinely offered. Long-stay detainees were given exercise. Catering was adequate, but food choice was limited. Magazines were available, but visits were rarely facilitated.

Individual rights

2.14 Custody sergeants authorised detention appropriately. Custody suites were not used as a place of safety for children. A large number of immigration detainees were held and there were some long delays before they were collected by the UK Border Agency. Interpreting services were well used.

2.15 Someone concerned about the welfare of detainees was informed of their whereabouts. Not all detainees were asked about any dependants. There were arrangements in place for dealing with vulnerable detainees on release.

2.16 Staff 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 there were some problems in getting appropriate adults for vulnerable adults with learning difficulties.

2.17 Arrangements for the storing and disposal of DNA and forensics needed to be improved. Court cut-off times were sometimes too early, resulting in bed blocking and unnecessarily long periods spent in custody. There were no video links facilities.

2.18 Staff were confused about the systems for dealing with complaints, but some detailed analysis had started. Detainees were not routinely given information on how to complain.

Healthcare

2.19 Healthcare was provided by local GPs on individual contracts that were not managed from custody. Conflicts with GP surgery hours caused delays and many consultations took place over the telephone. Some medical rooms were dirty, defibrillators were not available and there were some problems with the management of medicines.

2.20 Detainees being booked in were routinely asked if they wanted to see a healthcare professional. However, there was only one female doctor and health professionals provided a mixed level of care. There were not enough NSPIS terminals in medical rooms and no clear arrangements for the secure storage of medical in confidence case notes.

2.21 Substance misuse workers carried out sweeps to identify relevant cases. They assessed need and offered support for alcohol and drug-related issues. Continuity of care was good. Needle exchange was signposted on release.

2.22 Services for detainees with mental health issues were mixed. Community psychiatric nurses visited suites daily and provided a valued service, but this was under threat. There were no section 136 place of safety beds in the county, so all detainees held under the Mental Health Act were held in police custody. Custody staff found obtaining a mental health service out of hours extremely difficult.

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 custody suites and delivery of services was under the control of the central judicial services department. Trained custody staff were routinely used in all suites and a comprehensive custody procedures manual underpinned working practices. A number of quality assurance processes were in place, one of which was an analysis of all 'adverse incidents' within the designated custody suites over a year. This led to the production of a report, which provided a clear overview of the issues encountered and made recommendations for improvements, which was good practice.

3.2 An assistant chief constable was the senior portfolio holder for custody issues. There was ample evidence of strategic priority being given to custody and there was clear strategic direction in relation to the development of custody within the context of judicial services. An ongoing programme of work for the three designated custody suites had led to Nuneaton being built in 2005, while Rugby was scheduled to close for refurbishment at the end of October 2009 and Leamington Spa scheduled for refurbishment in May/June 2010. The refurbishment programme was strongly supported by the Police Authority.

3.3 The three designated custody suites operated under the control of the central judicial services department. At Nuneaton, the custody suite and police station were located in a justice centre where other criminal justice agencies such as the court, Crown Prosecution Service, youth offending team and probation were also based. Following refurbishment, the Leamington Spa custody suite and police station were due to become part of a similar centre, but planning restrictions at Rugby meant the refurbishment was on a smaller scale while still providing a multi-agency facility.

3.4 A superintendent (head of judicial services) based at Leamington Spa had oversight of custody provision within Warwickshire Police and was responsible for the strategic development of custody. The management of custody policies and working practices rested with the judicial services chief inspector. Each custody suite was managed by an inspector who was the custody suite manager (CSM). The inspectors were line managed by the judicial services chief inspector.

3.5 Police and criminal evidence (PACE) reviews of detention were carried out by the CSMs during their normal hours of duty, which were routinely 8am to 4pm on weekdays. Outside these hours, PACE reviews were carried out by duty Inspectors who provided coverage for critical incidents across the force area. CSMs also covered the role of duty inspector, which could lead to them being re-deployed from their core duties for a number of days at a time (minimum of 22 days a year). Staff reported concerns at the level of these re-deployments.

3.6 The CSMs had line management responsibilities for the custody sergeants, custody centre managers (CCMs) and custody detention officers (CDOs). The police sergeants in the custody suites were posted into custody roles from their patrol teams with a view to serving a minimum of 18 months in post.

3.7 There were 22 custody sergeants supported by two CCMs (one responsible for Nuneaton and one for Rugby and Leamington Spa) and 17 CDOs. The CCMs and CDOs were employed by Reliance, who were contracted by Warwickshire Police Authority. The CCMs were the first line managers for the CDOs, but were also trained CDOs and could cover their duties when necessary. The contracted staff were governed by their employer's terms and conditions and a separate discipline code and complaints process. There was some confusion over the level of 'vetting' that CCMs and CDOs were subject to. While Reliance was clear on the level of vetting carried out by the force, these members of staff were not vetted to the same level as similar grade police employees. No consideration had been given to carrying out enhanced criminal records bureau checks, despite their role bringing them into contact with children and vulnerable adults.

3.8 The current staffing model was a concern in that a large number of custody sergeants on duty were working at suites other than their recognised home station. Staff said this was not unusual and resulted from there being no resilience in staffing levels, which had been exacerbated by the fact that two members of staff had been absent for a long time on sick leave. In a custody suite such as Nuneaton, staffing levels could be one custody sergeant and one CDO covering 24 cells. The CDO could therefore have to deal with the physical welfare and safety of up to 24 detainees while also carrying out their duties of fingerprinting, photographing, DNA testing and, where appropriate, taking footwear impressions from everyone coming into custody. Staff said they felt under pressure at busy times when custody numbers were high.

3.9 All custody sergeants and detention staff had received specific custody training before their deployment into the custody suites. New custody sergeants attended a nine-day course provided by West Mercia Police and based on a nationally approved custody training course. Sergeants who had been in post for some years had attended this course as refresher training. New custody detention officers attended a five-week course, also provided by West Mercia Police but contracted through the private company rather than Warwickshire Police. This covered all aspects of the CDO custody duties as well as use of the police national computer and the national strategy for police information systems (NSPIS) custody and case computer system. First aid training had recently been introduced for all custody staff. The force had held a one-day refresher training over three days in May 2009 to allow all custody sergeants and some CDOs to attend. This covered cell searches, safer detention and handling of persons in police custody (SDHP) guidance, lessons learned and mental health issues. Staff were well trained and were also supported in their work by a comprehensive custody procedures manual that incorporated many issues contained within the SDHP guidance.

3.10 Custody sergeants worked nine-hour shifts while CDOs worked 12-hour shifts. This allowed custody sergeants a rostered handover period for all shifts apart from the nightshift to dayshift handover, when the force relied on staff goodwill to arrive early to complete a handover.

3.11 There were good working relationships with partners across Warwickshire, but some ongoing frustrations with the level of engagement with health services. The Police Authority was very positive about its relationship with the force, which they found very approachable and responsive on both a formal and informal basis. The force had entered into an agreement with Leicestershire Constabulary whereby it would accept detainees from the Hinckley area of Leicestershire at Nuneaton on Friday and Saturday evenings. This was supported by Leicestershire seconding a custody sergeant to work at Nuneaton at these times and this practice, which was due for evaluation, appeared to be working well.

3.12 At a strategic level, judicial services management team meetings, chaired by the head of judicial services, were supported by operational group meetings, chaired by the judicial

services chief inspector. Both took place on a staggered six-weekly basis. The judicial services chief inspector also held regular ad hoc meetings with the three CSMs. However, at a practitioner level, there was no evidence of any custody users meetings to provide a forum to discuss and resolve local custody issues with partner organisations.

3.13 Managers were aware of the complaints process as the professional standards department (PSD) fed back information on trends and patterns arising from the complaints procedure. However, it was not clear that the force had clearly communicated how complaints in custody should be dealt with (see section on individual rights).

3.14 There was a Police Authority lead for the independent custody visitors (ICV) scheme, which provided an effective independent oversight mechanism. ICVs were scheduled to visit the three designated custody suites weekly and this was mostly achieved. Feedback forms were submitted after every visit and left with the custody sergeant, with whom any issues were raised, before being viewed by the CSMs. The forms were then routed back to the respective area panel chairs and the clerk to the Police Authority, who could seek resolution of any ongoing issues formally and informally. ICV members we talked to were generally positive about the responsiveness of the force to feedback from visits and relationships were characterised as good.

3.15 Although the central judicial services provided policies and procedures for guidance, there were some policy gaps that needed to be underpinned by standard operating 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 (see section on individual rights).

3.16 A number of' cells with ligature points were identified, indicating clear gaps in relevant skills and knowledge among staff responsible for carrying out safety checks (see section on treatment and conditions).

