Report on an inspection visit to police custody suites in West Midlands

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by

HM Inspectorate of Prisons and

HM Inspectorate of Constabulary

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1. Introduction

This report is part of a programme of inspections of police custody carried out jointly by our two Inspectorates and which form a key part of the joint work programme of the criminal justice inspectorates. These inspections 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 strategy, treatment and conditions, individual rights and health care.

We found clear strategic leadership, well supported by the police authority and an active independent custody visitors scheme. The recent move to a centralised model had brought greater oversight and improved service delivery. The change programme included a reduction in the number of custody suites, a decision supported by comprehensive management information. Staffing levels were good, interactions with detainees were impressive and staff felt valued and empowered.

There had been significant investment across the custody estate, in particular at Steelhouse Lane in central Birmingham. However, that facility remained poor and virtually every cell surveyed across the estate failed to pass our safety examination – there were numerous ligature points and health and safety monitoring was inconsistent.

The approach to risk assessment, both on arrival and at the pre-release stage, was mixed. On arrival, assessments ranged from excellent to poor and pre-release assessments were restricted to only the most vulnerable. This issue required urgent attention.

Although partnerships worked generally well, there were problems providing appropriate adults for vulnerable detainees. There was a good system for capturing data on the use of force but actual reporting was inconsistent and the data was not used effectively to identify trends or issues. Detainees were not told how to make a complaint and arrangements for doing so were confused.

Health care provision was good, with strong governance and robust medicines management. We observed excellent care from health care professionals and waiting times appeared reasonable. Demand for substance misuse services was high and the services delivered were generally good.

Overall, this report reflects a positive picture of custody provision in the West Midlands police area, although there are a number of issues which require attention. We believe that this report, and the issues highlighted within our recommendations, will assist the Chief Constable and the police authority to further improve custodial services. We expect them to consider these issues within the wider context of force priorities and resourcing and to provide us with an action plan in due course.

Sir Denis O'Connor
HM Chief Inspector of Constabulary

Nick Hardwick
HM Chief Inspector of Prisons

December 2010

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

2. Background and key findings

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

2.2 At the time of this unannounced inspection, West Midlands police had 17 custody suites designated under PACE for the reception of detainees. The custody suites operated 24 hours a day and dealt with detainees arrested as a result of mainstream policing, and all were visited during the inspection. The force had a cell capacity of 296 in the designated suites but also had a number of additional cells in standby suites. In the year to September 2010, 96,457 detainees had been held. In the same period, 512 detainees had been held for immigration matters.

2.3 The designated suites and cell capacity of each was as follows:

Area	Custody suite	Number of cells
Birmingham West and Central	Steelhouse Lane	51
	Aston	11
Birmingham South	Bournville	17
	Harborne	14
Birmingham West	Kings Heath	17
	Stechford	16
Birmingham North	Sutton Coldfield	16
Wolverhampton Central		19
Dudley	Brierley Hill	7
	Halesowen	7
Sandwell	Smethwick	16
	West Bromwich	13

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

Walsall	Bloxwich	20
	Walsall	18
Solihull		9
Coventry	Coventry Central	26
	Willenhall	19

A survey of prisoners at HMP Birmingham and HMP Hewell who had formerly been detained at custody suites in the force area was conducted by HM Inspectorate of Prisons and constabulary researchers and inspectors to obtain additional evidence (see Appendix II).

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

Strategic overview

2.5 There was clear leadership by a chief officer and a strategy for the provision of custodial services which included a recent move to a centralised model. This had allowed the force to introduce greater central oversight, which had improved service delivery.

2.6 A large amount of management information had been used to inform the change programme. This had led to a decrease in the number of custody suites, and there were plans to reduce this further. There had been a substantial investment in resources across the custody estate, particularly at Steelhouse Lane in central Birmingham, although this was still a poor facility.

2.7 The police authority was supportive of this strategy and was also involved in overseeing the response to Independent Police Complaints Commission (IPCC) investigation recommendations. There was an active independent custody visitors (ICV) scheme operating.

2.8 Staffing levels were good and staff felt valued and empowered. Training arrangements were satisfactory and refresher training had recently been introduced. The force-wide 'whiteboard' for directing detainees to custody suites was an excellent initiative, although still bedding in. There were robust systems for capturing 'learning the lessons' information which most, but not all, staff were aware of.

2.9 Partnership work was a priority and mostly well developed, and in particular there had been some recent progress in engaging strategically with health partners. The force had introduced a 'community resolution' initiative, which was substantially reducing the number of detainees going through custody suites.

2.10 There was a good system for capturing use of force data but this was not always reported on effectively and the force was not adequately using the available data.

Treatment and conditions

2.11 The staff culture was impressive and the interactions we witnessed were professional and appropriate. The approach to the diverse range of detainees held was good, although in some

suites the specific needs of females were not being recognised or addressed adequately. The age of the estate meant that there were some access issues for detainees with disabilities but some adjusted provision was available in a small number of suites. Interpreting services were used when needed.

2.12 A lack of privacy at the booking-in desks was an issue at some custody suites and closed-circuit television (CCTV) and other confidential information was poorly located at others.

2.13 The approach to initial risk assessment was mixed, ranging from excellent to poor, and urgently needed to be addressed. In most cases, staff appeared to take a proportionate approach to managing risk, and CCTV was used extensively, although sometimes this was over-relied on. Staff were clear about the importance of rousing and we mostly saw this happening appropriately.

2.14 Nearly every cell which we surveyed failed to pass safety examinations. Many of the older cells contained ligature points. The safety issues identified at Steelhouse Lane were particularly concerning. Health and safety monitoring took place but inconsistently, and some staff were not trained or equipped to identify problems. A small number of custody records were being reviewed for lessons learned.