3.17 Quality assurance checks were carried out by CSMs, who were required to dip sample every 50th custody record (every 25th custody record at Rugby due to its smaller throughput) each quarter. Details of these checks were recorded on a spreadsheet and any findings addressed direct with individual staff members or discussed further at the informal meetings between the judicial services chief inspector and three CSMs or formally at the judicial services operational group meeting.

3.18 The change to quarterly checks was a direct result of a custody record audit carried out by the force's audit and inspection unit. This dip sampled 113 randomly selected custody records over the 2008 calendar year and resulted in eight recommendations that were communicated to all custody staff. The force intended these custody record audits to take place annually.

3.19 Reliance also submitted a quarterly audit report to the force. This was based on CCMs completing an audit quality check of 90 custody records (10 a month from each custody suite), which assisted in identifying common trends or issues. The company produced an action plan in consultation with the force, whereby it agreed what action would be taken and by whom.

3.20 Custody sergeants were required to complete a reporting form following any adverse incident that involved actual or possible serious illness, injury or self-harm of a detainee. The forms were submitted to the professional standards department, health and safety, the head of judicial services, the judicial services chief inspector, the three CSMs and every member of staff in the custody environment. The professional standards department analysed submitted forms and produced an annual report highlighting the key findings and recommendations and

identifying trends such as susceptible individuals, ethnicity, age and gender. This was emailed to all staff and had proved so useful that it was scheduled to be produced twice a year.

3.21 Custody staff were emailed information from the Independent Police Complaints Commission learning the lessons bulletin and other relevant material. Judicial services had also introduced 'The Brief' newsletter, circulated to all judicial services staff, which contained up to date news on subjects such as custody developments and audit findings.

3.22 The use of force was routinely recorded in an officer's pocket notebook, on a detainee's custody record and through the submission of a use of force monitoring form. These forms were submitted to the officer protection instructor, who monitored the content to identify future training scenarios and identify whether staff needed additional training from a personal safety perspective. By not collating and further analysing the available information that could be recorded on the monitoring form, the force was unable to identify patterns and monitor trends. There were no specific references in the use of force policies to issues related to the use of force in custody (such as the use of incapacitants in enclosed spaces).

Recommendations

3.23 The working arrangements for custody suite managers and custody detention officers should be such that they can fully discharge their duties in custody.

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

3.25 A strategic forum should be set up to facilitate partnership working at a practitioner level.

3.26 The force should urgently review the levels of 'vetting' for all staff in the custody environment.

3.27 The use of force should be monitored and analysed centrally to enable the identification of patterns and trends. This information should be disseminated to custody managers.

3.28 Use of force policies should make explicit reference to issues relevant to custody when force is deployed.

3.29 The reasons for the deployment of incapacitant sprays in custody should be recorded in custody records and centrally. Managers should quality assure such usage and satisfy themselves about appropriateness, proportionality and any health and safety issues.

Good practice

3.30 *Dynamic and 'real-time' learning from adverse incidents in custody was immediately circulated to all staff.*

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 Staff were respectful towards detainees. There were some dedicated cells for juveniles and telephone interpreters were used when needed. Staff had limited awareness of child protection issues and how women may experience detention differently. Booking in areas lacked privacy and some risk assessments carried out were superficial. There appeared to be little use of force and good de-escalation techniques were used. Detainees were not routinely told how and why to use call bells. The condition of cells varied and some were dirty with graffiti. A number of cells had ligature points, which presented significant safety issues. Bed linen was not regularly laundered and hygiene products had to be requested. Showers and exercise were seldom provided and usually only for longer-staying detainees. Most detainees whose clothing was removed were given paper suits. Detainees were given food and drinks at mealtimes and on request. Magazines were available, but visits were seldom facilitated.

Respect

4.2 Police cars or vans brought detainees in and Reliance often took them to court. Vans were always used for detainees who had been violent. We were told by staff and management that a high number of illicit items were found on detainees when they were searched on arrival in the custody suite, which the station inspector attributed to arresting officers not carrying out thorough initial searches in the community. We saw evidence that management were seeking to address this issue. Staff were consistently respectful towards detainees. First and preferred names were generally used and staff were relaxed and friendly, particularly with juveniles. Detainees and visiting youth offending team workers confirmed this was the case.

4.3 The booking in process was largely the same for all detainees. Staff had received some awareness training on the main elements of diversity, but had limited understanding of the specific needs of different groups of detainees. There was little evidence that women or detainees with learning difficulties were treated differently, and limited awareness of the impact of some disabilities on detainees in detention. The detention log for one woman with a hearing impairment detailed frequency of contact, whether she had a drink or food, when she had been interviewed and when her case had been reviewed by the inspector, but contained no evidence of any ongoing risk assessment. There were no special arrangements for foreign national detainees apart from unrestricted use of professional interpreters.

4.4 Detainees with disabilities were taken to Nuneaton, as it had specific facilities including wheelchair access, an adapted toilet and a hearing loop system. Basic religious needs were met and prayer mats and religious texts were available on request.

4.5 There was no separate policy on children and young people. Some basic awareness training on dealing with juveniles was included in the custody training module, but no refresher child protection awareness training was offered. Staff said they would liaise with the emergency duty team or the child protection team if they became aware of any child protection issues. Apart from the involvement of appropriate adults, young people were subject to the same treatment and facilities as other detainees. Girls were not always continually supervised by a female

member of staff, although staff said a female officer was always available in the stations who could be called on at short notice.

4.6 We observed a young person being searched at Leamington Spa. While the search was carried out appropriately, the fact that it was done in a public area was inappropriate. Leamington Spa and Rugby had a designated cell for juveniles. At Leamington Spa, this was slightly larger than the other cells and located next to the staff desk. If more than one juvenile was held, they were simply allocated to one of the other cells. At Nuneaton, juveniles were located in any cell that was free.

4.7 The booking in desk at Nuneaton was inappropriately high at both ends and the one at Rugby was also high. The booking in process took place at these desks with little privacy if other staff, visitors or detainees were also in the area.

Safety

4.8 The risk assessment process followed the locally agreed prescribed NSPIS questioning format. Police National Computer checks were routinely carried out and warning markers were flagged up. All custody sergeants had received training in risk assessments, but some of the interviews we observed were quite mechanistic, with sergeants rigidly following the set questions. No risk management plan was subsequently produced and the only action routinely commented on was the frequency of observations. Staff said the suite would be cleared of all other detainees when an individual judged to present a risk to others was moved around. Such detainees were taken directly to the cell and searched, sometimes under restraint, before being booked in formally. Cells were not shared.

4.9 None of the cells had closed-circuit television coverage. Four cells each at Leamington Spa and Nuneaton and two at Rugby had life signs monitoring equipment, but staff did not over-rely on this. Four cells at Nuneaton had glass fronts, which aided observation and were used for detainees deemed particularly vulnerable, such as juveniles and self-harmers and those who were claustrophobic. Staff said any detainee deemed high risk or who failed to cooperate was initially put on constant watch.

4.10 It was positive that in our survey, 27% of detainees, against a comparator of 40%, said they had felt unsafe and only 7%, against a comparator of 26%, had been subjected to insulting remarks.

Use of force

4.11 Staff said force was rarely used and this was supported by our observations and custody record analysis. It was positive that staff' relied heavily on de-escalation, which was supported by the fact that many detainees were local and known to staff.

4.12 Custody sergeants had all received training in the use of force and this was updated every six months. Detainees were not routinely seen by a healthcare professional after force had been used unless they asked to do so or were seen to have received an injury.

Physical conditions

4.13 The suite at Nuneaton had been built in 2005. It was maintained by SERCO and offered a good environment, although there was some graffiti in a number of cells. The cells were

relatively clean, but mattresses and pillows were not routinely wiped down and there was some debris on one of the pillows. The cells had internal sanitation and a number of the cells had hand washing facilities that were not working.

4.14 Rugby was scheduled to close for refurbishment at the end of October 2009 and a portable cell block was being erected in the car park. The current cells were generally dirty and in a poor state of repair, with graffiti, cracked pillows and no in-cell hand washing facilities.

4.15 Leamington Spa was due to be the last suite refurbished, with work scheduled for mid-2010. The cells we saw were dirty, particularly the toilet seats, and did not appear to have been cleaned between uses. There was graffiti on most cell doors. Cell temperatures were reasonably warm, but ventilation was poor. Many of the plastic pillows were cracked and neither pillows nor mattresses were wiped clean after use. The corridors were also dirty.

4.16 Cells in the two suites awaiting refurbishment had multiple ligature points, which presented significant safety issues, and staff were not clear what to look for to identify these. Once we had pointed out these issues, the force took steps during the week of the inspection to instigate urgent remedial action.