2.15 The use of cell call bells was not always explained to detainees but most staff carried anti-ligature knives. There had been recent improvements in fire safety and evacuation arrangements.

2.16 Showers were rarely offered, and only on request, and privacy was sometimes poor. There were adequate supplies of underwear, tracksuits and plimsolls, which were provided when needed.

2.17 Meals and drinks were generally offered when requested or at set mealtimes but the quality of microwave meals was poor. Exercise was rarely offered, which we were told reflected concerns after recent incidents of self-harm. Limited reading material was offered to detainees and few, if any, visits were facilitated.

Individual rights

2.18 We found an appropriate approach to balancing the priorities of progressing cases with the rights of individuals. Detainees were offered a copy of PACE and comprehensive leaflets in a range of languages. We found no breaches of PACE.

2.19 For most detainees, there were no problems in obtaining free legal assistance but there were sometimes delays in gaining access to a specialist immigration solicitor. Staff made calls to notify someone of the detainee's arrest.

2.20 A large number of immigration detainees had been held. Although we were told that relationships with the UK Border Agency (UKBA) had improved, there had sometimes been delays of up to five days in dealing with these detainees.

2.21 We found no examples of children being held in custody under section 46 of the Children Act 1989 but getting access to a PACE place of safety bed was a problem.

2.22 We witnessed a mixed approach to carrying out pre-release risk assessments, which were completed only for very vulnerable detainees.

2.23 Staff mainly called on family to act as appropriate adults (AAs). When this was not possible or appropriate, youth offending team staff acted as AAs for juveniles during the working day, although out of hours this became problematic. There were considerable difficulties in providing AAs for vulnerable adults.

2.24 The management of DNA was largely positive, with just a few minor issues to be addressed. The cut-off times for courts were sometimes too early. Detainees were not told how to make a complaint and the arrangements for taking them were confused.

Health care

2.25 Most health services were provided by the private contractor, Primecare. Clinical governance arrangements were good. Medicines management was robust. The force made efforts to collect medications from detainees' home addresses. No resuscitation equipment was available to custody staff.

2.26 We observed some excellent care provided to detainees by health services professionals and waiting times were reasonable, although not monitored by the force. Clinical rooms were variable in quality, lacked effective infection control and suffered from being multi-use. The quality of some clinical records reviewed was excellent.

2.27 Demand for substance misuse services was high. The services were delivered by a range of providers and were generally good. The force was taking a strong lead in seeking to develop mental health services, which were improving, although too many detainees were being held under section 136 of the Mental Health Act 1983. Mental health diversion services were inadequate.[3]

Main recommendations

2.28 **The safety issues concerning ligature points should be addressed as a matter of urgency and, where resources do not allow them to be dealt with immediately, the risks should be carefully managed. The concerns about the Steelhouse Lane custody suite should be prioritised.**

2.29 **A use of force form should be submitted in every appropriate instance and the force should monitor the use of force locally by ethnicity, age, location and officers involved.**

2.30 **Initial risk assessments should be comprehensive and uniform in format.**

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

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 Good progress had been made in custodial provision over the previous six to nine months. There was clear chief officer leadership and a clear strategy for the provision of custodial services which included a move from a de-centralised to a centralised model. This had allowed the force to introduce far greater central oversight, which had led to improved service delivery, safer provision for detainees and reduced risk.

3.2 An assistant chief constable (ACC) had portfolio responsibility for custody. He managed this through a chief superintendent who was in charge of the Community Justice and Custody Department (CJC), which was based at headquarters. He was supported by a superintendent and a chief inspector, who was the lead for custody. The CJC was responsible for ensuring that custody standards were maintained and that the force operated its centralised model of custody to corporate standards. It was also responsible for the central development of all policies and protocols pertaining to custody.

3.3 The force had used comprehensive management information which it used to inform its recent business change and this had led to a decrease in the number of custody suites. The force eventually wanted to move to having only 11 custody suites, with new builds in the West and Central Birmingham local policing units (LPUs).

3.4 There had been a large investment in resources across the custody estate, particularly at Steelhouse Lane, which was in the capital plan for replacement. The police authority (PA) had been supportive of the force's plans for the estate. Efforts had been made to 'professionalise' custody staff, with a focus on safer detention, enhanced training regimes and making the centralised model self-reliant. This was having positive effects, with staff feeling valued and empowered. The force had introduced an electronic force-wide 'whiteboard' for directing detainees to custody suites which were best able to deal with them, thereby managing risk more appropriately. It was an excellent initiative, although it was still bedding in and there was evidence that it was not always referred to.

3.5 We were told that there was a good relationship between the force and the PA, with professional dialogues taking place as necessary. The PA had oversight of all the recent recommendations emanating from a number of IPCC investigations and was 'very supportive' of the force. These recommendations had been selected by the strategic review of custody, and a senior responsible officer was responsible for ensuring delivery and compliance with them.

3.6 There was a good ICV scheme, which was well supported by the PA, and there was evidence of a performance regime operating. There were sound mechanisms for capturing, addressing and providing feedback on issues raised by the ICVs.

3.7 All custody sergeants were permanently posted into custody and had been trained through an approved custody course. The force also used detention escort officers (DEOs) who had received custody-specific training.

3.8 The ACC attended the Local Criminal Justice Board, which was chaired by the head of the Probation Service and attended by senior representatives from partnership organisations. Relationships with the Crown Prosecution Service (CPS) were described to us as difficult due to the financial cuts which the CPS was facing. However, this had led both partners to examine their working processes and consequently to work more effectively. This was largely as a result of moving toward provision by the police of a single full electronic prosecution file which interfaced directly with the CPS. This had led to a large reduction in the amount of work and bureaucracy in the criminal justice units.

3.9 There had recently been an increase in the support offered by the local health authorities and mental health trusts, particularly in respect of section136 detainees. Some facilities had been brought onstream in relation to providing these detainees with safe places of detention which were not police stations. Some of the work in mental health had been identified as good practice and developed templates had been adopted by the Offender Health Department for use by other forces and agencies.

3.10 The force had made a number of attempts to improve working relationships with UKBA, including provision of a custody suite for the detention of immigration detainees by UKBA. However, disengagement by UKBA at short notice had prevented this project coming to fruition. A national protocol was in the process of being agreed between the police service and UKBA which would improve response times and joint working arrangements.

3.11 The force had introduced a community resolution package. This sought to deal with low-level offences which did not involve detainees being brought into the custody suites, and had been used in approximately 1,000 cases per month. However, the force had recognised that approximately 10% of detainees who were subject to community resolution still came into the custody suites, and they were looking to address this issue.

3.12 Too few custody records were being dip sampled for the large throughput of detainees. Custody records were not being cross-referenced with CCTV recordings to check on the accuracy and quality of custody records.

3.13 Sergeants and DEOs were regularly updated about adverse incidents and other 'learning the lessons' information. A well-used custody intranet site was also available which contained this and other relevant information.

3.14 While the ACC and CJC were clear that police inspectors should take complaints in the custody environment, we found a lack of oversight across the LPUs.

3.15 There was an excellent system for capturing use of force data, which involved the completion of use of force forms, followed by electronic submission to headquarters. Officers also recorded incidents on the detainee's custody records. However, we were not convinced that the use of force was being reported in all appropriate cases, and sergeants differed in their interpretation of when the use of force forms should be completed. In Bloxwich, for example, we found that use of force forms were generally not used at all. The force carried out only limited analysis of the data captured and this was used to inform training and health and safety equipment needs. The data were reviewed by the Professional Standards Department (PSD) and maintained on a searchable database. The PSD did not systematically review where force was used, how often it was used, or what force had been deployed and by whom. It also did not monitor whom force was used against or their ethnicity (see main recommendation 2.29).

Good practice

3.16 *An electronic force-wide 'whiteboard' had been introduced for directing detainees to custody suites which were best able to deal with them, thereby managing risk more effectively.*

3.17 *The introduction of a single electronic file, which interfaced directly with Crown Prosecution Service systems, had reduced the bureaucratic burden of administration in criminal justice units.*

3.18 *Mental health templates had been adopted by the Offender Health Department for use by other forces and agencies.*

4. Treatment and conditions

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

Respect

4.1 Most detainees had relatively short journeys to custody suites. Detainees were transported in both police and Reliance cellular vehicles. Prisoner escort records accompanied detainees transported by private contractors and were properly completed and legible.

4.2 The staff culture in custody was positive. All of the staff we observed working in the custody suites consistently treated detainees with a high level of respect and this was confirmed by detainees we spoke to. First or preferred names were mostly used.

4.3 Some of the booking-in areas were cramped. At most of the custody suites, we observed more than one detainee being booked in at the same time and conversations could easily be overheard. At some of the custody suites, a separate room could be used to book in detainees whose alleged offence, or other circumstances, was particularly sensitive. There was no holding area at West Bromwich and this also created difficulties in managing detainees effectively.

4.4 At Steelhouse Lane, a large board on the wall contained a range of personal information about detainees, including their names, alleged offences and required referrals to health services. It was visible to all detainees being booked in and anyone else passing through the booking-in area.

4.5 Although staff were usually sensitive in the way they dealt with individuals, they did not always recognise or respond appropriately to the diverse needs presented by detainees. Custody staff awareness of the impact of detention on female detainees varied. Women, although located in nominated cells away from adult men, were treated differently only if assessed as being particularly vulnerable. Female detainees were not always given the opportunity to speak to a female member of staff and were expected to ask for hygiene products. We were told consistently that female detainees under the age of 18 were assigned to a female member of staff. At Halesowen, staff were particularly responsive to the needs of a pregnant detainee, who was given a chair to sit on in her cell instead of the wooden plinth. Staff also agreed to turn off the CCTV in her cell when she wanted to use the toilet, even though the toilet was properly obscured on the monitors.

4.6 Staff did not receive formal training in child protection awareness but safeguarding training was planned. Despite this, staff we spoke to showed some understanding about the distinctive needs of juveniles and explained information to them in less formal language. At all custody suites, staff were clear that juveniles should not remain in custody any longer than necessary and we saw evidence that children were being bailed at the earliest opportunity.

4.7 There was a good understanding of multi-cultural issues, which underpinned the work of custody staff. Staff readily utilised telephone and face-to-face interpreting services when needed.

4.8 In our survey, 22% of respondents, against the 20% comparator, said that they had a disability.[4] Three custody suites (Bloxwich, Willenhall and Kings Heath) were designated for detainees with disabilities and there were toilet facilities for those with disabilities at West Bromwich. Adaptations had been made at these custody suites to facilitate access for detainees who required wheelchair access but there were no specially adapted cells. The provision of portable hearing loops across the suites was poor. Religious needs were recognised and items such as prayer mats and religious texts were generally available. Some staff said that they would allow Muslim detainees to use washing facilities before praying if requested.

Recommendations

4.9 **Booking-in desks should allow effective and private communication between detainees and staff.**

4.10 **There should be clear policies and procedures to meet the specific needs of female and juvenile detainees and those with disabilities.**

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

Housekeeping points

4.12 Female detainees should be routinely offered hygiene products.

4.13 Portable hearing loops should be available in the designated custody suites and staff should be trained to operate them.