4.17 We visited Stratford upon Avon police station, where the custody facility was being leased to the court service. The suite was in a poor state of decoration and repair and we inspected two of the seven cells, which were dirty, with numerous ligature points. Staff said they were aware the accommodation was not up to the standard required to hold detainees subject to PACE. We relayed our concerns to Warwickshire Police and Her Majesty's Inspectorate of Court Administration (HMICA).

4.18 Custody sergeants were expected to carry out daily checks of their facilities to identify health and safety, maintenance and cleanliness issues and CSMs were expected to carry out a similar check every week. These checks were not always completed and their robustness varied. The CSMs were also expected to carry out a monthly health and safety 'walk through', but these checks were not always completed on time, although there were also examples where CSMs had carried out a monthly check at one of their peer's custody suites to introduce independence to the process. A six-monthly health and safety 'walk through' was also carried out by the custody manager and judicial services chief inspector. A health and safety representative was invited, but not always available to attend. These were carried out, but paperwork indicated that if cells were occupied by detainees, they were not moved out to facilitate such a check.

4.19 A clear no smoking policy was rigorously enforced for staff and detainees at Leamington Spa and Rugby. Nuneaton also operated a no smoking policy, but detainees were allowed to smoke in the exercise yard in exceptional circumstances as it was far enough away from the windows to comply with legislation.

4.20 All custody sergeants had completed fire training courses. A full fire drill, including an evacuation, was carried out every six months and we were told that the recent exercise had been completed successfully.

4.21 All cells had call bells. Individuals new to custody were told how to use them, but those who had been held before were not. The call bell system at Nuneaton was also an intercom system and could not be muted. We saw staff responding promptly to call bells.

Personal comfort and hygiene

4.22 There were enough blankets, mattresses and pillows, but these items were not always cleaned regularly and none of the suites routinely offered blankets.

4.23 Women's hygiene packs were available at all custody suites, but not routinely offered. Detainees could get sanitary products, soap, toothbrushes and toothpaste on request. Cells at Leamington Spa and Rugby did not contain in-cell hand washing facilities so detainees had to ask permission to use one of two communal sinks in the corridors that offered only limited privacy. Cells at Nuneaton had internal toilet and hand washing facilities, but not all the hand washing facilities were in working order. Detainees at Rugby could not use the toilet in private as passers by could clearly see them through a spy hole in the corridor. Toilet paper and soap were supplied only on request at all suites.

4.24 From what we saw and what staff told us, the two showers at Leamington Spa were seldom used. The shower at Rugby was small, dirty and located in a corridor in the middle of the men's block of cells. It was screened only by a shower curtain and offered limited privacy, particularly for female detainees. The showers at Nuneaton were generally clean and offered good privacy. Detainees who remained in custody for more than 24 hours might be given the opportunity to shower, but this was entirely at the discretion of staff.

4.25 Detainees whose clothing was taken were given paper suits, but where necessary were given track suits to wear on release. Nuneaton and Rugby had no other stock of clothing, but Leamington Spa had a few items including footwear. Staff said basic items were being bought from a local supermarket if detainees needed clothing urgently and that family members could also bring clothes in for detainees.

Catering

4.26 Food was served at appropriate meal times and was also provided on request. Only basic microwaveable meals were available, which were unappetising and not very filling. Hot and cold drinks were regularly provided and additional drinks were given on request. Visitors could also bring food in for detainees provided it was appropriately sealed.

Activities

4.27 All suites had an outdoor exercise yard, but detainees usually got to use it only if they had been in custody for over 24 hours and asked permission and if operational demands permitted it. A fairly large store of old magazines and books was available for detainees. These had been brought in by staff and were stored in a cupboard. Visits were not generally allowed. Staff said they could be granted at the custody sergeant's discretion, but that this rarely happened in practice.

Recommendations

4.28 Detainees should always be properly searched by arresting officers before being admitted to the custody suite.

4.29 The specific needs of all groups, particularly women and detainees with disabilities, should be properly met.

4.30 Staff should be aware of, and able to identify, the specific needs of children and suitable arrangements should be provided to meet those needs in relation to policy development and further training.

4.31 Risk assessments, particularly those relating to vulnerable detainees, should be conducted in private.

4.32 All areas of the custody suite, the facilities and equipment should be clean and in a good state of repair. Cells should be cleaned between uses and kept clean and free of graffiti.

4.33 All cells should be fit for purpose and free of ligature points, which custody staff should be trained to identify.

4.34 The daily, weekly and monthly health and safety, maintenance and cleanliness checks should be reviewed and formalised across the custody estate. These checks should be fully recorded and monitored by the custody suite managers and judicial services chief inspector to ensure that identified issues are progressed and actioned accordingly.

4.35 Information about how to use call bells should be given to all detainees on arrival.

4.36 Detainees should routinely be given clean mattresses, pillows and blankets.

4.37 A supply of track suits, underwear and plimsolls in a range of sizes should be readily available for use by detainees.

4.38 Female detainees should routinely be offered hygiene items.

4.39 Detainees should be able to wash and use the toilet in private and toilet paper should be routinely provided.

4.40 Detainees held overnight and those who are dirty should be offered a shower.

4.41 Shower areas should allow sufficient privacy, particularly for female detainees.

4.42 On an individual needs assessed basis, nicotine replacement should be available to smokers.

4.43 Detainees held for over 24 hours should be offered outdoor exercise.

4.44 Detainees who are held overnight, juveniles and otherwise vulnerable should be offered visits.

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 Custody reviews were generally carried out on time and sometimes by telephone. Suites were never used as a place of safety for children. There were some delays in immigration detainees being collected by the UK Border Agency. Detainees were not always asked about dependency obligations, but those who asked for help were usually given it. Some vulnerable detainees were helped to return home on release, but this was not systematic. The appropriate adult scheme for juveniles operated well during office hours, but did not cover 17 year olds and was less reliable out of hours. There were some delays when detainees tried to obtain a duty solicitor and no separate contact telephone number for immigration detainees. The official court cut-off time(s) were sometimes too early, although there was some flexibility and it was possible to negotiate quick access for vulnerable detainees. Detainees were not told how to complain and complaints were often not taken while they remained in custody.

Rights relating to detention

5.2 Detention reviews generally complied with the requirements of PACE. Custody sergeants regularly ascertained the circumstances of arrest and checked the grounds for detention, and we saw one reviewing inspector refusing to admit a detainee because he was not satisfied that the arresting officer had established adequate grounds. A significant number of reviews were carried out by telephone, but the inspector we spoke to said that when this happened he would always talk directly to the detainee.

5.3 A large number of immigration detainees were held. Available information indicated that there were delays in the UK Border Agency collecting them from the custody suite. Many of the 185 detainees held since November 2008 had remained in custody for a significant amount of time, with the longest stay being 66 hours. None of the custody suites were used as a place of safety for children under section 46 of the Children Act 1989.

5.4 Detainees' entitlement to have someone informed of their whereabouts was part of the NSPIS booking in system. All those we saw being booked in had this entitlement clearly explained to them and all took advantage of this opportunity. In our survey, 52% of respondents, against a comparator of 43%, said someone had been informed of their arrest and 69%, against a comparator of 50%, said they had been offered a free telephone call. Calls were usually made from the booking in desk so were not always in private. There was no policy or standard procedure to support detainees with dependency obligations and staff did not routinely ask about these. In practice, staff helped when asked by detainees, including for example bailing the detainee until later in the day if possible.

5.5 A professional telephone interpreting service was used for detainees who had difficulty communicating in English, particularly during the booking in process, while interviews usually took place in the presence of interpreters from a local database of interpreters and the National Register of Public Service Interpreters (NRSPI). We saw a signer used to support a woman with a hearing impairment. Rights and entitlements information was available in a range of

languages, but not in a format suitable for those with learning difficulties (see section on respect).

5.6 Questions had been added to NSPIS to ensure that issues of vulnerability were addressed pre-release, and staff quoted numerous examples where they had escorted vulnerable detainees back home or given them the money to pay for public transport. However, any action taken was at the discretion of the custody sergeant responsible for releasing the detainee. A list of support organisations was given to detainees if the custody sergeant felt this was necessary.

Rights relating to PACE

5.7 There was a duty solicitor scheme, but staff at Leamington Spa said the duty solicitor did not always attend promptly. This was not the case at the other suites. The duty solicitor scheme did not provide immigration solicitors, but could make contact with one who would then contact the custody suite.

5.8 Family members were contacted to act as an appropriate adult for juveniles so long as the arresting officer was satisfied that they were suitable to take on the role. Officers routinely checked the Police National Computer before calling family and friends to act as an appropriate adult. Otherwise, appropriate adults from the youth offending team were used. These were qualified youth offending team (YOT) workers and YOTs provided a good service for detainees under the age of 17 during office hours on weekdays. Out of hours, the service was provided by the emergency duty team and staff said this was often subject to delays.

The emergency duty team provided appropriate adults for vulnerable adult detainees, but the service was at best sporadic and slow. Vulnerable adults who were not already known to community services were unlikely to benefit from the support of an appropriate adult while in custody. Despite the high number of detainees going through custody, appropriate adults had been requested to support detainees with learning disabilities only eight times in the six months to end September 2009 and only four had been provided.

5.9 The initial search and giving rights and entitlements information took place without an appropriate adult, but rights and entitlements were explained again in their presence when they arrived. The appropriate adult service and solicitors always insisted on solicitors being present during interviews with juveniles and vulnerable adults. Juveniles were not interviewed by police officials unless accompanied by an appropriate adult, but Warwickshire continued to adhere to the PACE definition of a child instead of the Children Act definition, which meant those aged 17 were not provided with an appropriate adult unless otherwise deemed vulnerable.

5.10 All detainees were told that they could see an up-to-date copy of the PACE guidelines and these were available in the custody suites. Detainees were not interviewed while under the influence of alcohol or drugs. We were told, and custody records indicated, that sergeants ensured that eight-hour breaks were provided.

5.11 A small number of forensic samples were inadequately stored in fridges in all custody suites. The oldest of these dated back to 2007 and it was unclear whether they should have been sent for analysis, stored elsewhere or suitably disposed of. Evidence at Leamington Spa and Rugby indicated that attempts had been made to move or dispose of the samples. Only Rugby had a register to record details of blood samples placed in a fridge, but even here some samples in the fridge had not been entered on the register. None of the suites recorded when DNA was

taken (other than on NSPIS updates), stored or submitted for processing, so there was no clear audit trail to show whether DNA samples had been taken in appropriate cases. There was no monitoring of DNA later rejected for being improperly completed or packaged, so valuable learning opportunities were missed. This was also an area of performance that was not routinely monitored by Reliance.

5.12 Court cut-off times were sometimes too early, resulting in detainees spending far longer in custody than would otherwise have been the case. Leamington Spa was served by Stratford upon Avon magistrates court, but detainees processed at the police station later than noon were unlikely to be dealt with in court the same day. Staff said they could negotiate with court staff to avoid vulnerable detainees being held overnight unnecessarily. At Rugby, the next door court, which was usually closed on Mondays, had stopped taking new cases as it was being refurbished. Detainees were therefore taken to Nuneaton, where the court cut-off time was sometimes as early as 12.30pm. There were no video link facilities.

5.13 Detainees could obtain copies of their records, although this was seldom requested and records were more often supplied to their solicitors. Staff said there was no difficulty in providing full copies to solicitors on request.

Rights relating to treatment

5.14 Detainees were not told how to complain. They could make a verbal complaint to the custody sergeant and, if they were dissatisfied with the response, this was reported to the inspector. In one case where a detainee had complained about how officers had spoken to him, the inspector had carefully investigated the incident, found fault with the conduct of staff, given them 'words of advice' and reported the outcome to the complainant. However, some staff told us that details of complaints relating to a matter in custody would be taken only once the period of detention had finished.

5.15 There was no specific process for detainees to complain or comment on their treatment prior to arrival at the station and no arrangements specifically to monitor racist complaints.

Recommendations

5.16 The force should liaise with the UK Border Agency to ensure that immigration detainees are held for the shortest possible time.

5.17 All detainees should be routinely asked if they have any dependency issues and, where necessary, offered appropriate support.

5.18 Detainees who have been charged should appear in court promptly.

5.19 All detainees should have prompt access to legal support.

5.20 Detainees aged 17 years should be provided with an appropriate adult.

5.21 Juveniles and vulnerable adults should be promptly provided with an appropriate adult when required or deemed necessary.

5.22 The force should review how it takes, stores, tracks and submits all DNA and forensic samples. The review should identify gaps in policies, training, storage facilities and

audit trails and a senior officer should be made responsible for delivery of an action plan to address the issues raised.

5.23 Staff should be made aware of the complaints process and this should also be clearly communicated to detainees on arrival in custody.

5.24 There should be an effective system for monitoring any trends in racist incidents.

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 The forensic medical examiner (FME) service was provided by local GP practices under individual contracts. Doctors also worked for their own practices, which caused conflicts and delays. Some consultations were cursory and others took place over the telephone. Not all the medical rooms were fit for purpose and medicines management was inconsistent. There were no defibrillators, oxygen or suction kits and some first aid kits were not fully stocked. Detainees could continue to receive prescribed medications, including Methadone. The security of the doctors' clinical records did not comply with data protection or Caldicott guidelines. Addaction provided substance misuse services, including a specialist alcohol worker. Custody staff relied on forensic community psychiatric nurses to liaise with mental health services, but their funding was under threat. There were no section 136 beds in Warwickshire, so detainees held under the Mental Health Act were routinely held in custody until assessments could take place. There was some good analysis of the statistics relating to section 136 detainees

Clinical governance

6.2 Health services were provided by FMEs, with doctors required to join a rota for either the south or north of the county. The northern doctors supported Nuneaton and Rugby, while the southern doctors supported Leamington Spa. There was always one northern and one southern doctor on call. Under the terms of their contract, doctors were required to be immediately contactable by telephone and to attend 'as soon as reasonably practicable'. Apart from two FMEs, all doctors worked as GPs in local practices. Only one was a woman and female detainees were not given the option of seeing a female FME. Response times were inconsistent and often prolonged and many consultations took place over the telephone because most doctors were working in their general practice surgeries at the same time.

6.3 The FMEs provided details of their General Medical Council registration when they were first employed, but no further checks were made. Initial training was provided by the National Policing Improvement Agency (NPIA) and the force also funded FME attendance at occasional conferences and presentations. FMEs met with the force two or three times a year and action points were noted. Each group of doctors apparently also met together, but the force did not receive copies of any minutes. FMEs did not have specific appraisals for their role.

6.4 We were told by healthcare managers that the NHS mental health teams had their own discrete clinical governance arrangements, with systematic monitoring and audit measures and a framework for ensuring that actions were planned, taken and evaluated as appropriate. The mental health nurses had also established peer support, meeting formally every quarter and providing regular informal support and peer supervision. Addaction staff said they received initial and ongoing training from their employer as well as supervision and appraisals.

6.5 Each custody suite had a dedicated medical room, but these were not locked when not in use. The room at Leamington Spa also housed the intoxyliser, while that at Rugby was accessed through an anteroom that housed the intoxyliser. The medical examination rooms contained minimal equipment and we were told that healthcare professionals carried their own with them

at all times. There was no inventory or evidence that the type of quality of equipment was monitored. Some basic equipment was old and outdated, including the folding screen and weighing scales at Rugby. The room at Leamington Spa was carpeted, with thick dust on the window ledges and litter in the corner and poorly laid out. Some of these issues were addressed during the inspection. None of the rooms had privacy curtains and paper couch roll was available, but not used. All examination couches were fixed and no footstools were available, making access difficult for detainees with mobility difficulties.

6.6 Apart from a poster about needlestick injury, no infection control policies or protocols were held in the medical rooms and there was no evidence of infection control audit. There were no specific cleaning protocols for the medical rooms. Hand washing facilities were available, but limited. None of the medical rooms had sharps boxes. At Nuneaton, these were kept behind the custody desk and issued to FMEs as required, but none were signed or dated. Clinical waste bags were used and staff said waste was collected fortnightly by a contractor.

6.7 Medicines were stored by custody staff in locked cabinets either behind the custody desk or in an adjoining room. Stock levels were low and had been agreed with the FMEs. Medicines were bought using petty cash on the provision of a private prescription or signed order by the FME. Medications were then given labels such as 'for the use of detainees' or 'Warwickshire Justice Centre'. There was no consistency and no system to coordinate this process. Ordering was ad hoc and there was some duplication.

6.8 The frequency of, and system for, stock control arrangements varied, but a designated officer had responsibility for medicines management at each custody suite and there was evidence of periodic stock control. Most medications were supplied in blister packs, but some were in bottles and therefore had to be handled when counted, which presented a contamination risk. At Nuneaton, the blister packs had been removed from their original boxes and some had been cut in to smaller quantities, so not all expiry dates were known. Out of date medications included GTN sprays and salbutomol inhalers. Unused medicines prescribed for individual detainees were stored in medicine cupboards pending disposal, but there were no clear procedures for this and some medication had been held for some time.