Safety

4.14 With the exception of the custody suite at Sutton Coldfield, nearly every cell which we surveyed failed to pass safety examinations. Many of the older cells had design flaws, with many ligature points (see main recommendation 2.28). Many of the identified issues could be easily remedied but others needed further investigation to resolve them. The safety issues identified at Steelhouse Lane, which had been given a Grade II listed status, were particularly concerning. We were told that restrictions had been placed on the force by English Heritage which, for example, prevented them from replacing cell doors. This custody suite was inherently unsafe due to the age of its fabric, and staff were not trained or equipped to identify the full range of ligature points that we found.

[4] **Inspection methodology:** There are five key sources of evidence for inspection: observation; detainee surveys; discussions with detainees; discussions with staff and relevant third parties; and documentation. During inspections, we use a mixed-method approach to data gathering, applying both qualitative and quantitative methodologies. All findings and judgements are triangulated, which increases the validity of the data gathered. Survey results show the collective response (in percentages) from detainees in the establishment being inspected compared with the collective response (in percentages) from respondents in all establishments of that type (the comparator figure). Where references to comparisons between these two sets of figures are made in the report, these relate to statistically significant differences only. Statistical significance is a way of estimating the likelihood that a difference between two samples indicates a real difference between the populations from which the samples are taken, rather than being due to chance. If a result is very unlikely to have arisen by chance, we say it is 'statistically significant'. The significance level is set at 0.05, which means that there is only a 5% chance that the difference in results is due to chance. (Adapted from the *Dictionary of Forensic Psychology*: HM Inspectorate of Prisons.)

4.15 Health and safety 'walk-throughs' took place on a daily, weekly and monthly basis utilising checklists but there was no consistency in who carried them out, there was a lack or oversight and the checklists were not meaningful (see main recommendation 2.28).

4.16 Custody sergeants completed risk assessments with detainees on arrival. They usually had access to information held on the Police National Computer (PNC) but we were told that arresting officers did not always provide this information in advance of them arriving at the suite, which was the procedure, although this was improving. All detainees were asked questions about their potential to self-harm and any recent suicide attempts. In addition to the background material available from the PNC, custody sergeants obtained information from the arresting officer. Answers were recorded directly onto the custody record. Risk levels were determined by the custody sergeant, who established how often each detainee would be observed. These timings were reviewed or revised as circumstances changed.

4.17 The assessments we examined were generally balanced and proportionate but the approach was not standardised. Guidance had been issued on how the risk assessments should be carried out but this was not adhered to. Some sergeants used their own 'aide memoirs', while others followed set questions, which they had memorised. Although staff were clearly focused on the detainee's current state of mind, they sometimes failed to obtain relevant historical information. At Bloxwich and Walsall, for example, questions about past drug or alcohol dependency were not always asked and not all of the factors concerning previous self-harm attempts or ongoing medical conditions were always taken into account. This led to an inconsistency in the amount of detail recorded in assessments and also meant that they were difficult to read because they were recorded in many different formats (see main recommendation 2.30).

4.18 Despite these weaknesses, staff were appropriately cautious when dealing with individuals who were identified as presenting a risk. Those considered to be at risk of self-harm were nearly always located in special observation cells equipped with CCTV cameras and were constantly observed by officers until reassessed by the custody sergeant. In more extreme cases, where detainees were considered at the highest risk (level four), close proximity watches were put into place, where an officer was in constant contact with the detainee. This usually meant that the officer sat outside a special observation cell with the door open. The engagement we observed between staff and detainees on constant observation was reasonable, although at some custody suites there was no interaction with the detainee. At Walsall and Wolverhampton, although the doors of occupied observation cells were open and staff interacted with detainees, the observations in custody records did not reflect this. Entries in documents were generally poor, with most being observational. Care planning was generally poor, with some notable exceptions at Bournville, Walsall and Smethwick.

4.19 Staff routinely roused detainees when appropriate and varied the frequency of observations to make them less predictable. It was clear that all staff were aware of the importance of regular monitoring and that rousing meant eliciting a verbal or physical response.

4.20 Staff attendance times overlapped, allowing custody sergeants and DEOs enough time for a comprehensive handover, even when the custody suites were busy. Briefings included an exchange of relevant information about individuals, with a particular focus on vulnerable detainees, such as juveniles and those with mental health issues. There was no sharing of cells in any of the sites. All custody sergeants and most DEOs carried anti-ligature knives.

4.21 We were told that when a violent detainee was brought into the custody suite, the custody area was cleared of non-custody staff and preparation was made to manage the situation.

Handcuffs were removed only if there was no risk of the detainee being violent. Violent detainees were nearly always put into close observation cells.

Recommendation

4.22 **Care planning for detainees at risk of self-harm should be developed.**

Housekeeping point

4.23 Arresting officers should always provide custody sergeants with all of the available background information when a detainee is being brought into custody suites.

Use of force

4.24 Staff had been trained in the approved use of force techniques and received annual refresher training. Officers were clearly focused on the welfare of detainees. Most detainees arrived at the custody suite with handcuffs but most were removed by the arresting officers or at the custody sergeant's discretion when the detainee was interviewed at the front desk. Detainees subject to use of force were not routinely seen by a health care professional unless they had an obvious injury or asked to do so.

4.25 Most custody staff and officers described force as any occasion when they had to lay hands on a detainee, even if this comprised a gentle push. All agreed that only the more serious use of force, such as that leading to an injury, would be recorded. There was no evidence that force was used unnecessarily or as a first resort when dealing with difficult and violent behaviour.