6.9 Medicines administered to detainees were recorded by custody staff on the custody record and in a central book. There was evidence that medicines were administered from stock to police staff, despite being labelled 'for use at police station for detainees'. Medicines were administered in the absence of FMEs and frequently under verbal instructions over the telephone, even though the FME had not seen or assessed the patient.

6.10 There were no medicines management care policies, current British National Formulary or other reference resources available in the medical examination rooms.

6.11 There were no suction machines, oxygen cylinders, masks or defibrillators available for resuscitation. Each custody suite had a first aid kit and red 'suicide bag', but these were not checked regularly and not all were fully stocked.

Patient care

6.12 The FME rotas demonstrated adequate 24-hour coverage, but response times varied and some long delays were reported (see paragraph 6.2). Custody records indicated that the longest wait had been three hours 15 minutes, but many consultations took place over the telephone, which was frequently inappropriate. In one case, the doctor took over an hour to respond to a call about a detainee who was an insulin-dependent diabetic and suffered from

sleep apnoea. He prescribed medications without seeing the patient and did so a second time when later telephoned about the sleep apnoea. On another occasion, a doctor who was called about a detainee showing signs of withdrawal from alcohol said he could not attend because he had a GP surgery, but would be available in four hours. The custody sergeant raised concerns with his inspector who contacted another doctor. Both cases were examples of poor practice. There was no evidence that response times were directly monitored by the police.

6.13 The remuneration system for doctors was cumbersome, time consuming and potentially inaccurate. On one evening, a GP at Rugby attended the suite simply to get accurate details for his time sheet, which took the custody sergeant away from his duties for some considerable time.

6.14 Detainees could request to see a healthcare professional at any point and the custody officer requested brief details to determine the level of urgency. If a detainee was displaying obvious signs of physical and/or mental health needs, the custody officer logged a call for a healthcare professional and noted it on the custody record. Where there was an obvious physical need, such as pain or open wounds, a paramedic was called or the detainee was taken to the local accident and emergency department.

6.15 If a detainee told custody staff or the FME that he or she was on prescribed medications, attempts were made to obtain it from the detainee's property or, for supervised consumption of Methadone, from the supervising pharmacists. FMEs prescribed Methadone to detainees who could prove they received it in the community. The FME at Nuneaton said he administered it to detainees at the custody desk to ensure that this was recorded on closed-circuit television as an additional safeguard.

6.16 A custody record opened on all detainees on arrival included details of any health event or assessment and ethnicity. The recording of healthcare interventions was consistent. FMEs entered a summary directly on the custody record through NSPIS, although not all medical rooms had an NSPIS terminal and not all FMEs had their own 'log in' details so had to use someone else's. Telephone advice provided by FMEs was recorded on the custody record by custody staff using NSPIS. FMEs routinely also recorded clinical interventions as handwritten notes in a variety of ways including loose A4 sheets and spiral note books. They kept these records themselves. Not all the FMEs were aware of their responsibilities in relation to the Data Protection Act or Caldicott guidelines and were not clear whether they would provide detainees with a copy of their handwritten notes without a request from a solicitor. There were no quality monitoring arrangements or steps taken by the force to ensure that FME records were completed appropriately or held securely.

6.17 Substance misuse workers and mental health nurses did not have direct access to NSPIS, so also used someone else's log in, or custody staff recorded brief details of interventions. The workers also completed their own records. In the case of forensic community psychiatric nurses (CPNs), these included care programme approach care plans when required, which were stored electronically on the Mental Health Trust's system. Detainees gave written consent for the use of their information and were advised to disclose information to healthcare staff with caution in detention.

Substance use

6.18 Drug and alcohol misuse services had been established for five years and were provided by Addaction as the single point of contact for Warwickshire. Addaction provided a team of substance misuse workers. It had offices at Rugby, Nuneaton and Leamington Spa and

offered a seven day a week advisory and assessment service. A worker was allocated to each custody suite. The team included one alcohol worker and one who worked specifically with persistent and prolific offenders (PPOs). Referrals to the service were through custody staff or mental health nurses, but staff said they did not receive referrals directly from FMEs. In 2008-09 the service spoke to 2,645 detainees in Warwickshire.

6.19 A worker visited each suite every weekday, identified priority detainees according to offence and requests for intervention, and carried out a 'cell sweep' of all detainees. They provided advice and further assessment through prison or community teams as appropriate. An on-call service was available at other times.

6.20 A follow-up appointment with the same worker was confirmed before release or detention. Most workers could offer appointments within one or two days of custody when a care plan was agreed and appropriate onward referral to tier 2 services arranged. The Addaction alcohol worker offered maintenance support for detainees awaiting referral to the community alcohol service as waiting times were reported to be up to 12 weeks.

6.21 Detainees were given a pack of information from Addaction that included contact details for needle exchange services. Addaction provided a swabbing service for clients using opiates to ensure timely access to the rapid prescribing service and were responsible for seeing all detainees receiving conditional cautions or required assessments.

6.22 Addaction workers also provided professional information for police staff at an annual police event, but were not involved in any formal training programme. Workers said they would like better communication with the police at a strategic level about planned operations to enable them to be more proactive in service planning and meeting the needs of detainees.

Mental health

6.23 Mental health services were provided by Coventry and Warwick NHS Mental Health Trust. Detainees were referred to forensic nurses by custody staff or the FME following brief assessment. Forensic CPNs were allocated to each suite and visited on weekdays to pick up referrals and undertake a 'cell sweep'. They provided an assessment and onward referral service from 7am to 3pm. At other times, detainees received a more basic service through community mental health teams. Detainees were referred to the emergency duty team (EDT) out of hours, but the service referred them on to the day service approved mental health practitioners (AMHPs) rather than dealing with the case, causing unnecessary delays. Some solicitors reportedly discouraged their clients from talking to mental health staff due to the risk of disclosure.

6.24 Interventions were prioritised according to detainees with known mental health problems and index offences. The Mental Health Trust provided appropriate adults for detainees already known to its service or for those with clear mental health issues. The forensic CPNs offered direct contact arrangements for custody staff to ensure timely referral. They also offered informal education to police staff they were in contact with to raise awareness of mental health issues, including identification and management. Mental health staff had had formal input into induction training for custody staff, but this had been discontinued.

6.25 Mental health nurses working in the custody suites had good links to the local learning disabilities team, including a direct link to the team's psychiatrist.

6.26 The mental health forensic nursing services were well established and custody staff valued their assistance and expertise. However, problems with the funding of the service meant that its future was in jeopardy. Most custody staff we talked to raised this issue and were clearly concerned about the consequences.

6.27 There were no section 136 (S136) suites in Warwickshire, so those detained under S136 of the Mental Health Act were taken to a custody suite, which was not an appropriate place of safety. The corporate development department collated details of all those detained under a S136 and provided monthly analysis. In the first eight months of 2009, there had been 124 detentions, of which 101 (81%) had been detained. The analysis included ethnic breakdown and a breakdown of times from detention to assessment and final outcome, although this was not always complete due to lack of information by custody staff in the individual's custody records. The analyses were presented and discussed at the Mental Health Act multi-agency meeting, as were individual cases that had caused concern. The meetings were attended by Warwickshire county council staff as well as representatives from the corporate development department and the custody senior managers. Members of the committee also contributed to training for custody staff.

6.28 A range of comprehensive policies on the management of detainees with mental health problems and S136 detainees were available on the force intranet and updated regularly. However, some custody staff were unaware of their existence.

6.29 We were told that the lack of S136 suite provision by the local health economy was the subject of discussion at a senior level, although these had been prolonged without reaching an adequate conclusion.

Recommendations

6.30 Forensic medical examiners (FMEs) should not work for any other organisation, including working as a GP, when on call for FME duties.

6.31 Female detainees should be able to see a female FME on request.

6.32 The contract monitoring of health services should include monitoring to ensure that robust clinical governance arrangements are in place, such as General Medical Council registration, continual professional development and appraisal.

6.33 All FME rooms should be fit for purpose and contain all necessary equipment.

6.34 There should be clear infection control procedures, including cleaning schedules that should be adhered to and monitored.

6.35 There should be safe pharmaceutical management and use of all medications. All medications should be stored safely and securely and any not consumed should be disposed of safely.

6.36 Medications should not be issued to police staff unless prescribed by an FME after an accident or injury.

6.37 Resuscitation equipment should be available in each custody suite. It should be checked at least weekly and there should be documentary evidence that such checks are completed.

6.38 All staff should be able to use the resuscitation equipment and have at least annual updates.

6.39 Response times of medical examiners should be monitored and challenged if deemed unacceptable.

6.40 All clinical staff working regularly in custody should have individual 'log in' details for NSPIS.

6.41 Forensic medical examiners should ensure that all clinical records are stored in accordance with the Data Protection Act and Caldicott guidance.

6.42 The forensic community psychiatric nurse service should be adequately funded to ensure care for detainees with mental health needs.

6.43 Police custody should not be used as a place of safety for those detained under Section 136 of the Mental Health Act.

6.44 Discussions involving the care of detainees with mental health issues should continue involving the strategic health authority or department of health (offender health) if necessary.

Housekeeping points

6.45 The medical rooms should be locked when not in use.

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

6.47 There should be regular checks of all stocks to ensure that they are not out of date.

6.48 To avoid contamination, medications should not be handled.

6.49 Staff should have access to up to date medical reference books such as the British National Formulary.

Good practice

6.50 *The presence of forensic community psychiatric nurses in the custody suites and their availability to provide advice and organise mental health assessments was an example of health and custodial services working together to provide care for detainees with mental health issues.*

6.51 *The breakdown and analysis of information on detainees held under section 136 of the Mental Health Act was an example of what evidence can be collected and used and could be undertaken by other forces.*

7. Summary of recommendations

Strategy

7.1 The working arrangements for custody suite managers and custody detention officers should be such that they can fully discharge their duties in custody. (3.23)

7.2 Shift patterns should be reviewed to ensure handovers are factored into all shifts. (3.24)

7.3 A strategic forum should be set up to facilitate partnership working at a practitioner level. (3.25)

7.4 The force should urgently review the levels of 'vetting' for all staff in the custody environment. (3.26)

7.5 The use of force should be monitored and analysed centrally to enable the identification of patterns and trends. This information should be disseminated to custody managers. (3.27)

7.6 Use of force policies should make explicit reference to issues relevant to custody when force is deployed. (3.28)

7.7 The reasons for the deployment of incapacitant sprays in custody should be recorded in custody records and centrally. Managers should quality assure such usage and satisfy themselves about appropriateness, proportionality and any health and safety issues. (3.29)

Treatment and conditions

7.8 Detainees should always be properly searched by arresting officers before being admitted to the custody suite. (4.28)

7.9 The specific needs of all groups, particularly women and detainees with disabilities, should be properly met. (4.29)

7.10 Staff should be aware of, and able to identify, the specific needs of children and suitable arrangements should be provided to meet those needs in relation to policy development and further training. (4.30)

7.11 Risk assessments, particularly those relating to vulnerable detainees, should be conducted in private. (4.31)

7.12 All areas of the custody suite, the facilities and equipment should be clean and in a good state of repair. Cells should be cleaned between uses and kept clean and free of graffiti. (4.32)

7.13 All cells should be fit for purpose and free of ligature points, which custody staff should be trained to identify. (4.33)

7.14 The daily, weekly and monthly health and safety, maintenance and cleanliness checks should be reviewed and formalised across the custody estate. These checks should be fully recorded and monitored by the custody suite managers and judicial services chief inspector to ensure that identified issues are progressed and actioned accordingly. (4.34)

7.15 Information about how to use call bells should be given to all detainees on arrival. (4.35)

7.16 Detainees should routinely be given clean mattresses, pillows and blankets. (4.36)

7.17 A supply of track suits, underwear and plimsolls in a range of sizes should be readily available for use by detainees. (4.37)

7.18 Female detainees should routinely be offered hygiene items. (4.38)

7.19 Detainees should be able to wash and use the toilet in private and toilet paper should be routinely provided. (4.39)

7.20 Detainees held overnight and those who are dirty should be offered a shower. (4.40)

7.21 Shower areas should allow sufficient privacy, particularly for female detainees. (4.41)

7.22 On an individual needs assessed basis, nicotine replacement should be available to smokers. (4.42)

7.23 Detainees held for over 24 hours should be offered outdoor exercise. (4.43)

7.24 Detainees who are held overnight, juveniles and otherwise vulnerable should be offered visits. (4.44)

Individual rights

7.25 The force should liaise with the UK Border Agency to ensure that immigration detainees are held for the shortest possible time. (5.16)

7.26 All detainees should be routinely asked if they have any dependency issues and, where necessary, offered appropriate support. (5.17)

7.27 Detainees who have been charged should appear in court promptly. (5.18)

7.28 All detainees should have prompt access to legal support. (5.19)

7.29 Detainees aged 17 years should be provided with an appropriate adult. (5.20)

7.30 Juveniles and vulnerable adults should be promptly provided with an appropriate adult when required or deemed necessary. (5.21)

7.31 The force should review how it takes, stores, tracks and submits all DNA and forensic samples. The review should identify gaps in policies, training, storage facilities and audit trails and a senior officer should be made responsible for delivery of an action plan to address the issues raised. (5.22)

7.32 Staff should be made aware of the complaints process and this should also be clearly communicated to detainees on arrival in custody. (5.23)

7.33 There should be an effective system for monitoring any trends in racist incidents. (5.24)

7.34 Forensic medical examiners (FMEs) should not work for any other organisation, including working as a GP, when on call for FME duties. (6.30)

7.35 Female detainees should be able to see a female FME on request. (6.31)

7.36 The contract monitoring of health services should include monitoring to ensure that robust clinical governance arrangements are in place, such as General Medical Council registration, continual professional development and appraisal. (6.32)

7.37 All FME rooms should be fit for purpose and contain all necessary equipment. (6.33)

7.38 There should be clear infection control procedures, including cleaning schedules that should be adhered to and monitored. (6.34)

7.39 There should be safe pharmaceutical management and use of all medications. All medications should be stored safely and securely and any not consumed should be disposed of safely. (6.35)

7.40 Medications should not be issued to police staff unless prescribed by an FME after an accident or injury. (6.36)

7.41 Resuscitation equipment should be available in each custody suite. It should be checked at least weekly and there should be documentary evidence that such checks are completed. (6.37)

7.42 All staff should be able to use the resuscitation equipment and have at least annual updates. (6.38)

7.43 Response times of medical examiners should be monitored and challenged if deemed unacceptable. (6.39)

7.44 All clinical staff working regularly in custody should have individual 'log in' details for NSPIS. (6.40)

7.45 Forensic medical examiners should ensure that all clinical records are stored in accordance with the Data Protection Act and Caldicott guidance. (6.41)

7.46 The forensic community psychiatric nurse service should be adequately funded to ensure care for detainees with mental health needs. (6.42)

7.47 Police custody should not be used as a place of safety for those detained under Section 136 of the Mental Health Act. (6.43)

7.48 Discussions involving the care of detainees with mental health issues should continue involving the strategic health authority or department of health (offender health) if necessary. (6.44)

Housekeeping points

Healthcare

7.49 The medical rooms should be locked when not in use. (6.45)

7.50 Sharps bins should be dated and signed when first used. (6.46)

7.51 There should be regular checks of all stocks to ensure that they are not out of date. (6.47)

7.52 To avoid contamination, medications should not be handled. (6.48)

7.53 Staff should have access to up to date medical reference books such as the British National Formulary. (6.49)

Good practice

Strategy

7.54 Dynamic and 'real-time' learning from adverse incidents in custody was immediately circulated to all staff. (3.30)

Healthcare

7.55 The presence of forensic community psychiatric nurses in the custody suites and their availability to provide advice and organise mental health assessments was an example of health and custodial services working together to provide care for detainees with mental health issues.(6.50)

7.56 The breakdown and analysis of information on detainees held under section 136 of the Mental Health Act was an example of what evidence can be collected and used and could be undertaken by other forces.(6.51)

Appendix I: Inspection team

Sean Sullivan	HMIP team leader
Anita Saigal	HMIP inspector
Ian MacFadyen	HMIP inspector
Ian Thomson	HMIP inspector
Fiona Sheerlaw	HMIC inspector
Paul Eveleigh	HMIC inspector
Jan Fooks-Bale	CQC healthcare inspector
Elizabeth Tysoe	HMIP healthcare inspector
Catherine Nichols	HMIP researcher

Appendix II: Custody record analysis

Background

As part of the inspection of Warwickshire police custody cells, a sample of the custody records of detainees held between 5 and 11 October 2009 were analysed. Custody records were held electronically on NSPIS. A total of 30 records were analysed from across the Warwickshire area:

Custody suite	Number of records analysed
Nuneaton	12
Leamington Spa	9
Rugby	9
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

- Six (20%) of the detainees were female and 24 were male.
- Three people (10%) under the age of 17 were included in the sample, the youngest was 12 years old.
- Twenty-seven (90%) detainees were White British, one was White Irish, one Black Caribbean and one Mixed White and Asian.
- Fourteen (47%) detainees had been held overnight, including those who had arrived during the night and were not released until the morning. None of the detainees in the sample had been held for 24 hours or more. Six (20%) had been held for less than one hour. Five (17%) had been held over 12 hours, but less than 24, the longest being 17 hours.
- All of the sample could understand English, so the use of interpreters could not be gleaned.
- Two detainees were not British nationals: one was from Canada the other was Irish. Neither of these detainees had their foreign national rights explained to them.
- Five (17%) detainees arrived with self-harm/suicide issues, one (3%) had learning difficulties, eight (27%) had mental health problems, six (20%) detainees had not been in custody before and 19 (63%) entered custody intoxicated.
- All but two (7%) detainees went home, either with no further action or bailed to the court or police station. The other two detainees went to straight court.