Physical conditions

4.26 In our survey, 37% of respondents, against the 30% comparator, said that the cells were clean. Staff adopted a zero-tolerance approach to graffiti or damage, and signs were displayed in custody suites informing detainees that they would be prosecuted if there was any damage to the cell. Conditions in most of the suites were good, with well-maintained communal areas, little graffiti and clean cells. All of the suites contained accommodation which had been designated for adult males, females and juveniles. The juvenile detention rooms had no toilets and were usually located close to the custody desk. Each suite had a small number of 'drunk' cells, containing low benches. All of the suites also had a number of cells monitored by CCTV, which was of a high quality. These cells contained notices alerting detainees that they were being observed by camera.

4.27 Despite extensive refurbishment, the custody suite at Steelhouse Lane was old and worn. The three galleried landings were narrow and dark, with little natural light. Floors were cracked and worn in places. Generally, however, communal areas were clean and the conditions in cells were adequate, although in some there was no natural light.

4.28 The cell call bell system at several of the suites had an intercom that enabled staff to speak to detainees when they used their call bell, to find out what they needed, before going to the cell. In our survey, only 12% of detainees, against the 22% comparator, said that they had had the correct use of the cell bell explained to them. Bells were usually responded to promptly, either by a DEO or a custody sergeant.

4.29 A no-smoking policy was strictly enforced and there was no evidence of smoking taking place at any of the suites. Staff told us that nicotine patches were not routinely available, although staff working at Willenhall said that they could issue nicotine gum.

4.30 Fire evacuation procedures were clearly displayed in corridors and at the main booking-in desks. Fire alarms were tested at least weekly and smoke detectors were checked regularly but a schedule of fire evacuation drills had not yet been introduced.

Recommendation

4.31 **A schedule of fire evacuation tests should be implemented.**

Housekeeping point

4.32 Nicotine replacement items should be introduced.

Personal comfort and hygiene

4.33 Although there were sufficient mattresses and clean blankets, including non-tear blankets for detainees at risk of ligaturing, and detainees had good access to them, pillows were not offered at any of the suites. A blanket was routinely placed in each cell at Bournville but this was not the practice at the other suites, where blankets were sometimes offered and sometimes had to be requested. Blankets were washed after each use but mattresses were not routinely wiped down with a disinfectant spray when cells were vacated.

4.34 Most cells had integral sanitation but no hand-washing facilities. At West Bromwich, only two of the 13 cells had in-cell sanitation. Toilets in cells monitored by CCTV were obscured. Communal toilets were clean and in good working order. All suites had adequate supplies of soap and towels. Toilet paper was available in-cell at some suites but at Bournville and West Bromwich detainees had to request it.

4.35 Our custody record analysis indicated that no detainees were offered a shower, and only 6% of respondents to our survey said that this had happened. A few had been offered a wash. One 15-year-old boy had been held for 54 hours and released to court without a shower. The showers at some suites, for example West Bromwich and Willenhall, offered little privacy. The women's shower at Harborne was visible on the CCTV. There was only one shower at Coventry Central, for 26 cells.

4.36 Hygiene packs were available for men and women but they were supplied only on request. Detainees who had had their clothes taken away for forensic examination were given new tracksuit tops and bottoms, T-shirts and slippers. Plimsolls were also available at the point of discharge. A large stock of these items was held in the custody suites. Replacement underwear was available but not at all of the suites. Family and friends were permitted to bring in approved items of clothing.

Recommendation

4.37 **All detainees held overnight, or who require one, should be offered a shower, which they should be able to take with a reasonable level of privacy.**

Housekeeping points

4.38 Pillows and blankets should be offered to detainees.

4.39 Mattresses should be wiped clean after each use.

4.40 All cells should contain a supply of toilet paper.

4.41 Replacement underwear should be available in all custody suites.

Catering

4.42 Microwave meals and cereals were available for detainees. Vegetarian and halal diets were catered for but some meals had low nutritional and calorific content. Food was served at regular intervals, although in our custody record analysis we found two examples of detainees held for more than 10 hours without apparently being offered a meal. If detainees requested additional food or a drink outside the set times, staff responded quickly to provide this. Family and friends were able to hand in food that had been bought in sealed containers (for example, sandwiches or plastic bottled drinks) but this rarely happened and in any event had to be checked carefully by staff to ensure that the packaging had not been tampered with before being given to detainees.

4.43 Custody staff told us that they offered food at mealtimes but did not always check if newly arrived detainees had eaten. In the custody record analysis, 45% of detainees in our sample had been offered at least one meal while in custody.

Activities

4.44 Detainees were not routinely offered outdoor exercise and there was no exercise area at Brierley Hill and Steelhouse Lane. In our custody record analysis, only one of the 60 records we sampled recorded outdoor exercise being provided. The exercise yards were stark. Detainees were supposed to be supervised when on exercise but this was not always the case. At Harborne, one detainee who had said that he was claustrophobic had been allowed to stay in the yard rather than be put into a cell. He was known to staff, who had made an informed decision about the risks he posed and monitored him in the yard via CCTV and by talking to him. Staff told us that they were uncertain about facilitating outside exercise after some incidents of self-harm in yards.

4.45 A small selection of books and magazines was available at each suite. These had mainly been provided by staff or left by other detainees, and the selection was poor. In our survey, only 4% of detainees said that they had been offered reading material, against the 14% comparator. In our custody record analysis, one out of 60 detainees had been offered reading material. Visits were not normally allowed and most of the custody suites did not have adequate facilities to provide them. At Bournville, there was a room that could be used for visits, but rarely was.