Removal of clothing

Four detainees had had clothing removed from them. The records of when, what and why were poor:

- One record, after around seven hours in custody and just before charging and release, notes that the detainee had been given his clothing back. There had been no indication previously that his clothing had been removed, nor what replacement had been given, or even why the clothing had been removed. This detainee was also subject to a 'routine' cell search.

- One detainee had her cords cut from her trousers and her tracksuit top removed, but no indication was given of the replacement clothing provided. The same detainee, after 12 hours in custody and when about to be released, was offered the opportunity of a member of her family bringing fresh clothes in as the trousers she was wearing had dog excrement on them. It is not clear why this had no been offered this before.
- One detainee was placed in a paper suit, but with no indication of why.
- The records also indicated, through lack of contrary entries, that the detainees were released in the paper suits.

Young people

- For the two young people interviewed in the sample, appropriate adults had been requested and were present both for the interview and for a re-reading of their rights and entitlements. The other young person was released within an hour without interview, as it was deemed too late an hour, but an appropriate adult from the care home he lived in was called and was present during his time in custody.
- Appropriate adult enquires were substantial. One young person could not remember the address or number of his aunt, but police contacted other departments and then directory enquires. In another case, foster carers were called and, when they stated they could not be an appropriate adult, the social services and his mother were contacted. However, efforts to contact the mother were stopped when it was realised that she no longer had parental responsibility.
- Two of the young people were driven home by the police.
- One young person was bailed to allow a restorative justice approach.

Inspector reviews

Inspector reviews were held in line with requirements, many over the telephone, but with the detained person involved. A few reviews were conducted at a delayed time due to other operational commitments or difficulties contacting inspectors. A few reviews happened while the detainee was said to be sleeping, when it was questionable whether this was the case. In one example, a fire evacuation was happening during the time the detainee was allegedly asleep. Another was not roused during the day for his review as there was no likelihood of an immediate interview.

Services

- Four (13%) detainees had made telephone calls themselves while in the station.
- All detainees had been asked if they wanted a solicitor. Nine (30%) detainees had requested a solicitor and spoken/seen either their solicitor or a duty solicitor.
- No detainees shared a cell while in custody.
- Six (20%) detainees had requested to see the FME. Five of these detainees had seen the FME. The longest wait was 3 hours 15 minutes, with no explanation for the delay. One detainee who was not seen by the FME was released before they could do so after a two hour 20 minute wait. The detainee had spoken to a doctor in the charge area over the telephone and this doctor had decided he could continue taking his medication. However, a doctor was requested half an hour later, but there were no further entries about contact with a healthcare professional.
- Four (13%) detainees had been offered the opportunity of seeing a drugs/alcohol worker. However, only one detainee actually agreed to speak to them.
- Of those who stayed between six and 24 hours, seven detainees (50%) had nothing to eat, although four had been offered food and refused it. The three who had not been

offered any food, were all in Nuneaton station, came in the middle of a Friday night and were released at breakfast time on the Saturday.

- None of the detainees in the sample had had a shower. Although none of the detainees stayed longer than 24 hours, one detainee had vomited, been given different clothes and some wipes, suggesting a shower may have been appropriate.
- Two (7%) detainees, both at Rugby, had received outside exercise.
- Three (10%) detainees had been provided with reading materials.

Additional points of note

- NSPIS automatically generated a prompt to conduct a pre-release risk assessment. No issues were raised, although risk appeared to be addressed (e.g. conveying detainee home when the detainee was young and it was late at night). Beyond the risk assessment, there were examples of good inter-agency working and efforts to ensure care after release. For example, one detainee in Nuneaton said had had problems with drink and hearing voices, but declined to see a doctor while in custody. Custody staff sent papers for contact support/Mind and Addaction to follow up. A mental health social worker rang back the following day, after release, with an update about potential hospitalisation.
- There were a couple in of instances were the detainee was left in a soiled state. One detainee in Nuneaton was noted to have urinated on the floor next to the toilet and was left in that cell for 11 hours before being moved because he was claustrophobic.
- Three detainees reported that they would like to make a complaint about their time in custody. All were initially told that they could make a complaint at the front desk when released.
    - For one detainee in Nuneaton, a scene of crime officer (SOCO) was contacted to take photographs of his injuries, but they were busy and were going to call the station when free. There was no record before release of SOCO contacting the station. On release, the detainee was given an Independent Police Complaints Commission leaflet and a copy of the complaints form.
    - One detainee in Rugby asked to make a complaint in custody and was told it was her right, but no further comments were made on the record about whether this was followed up.
    - One detainee in Rugby asked to complain, was given a complaint form on release, but did not want to wait for an inspector to arrive at the station.
- All detainees who expressed violence or verbal abuse on entering custody were immediately placed in cells and given time to calm down. On no custody records was there any indication of use of force.

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 Warwickshire 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 1 October 2009. A list of potential respondents to have passed through Rugby, Leamington Spa and Nuneaton police stations was created, listing all those who had arrived from Stratford upon Avon, Rugby, Nuneaton and Leamington Spa magistrates courts within the past two months.

Selecting the sample

In total, 53 respondents were approached. Sixteen respondents reported being held in a police station outside Warwickshire.

On the day, the questionnaire was offered to 37 respondents. There were no refusals, but there were three non-returns and four questionnaires were returned blank. All those sampled had been in custody within the last two months.

Completion of the questionnaire was voluntary. Due to operational reasons, interviews were impossible to conduct with prisoners with 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, 30 (81%) 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 15 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 is excluded). The actual numbers will match up as the data is 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 has been weighted for comparison purposes.

Police Custody Survey

Section 1: About you

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

Nuneaton - 12 (40%); Rugby – 10 (33%); Leamington Spa – 5 (17%); Unrecorded – 3 (10%)

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

Police detainee	90%
Prison lock-out (i.e. you were in custody in a prison before coming here)	3%
Immigration detainee	3%
I don't know	3%

Q4 **How old are you?**

16 years or younger	0%	*40-49 years*	20%
17-21 years	3%	*50-59 years*	17%
22-29 years	23%	*60 years or older*	0%
30-39 years	37%		

Q5 **Are you:**

Male	100%
Female	0%
Transgender/transsexual	0%

Q6 **What is your ethnic origin?**

White - British	79%
White - Irish	7%
White - Other	3%
Black or Black British - Caribbean	3%
Black or Black British - African	0%
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	0%
Mixed Race - White and Black Caribbean	7%
Mixed Race - White and Black African	0%
Mixed Race - White and Asian	0%
Mixed Race - Other	0%
Chinese	0%
Other ethnic group	0%
Please specify:	0%

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

Yes	4%
No	96%

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

None	34%
Church of England	52%

Catholic 7%
Protestant 3%
Other Christian denomination 3%
Buddhist 0%
Hindu 0%
Jewish 0%
Muslim 0%
Sikh 0%
Any other religion, please specify

Q9 **How would you describe your sexual orientation?**
Straight /heterosexual 100%
Gay/lesbian/homosexual 0%
Bisexual 0%
Other (please specify):

Q10 **Do you consider yourself to have a disability?**
Yes 31%
No 69%
Don't know 0%

Q11 **Have you ever been held in police custody before?**
Yes 90%
No 10%

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 4%
More than 1 hour, but less than 6 hours 0%
More than 6 hours, but less than 12 hours 11%
More than 12 hours, but less than 24 hours 21%
More than 24 hours, but less than 48 hours (2 days) 36%
More than 48 hours (2 days), but less than 72 hours (3 days) 21%
72 hours (3 days) or more 7%

Q13 **Were you given information about your arrest and your entitlements when you arrived there?**
Yes 82%
No 14%
Don't know/can't remember 4%

Q14 **Were you told about the Police and Criminal Evidence (PACE) codes of practice** (the 'rule book')**?**
Yes 46%
No 46%
I don't know what this is/I don't remember 7%

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

My clothes were not taken	78%
I was offered a tracksuit to wear	4%
I was offered an evidence suit to wear	11%
I was offered a blanket	7%

Q16 Could you use a toilet when you needed to?

Yes	96%
No	4%
Don't know	0%

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

	Yes	*No*
Toilet paper	54%	46%

Q18 Did you share a cell at the police station?

Yes	4%
No	96%

Q19 How would you rate the condition of your cell:

	Good	*Neither*	*Bad*
Cleanliness	41%	37%	22%
Ventilation/air quality	8%	38%	54%
Temperature	8%	36%	56%
Lighting	48%	22%	30%

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

Yes	57%
No	43%

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

Yes	24%
No	76%

Q22 Were you held overnight?

Yes	97%
No	3%

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

Not held overnight	3%
Pillow	26%
Blanket	59%
Nothing	13%

Q24 Were you offered a shower at the police station?

Yes	17%
No	83%

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

Yes	13%
No	87%

Q26 Were you offered anything to:

	Yes	*No*
Eat?	83%	17%
Drink?	83%	17%

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

I did not have any food or drink	13%
Yes	40%
No	47%

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

I do not smoke	18%
I was allowed to smoke	4%
I was not offered anything to cope with not smoking	79%
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	24%
No	76%

Q30 Was someone informed of your arrest?

Yes	52%
No	31%
I don't know	7%
I didn't want to inform anyone	10%

Q31 Were you offered a free telephone call?

Yes	69%
No	31%

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

My phone call was not denied	75%
Yes	0%
No	25%

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

	Yes	*No*
Who was taking care of your children	20%	80%
Contacting your partner, relative or friend	52%	48%
Contacting your employer	6%	94%
Where you were going once released	26%	74%

Q34 Were you interviewed by police officials about your case?

Yes	79%	
No	21%	If no, go to Q36

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

	Yes	*No*	*Not needed*
Solicitor	74%	26%	0%
Appropriate adult	7%	27%	67%

Interpreter	0%	21%	79%

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

- ***I did not requested a solicitor*** 35%
- *2 hours or less* 12%
- *Over 2 hours but less than 4 hours* 15%
- *4 hours or more* 38%

Q37 Were you officially charged?

- *Yes* 80%
- *No* 20%
- *Don't Know* 0%

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

- ***I have not been charged yet*** 20%
- *1 hour or less* 3%
- *More than 1 hour, but less than 6 hours* 10%
- *More than 6 hours, but less than 12 hours* 27%
- *12 hours or more* 40%

Section 3: Safety

Q40 Did you feel safe there?

- *Yes* 74%
- *No* 26%

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

- *Yes* 32%
- *No* 68%

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

I have not been victimised	61%	*Because of your crime*	6%
Insulting remarks (about you, your family or friends)	6%	*Because of your sexuality*	0%
Physical abuse (being hit, kicked or assaulted) .	3%	*Because you have a disability*	0%
Sexual abuse	0%	*Because of your religion/religious beliefs*	3%
Your race or ethnic origin	6%	*Because you are from a different part of the country than others*	3%
Drugs	10%		

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

- *Yes* 38%
- *No* 62%

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

- *Yes* 14%
- *No* 86%

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

- *Yes* 14%
- *No* 86%

Section 4: Healthcare

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

Yes 60%
No 40%

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

Not taking medication 41%
Yes 31%
No 28%

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

Yes 32%
No 54%
Don't know 14%

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

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

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

Yes 29%
No 46%
Don't know 25%

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

Yes 57%
No 43%

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 45%
Yes 24%
No 31%

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

I didn't have any drug/alcohol problems 43%
Yes 30%
No 27%

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	52%	3%	10%	17%	0%	17%

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

No 64%
Yes 36%

Q57 Did you have any specific mental healthcare needs?

No	75%
Yes	25%

Prisoner survey responses for Warwickshire 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

		Warwickshire 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		30	537
SECTION 1: General information			
2	Are you a Police detainee?	**90%**	**87%**
3	Are you under 21 years of age?	**4%**	**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)?	**10%**	**36%**
6	Are you a foreign national?	**4%**	**15%**
7	Are you Muslim?	**0%**	**12%**
8	Are you homosexual/gay or bisexual?	**0%**	**2%**
9	Do you consider yourself to have a disability?	**31%**	**18%**
10	Have you been in police custody before?	**90%**	**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?	**64%**	**65%**
12	Were you given information about your arrest and entitlements when you arrived?	**83%**	**73%**
13	Were you told about PACE?	**47%**	**54%**
14	If your clothes were taken away, were you given a tracksuit to wear?	**20%**	**39%**
15	Could you use the toilet when you needed to?	**96%**	**88%**
16	If you did use the toilet, was toilet paper provided?	**53%**	**53%**
17	Did you share a cell at the station?	**4%**	**4%**
18	Would you rate the condition of your cell, as 'good' for:		
18a	Cleanliness?	**40%**	**29%**
18b	Ventilation/air quality?	**8%**	**20%**
18c	Temperature?	**7%**	**14%**
18d	Lighting?	**47%**	**44%**
19	Was there any graffiti in your cell when you arrived?	**56%**	**56%**
20	Did staff explain the correct use of the cell bell?	**25%**	**22%**
21	Were you held overnight?	**96%**	**91%**
22	If you were held overnight, were you give**no** clean items of bedding?	**17%**	**32%**

Key to tables

		Warwickshire 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.		
23	Were you offered a shower?	**16%**	**8%**
24	Were you offered a period of outside exercise?	**14%**	**5%**
25a	Were you offered anything to eat?	**86%**	**79%**
25b	Were you offered anything to drink?	**83%**	**82%**
26	Was the food/drink you received suitable for your dietary requirements?	**47%**	**41%**
27	For those who smoke: were you offered **nothing** to help you cope with the ban there?	**79%**	**77%**
28	Were you offered anything to read?	**25%**	**14%**
29	Was someone informed of your arrest?	**52%**	**43%**
30	Were you offered a free telephone call?	**69%**	**50%**
31	If you were denied a free call, was a reason given?	**0%**	**16%**
32	Did you have ay concerns about:		
32a	Who was taking care of your children?	**21%**	**17%**
32b	Contacting your partner, relative or friend?	**53%**	**53%**
32c	Contacting your employer?	**7%**	**22%**
32d	Where you were going once released?	**26%**	**36%**
34	If you were interviewed were the following people present:		
34a	Solicitor	**74%**	**75%**
34b	Appropriate adult	**8%**	**8%**
34c	Interpreter	**0%**	**8%**
35	Did you wait over four hours for your solicitor?	**59%**	**64%**
37	Were you held for 12 hours or more in custody after being charged?	**50%**	**65%**
SECTION 3: Safety			
39	Did you feel unsafe?	**27%**	**40%**
40	Has another detainee or a member of staff victimised you?	**32%**	**44%**
41	If you have felt victimised, what did the incident involve?		
41a	Insulting remarks (about you, your family or friends)	**7%**	**26%**
41b	Physical abuse (being hit, kicked or assaulted)	**4%**	**15%**

Key to tables

		Warwickshire 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.		
41c	Sexual abuse	**0%**	**2%**
41d	Your race or ethnic origin	**7%**	**6%**
41e	Drugs	**11%**	**17%**
41f	Because of your crime	**7%**	**20%**
41g	Because of your sexuality	**0%**	**0%**
41h	Because you have a disability	**0%**	**3%**
41i	Because of your religion/religious beliefs	**4%**	**4%**
41j	Because you are from a different part of the country than others	**4%**	**5%**
42	Were you handcuffed or restrained whilst in the police custody suite?	**38%**	**48%**
43	Were you injured whilst in police custody, in a way that you feel is not your fault?	**14%**	**27%**
44	Were you told how to make a complaint about your treatment?	**15%**	**13%**
SECTION 4: Healthcare			
46	Were you on any medication?	**60%**	**45%**
47	For those who were on medication: were you able to continue taking your medication?	**54%**	**38%**
48	Did someone explain your entitlement to see a healthcare professional, if you needed to?	**32%**	**36%**
49	Were you seen by the following healthcare professionals during your time in police custody?		
49a	Doctor	**42%**	**51%**
49b	Nurse	**0%**	**20%**
49c	Paramedic	**0%**	**2%**
49d	Psychiatrist	**9%**	**4%**
50	Were you able to see a healthcare professional of your own gender?	**28%**	**29%**
51	Did you have any drug or alcohol problems?	**56%**	**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?	**44%**	**42%**
53	Were you offered relief medication for your immediate symptoms?	**54%**	**36%**
54	For those who had been seen by healthcare, would you rate the quality as good/very good?	**29%**	**31%**
55	Do you have any specific physical healthcare needs?	**36%**	**36%**
56	Do you have any specific mental healthcare needs?	**26%**	**25%**