Recommendation

4.46 **Detainees held for longer periods should be offered outdoor exercise.**

Housekeeping point

4.47 A range of reading material should be provided.

5. Individual rights

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

Rights relating to detention

5.1 Custody sergeants checked that the arrest and detention of detainees was appropriate before authorising detention. They were prepared to challenge the proportionality of arrest and detention, particularly when involving vulnerable detainees. At Walsall custody suite, we saw an inspector intervening before a detainee with suspected mental health issues arrived at the custody suite, diverting him to a local hospital. Operational staff had recently been issued with 'detainee prompt cards'. These contained reminders about giving consideration to whether it was necessary to make an arrest and the type of information which an arresting officer should always bring to the attention of the custody sergeant.

5.2 In the year to September 2010, the force had held 512 immigration detainees solely under immigration powers. Custody sergeants described relationships with UKBA as reasonable but told us that immigration detainees were usually held for long periods. Data provided by the force recorded that the average length of stay in custody for these detainees was 28 hours, although some had been held for up to five days. In our custody record analysis, we found that one foreign national detainee had been held for approximately 46 hours while waiting for transfer to an immigration removal centre. Police custody was not used as a place of safety for juveniles under section 46 of the Children Act 1989.

5.3 All detainees were given a notice of their rights and entitlements, which was available in a range of languages. Custody staff had access to professional interpreting services and to police-trained interpreters. Detainees were asked on arrival if they wanted someone to be told of their whereabouts, and any delays in exercising this right were authorised at inspector level. We were told at Steelhouse Lane that they had the facility for detainees, immigration detainees in particular, to make contact with someone in another country but there was no evidence that this option was offered. Telephone calls were made in a public area and afforded little privacy. Custody records showed that some detainees were asked if they had any dependency obligations. However, not all detainees that we observed being booked in were asked this question. Staff seemed either to use their discretion about whether to elicit this information or presumed that the detainee would raise any such problems without prompting.

5.4 When a vulnerable detainee was due to be released, it was not unusual for them to be transported home by police staff. We were told about various other 'additional steps' taken to support vulnerable detainees on release. This occasionally involved collaboration with community-based services such as social work and housing departments, but this was unusual and did not take place systematically. Staff that we spoke to referred to 'pre-release plans', which were completed on all vulnerable detainees, but in practice these consisted of no more than a short description of the individual's problems, along with a brief account of any action taken. Our observations indicated that pre-release risk management occurred only in extreme cases, usually for those with obvious mental health issues. There were information leaflets detailing support organisations and agencies but these were not routinely given to detainees.

Recommendations

5.5 **The UK Border Agency should ensure that immigration detainees are held in police custody suites for the shortest possible time.**

5.6 **Custody staff should ensure that detainees' dependency issues are identified and, where possible, addressed.**

5.7 **Comprehensive risk assessments and, if appropriate, care plans should be completed before release for all vulnerable detainees.**

Housekeeping points

5.8 When the investigation allows, detainees should be able to make telephone calls with some degree of privacy.

5.9 Information leaflets should be given to detainees when being released.

Rights relating to PACE

5.10 The procedural requirements of PACE were applied efficiently. Reviews of detention were timely and in line with requirements. All were conducted by a nominated police inspector. The role of the reviewing inspector was explained to detainees, who were spoken to directly or given the opportunity to speak to the reviewing officer by telephone. We were told that delays for operational reasons were endorsed on the custody record. Detainees were not interviewed if under the influence, or thought to be under the influence, of alcohol or drugs; a medical opinion was always sought if there was any doubt. Detainees were given adequate breaks between formal interviews.

5.11 All custody suites had up-to-date copies of PACE available for detainees to read. Detainees were able to consult their legal representatives, free of charge, and custody sergeants were able to provide details of the duty solicitor scheme and to name locally available practices and solicitors who spoke a range of languages and worked on immigration cases. Each of the custody suites contained sufficient, adequately equipped interview rooms. Solicitors were routinely given copies of custody records on arrival and detainees could apply for these in writing on release. Defence solicitors were positive about relationships with staff and said that they were respectful to detainees.

5.12 Juveniles were not interviewed without an AA present. However, police adhered to the PACE definition of a child instead of that in the Children Act 1989, which meant that those aged 17 were not provided with an AA unless otherwise deemed vulnerable.[5] Family and friends were usually approached to act as AAs in the first instance. The local youth offending service coordinated the AA service up to 5pm on weekdays. Thereafter, the social services emergency duty team was responsible for the AA service. Custody staff said that the AA service was reliable but that they experienced long delays in the evening and at weekends.

5.13 In our custody record analysis, there were six (10%) young people in our sample below the age of 17. They had all been provided with an AA. Two had been held for more than 24 hours,

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

one of whom for approximately 54 hours, between 3am on a Saturday until 9am on the following Monday. In the latter case, no secure accommodation had been available for him over the weekend, so he had waited in custody until his court appearance on Monday morning. At the time of the inspection, the force was working with the local authority to identify accommodation for juvenile detainees who could not be bailed. Social services could be called to act as an AA for vulnerable adults but this system was problematic and staff reported major delays in a member of social services attending the custody suite.

5.14 DNA and forensic matters were handled well. The force had taken recent steps to ensure that exhibits were submitted or dealt with as appropriate. However, we found several samples from suspected drunk drivers which appeared not to have been submitted for analysis.

5.15 Detainees were transported to court in a timely manner but the court cut-off times varied, with most courts not accepting detainees after 12.30pm on weekdays, which was very early and could have resulted in unnecessary overnight stays in custody. This was the case at Birmingham, despite the presence of a secure corridor from Steelhouse Lane into the court. Custody staff appeared to have reasonably good working relationships with court staff at Coventry, where they were able to take detainees to court up to 3pm; this enabled vulnerable detainees to be dealt with on the same day, avoiding unnecessary overnight remands. Weekend courts operated early cut-off times, some as early as 9am, as at Bournville and Harborne.

Recommendations

5.16 **Appropriate adults should be readily available to support vulnerable adults in custody, including out of hours.**

5.17 **All evidential samples taken from suspected drunk drivers should be submitted for analysis in a timely fashion.**

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

Rights relating to treatment

5.19 Detainees were not routinely informed how to make a complaint about their treatment. Custody records showed that if detainees were in custody long enough to have their detention reviewed by an inspector, they were routinely asked if they wanted to make any representations about their time in custody. Inspectors we spoke to at Walsall said that this was intended to act as an opportunity for detainees to raise complaints. Detainees we interviewed said that this had not been made clear to them.

5.20 All custody sergeants said that complaints would not be taken during a detainee's time in the custody suite, and that detainees were advised to raise any issues in writing after being released from custody, using the IPCC complaint forms, which were usually available at the station front desk. We were told that there were some circumstances in which the custody sergeant would immediately inform the duty inspector of a complaint from a detainee, such as an allegation of assault by a member of staff. However, we saw an example of a detainee's request to make such a complaint which had led to no action being taken after the duty inspector had been informed.[6]

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

5.21 Custody sergeants said that they would deal directly with low-level complaints informally and with some immediacy where possible.

Recommendation

5.22 **Detainees should be told how to make a complaint and should be facilitated to do so before they leave custody.**

6. Health care

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

Clinical governance

6.1 Primecare was contracted to provide health services to detainees, supplying nurses and forensic medical examiners (FMEs). Mental health services were provided by five NHS trusts across the force area. Substance use services were provided by four different providers, the largest being the substance misuse arrest referral team (SMART), who were employed by the force.

6.2 Primecare had robust clinical governance arrangements, which included clear lines of management and an escalation process, so that staff could obtain further advice at any time if required. Primecare aimed to recruit nurses who had been qualified for at least four years and had experience in prison nursing or accident and emergency services (A&E). Doctors were self-employed and contracted to Primecare; they usually had experience in A&E, general practice or psychiatry.

6.3 There was a comprehensive induction programme for new nurses, which included external speakers from the police and the IPCC. There were opportunities for staff to have clinical supervision and there was a programme for staff appraisal. Staff had access to a range of continual professional development opportunities.

6.4 The clinical manager had bimonthly meetings with the inspector who held the portfolio lead; they also had regular informal contact. Primecare investigated any complaints or contract breaches raised by the lead inspector; however, he relied on custody staff reporting such breaches. Not all staff whom we spoke to were aware of the procedure or whom to contact when Primecare failed to meet their contract obligations.

6.5 Nursing staff whom we observed were courteous, caring and respectful. Staff had access to, and used, interpreting services if required.

6.6 The state of the clinical rooms varied throughout the custody estate. Most were of a reasonable size and some had been refurbished. Infection control audits were being undertaken by Primecare and, once completed, the results were to be shared with the force. The clinical rooms at Bournville, Aston and Solihull Central were clean and tidy. The room at Steelhouse Lane was small, hot and untidy. Many custody suites contained clinical and forensic equipment that was out of date. Across the estate, no sharps bins were secured to the wall or signed and dated at the start of use. Some sharps bins and clinical waste sacks contained domestic rubbish. Rooms at West Bromwich, Wolverhampton and Brierley Hill were drab and did not have a suitable area to undertake clinical procedures such as dressings. Many rooms were used for searches, mandatory drug testing or storage of clothing, were left unlocked when not in use and all had a staff toilet adjoining the room. When present, medical literature was out of date. Patient information leaflets were available but were not usually issued to detainees.

6.7 Nurses collected small locked boxes of medicines either from their custody suite base or Primecare central offices at the beginning of their shift. They were stocked by a Primecare pharmacist. Each box contained minimal stock and a record book, which was completed on each drug administration; we found the records to be accurate. FMEs carried a similar stock of medications. Custody staff assured us that they did not keep any medications at the custody suites. Nurses were able to supply and administer a reasonable range of medications using patient group directions (PGDs) and FMEs were able to dispense medications to be given at a later date by custody staff.

6.8 None of the custody suites had an automated external defibrillator, oxygen or suction, and the contents of first-aid kits and 'grab bags' varied in every suite, which was extremely unusual.

Recommendations

6.9 **There should be robust infection control procedures for all the clinical rooms, which should be clean and capable of being used for the taking of forensic samples.**

6.10 **Custody staff should have access to a full range of appropriate first-aid and resuscitation equipment.**

Housekeeping points

6.11 Medical information, such as the *British National Formulary*, should be up to date.

6.12 Patient information leaflets should be accessible in all custody suites.

Patient care

6.13 Primecare aimed to provide five nurses and three doctors across the force area, with additional nursing staff at peak times between Thursday and Saturday, inclusive. Staff were nominally allocated to specific LPUs but were directed anywhere in the force area if required. We found evidence that the rota was not always fully staffed, which led to delays in detainees being seen. We were also told by custody staff that Primecare call centre staff sometimes contacted the custody suite when a health professional could not attend within the required time, in order to reset the call. Some staff accepted this line of action, effectively setting a new response time, while other staff insisted that the original call be acted on, with a delay.

6.14 Primecare provided the force with monthly statistics relating to their Service Level Agreement (SLA), although these were not verified by the police. Across the force, Primecare's monitoring data indicated that they generally met the response time targets agreed in the SLA, but this was not always the case in some individual custody suites. In our analysis of custody records, 30 (50%) detainees in our sample had been seen by a health services professional, of whom seven (23%) had waited longer than 90 minutes to be seen; the average wait was approximately one hour.

6.15 We witnessed good nursing care and there were decent working relationships between nurses and custody staff. Information sharing was appropriate. Nurses led the clinical care, with telephone reference to the FME when they had clinical concerns or queries or required a prescription. Female detainees could not be guaranteed to see a female doctor if needed, although a chaperone was made available if necessary.

6.16 In our survey, 71% of detainees said that they had been on medication on arrival in custody, which was higher than the 41% comparator. Of those on medication, 48% had been able to continue it while in custody. Custody staff made attempts to retrieve medications, including methadone, from a detainee's home or pharmacy if required. We found examples of the FME attending the custody suite to prescribe and administer medications. However, in our analysis of custody records we found one case of a detainee who had gone to court without receiving his methadone. The doctor had not attended the custody suite to administer it, even though the methadone was available. If a detainee was prescribed medication by the FME, it was left for the DEOs to administer. At Steelhouse Lane, a system had been devised whereby detainees were asked to sign to acknowledge receipt of medications administered by DEOs.

6.17 Health professionals used paper records to record their contemporaneous notes about a consultation; the nurses used a proforma document, as did some of the doctors. Arrangements for storing clinical records were in line with Caldicott guidelines, although at Bournville we found a small number in an unlocked drawer. The Primecare clinical manager undertook a comprehensive six-monthly audit of nurses' clinical records, and the results were used in staff appraisals. The lead FME undertook a similar exercise for the FMEs' clinical records. We looked at the latest audit of nurses' records and noted that in most cases nurses achieved a high standard of record keeping. Clinical staff did not have access to the police computer system.[7]

Good practice

6.18 *The system for recording the administration of medications at Steelhouse Lane, where detainees signed to acknowledge receipt of the medication, was effective and should be replicated in other custody suites.*

Substance use

6.19 Substance use services were offered to adults aged 18 or above and referrals were made to ensure that juveniles had contact with services for young people. Each of the service providers consisted of five to eight workers, a manager and administrative support.

6.20 Members of SMART were employed by the force, and the team covered most of the LPUs. Cranstoun (a drug and alcohol charity) covered Brierley Hill, Stourbridge and Halesowen; Wolverhampton Primary Care Trust (PCT) covered Bilston Street Station; and Addaction (another drug and alcohol charity) covered Walsall LPU.

6.21 In our survey, 74% of respondents, against the 53% comparator, said that they had a drug or alcohol problem. Of these, 67%, against the 42% comparator, had been offered the chance to see a substance use worker, and 57%, against the 32% comparator, had been offered symptomatic relief.

6.22 Across the estate, any detainee who had committed a 'trigger offence' was automatically drug tested; refusal of a test constituted a further offence. Arrest referral workers saw detainees during duty hours. When they were unavailable or off duty, custody staff made appointments for detainees; failure to attend resulted in a breach.

[7] The Caldicott review (1997) stipulated certain principles and working practices that health care providers should adopt to improve the quality of, and protect the confidentiality of, service users' information.

6.23 Arrest referral workers visited all detainees in the custody suites and, where required, an initial assessment was carried out. Detainees were offered a second appointment in the community or referred to counselling, assessment, referral, advice and throughcare (CARAT) services in prisons, if the detainee was remanded into custody. If a detainee wanted to see a worker at times when they were not available, custody staff arranged an appointment with a worker in the community. There were good working relationships between the workers, custody staff and community prescribers and effective links with the blood-borne virus nurse and community psychiatric nurse.

6.24 SMART, Addaction and Cranstoun drug services had robust tracking methods which ensured that detainees had every opportunity to attend appointments. Arrest referral workers offered to attend the first appointment with these services and, where possible, met clients at the gate when they were released from prison. Wolverhampton PCT received arrest referrals via a single point of contact and was aware that other detainees who needed its services were not always referred.

6.25 There were limited alcohol services across the West Midlands. Arrest referral workers referred to Aquarius, the main charity provider of alcohol and other addiction services, based in Birmingham. Custody sergeants could refer to the arrest referral alcohol scheme in Dudley and Walsall LPU; this scheme was not available in Wolverhampton. The Coventry and Birmingham drug intervention programmes offered provision for alcohol users.

6.26 Arrest referral workers could refer clients to a variety of wrap-around services, such as housing departments, substance misuse services, community mental health teams and education, training and employment services.

6.27 Generally, there was good access to needle exchange services in the community but clean needles and syringes were not available in most custody suites. Custody suites were no-smoking sites and detainees were not routinely offered nicotine replacement therapy during their stay, although they could be referred to the FME if necessary.

6.28 The drug intervention workers across the West Midlands had well-established services for engaging with prolific or priority offenders and high crime-causing users (HCCUs). Sandwell had received a national award for its work with HCCUs and Cranstoun had received an award for its partnership working and had recently appointed a peer support worker.

Housekeeping point

6.29 Health services staff at all custody suites should offer clean needles and syringes to injecting drug users who are being released into the community.

Good practice

6.30 *The drug intervention workers across the West Midlands had well-established services for engaging with prolific or priority offenders and high crime-causing users).*

Mental health

6.31 The force had forged strategic links with the five mental health trusts, nine PCTs and seven local authorities within the force area. It had involved the strategic health authority (SHA) in its discussions and the lead inspector worked closely with the offender health team at the SHA. It

had devised an assessment tool to ascertain the readiness of each PCT commissioner to provide a section 136 suite (place of safety); this had been sent out by the SHA, and PCTs were required to submit a monthly return. A deadline of 31 March 2011 had been set for all PCTs, to ensure that there were section 136 suites in place; this date was in line with the application of the Corporate Manslaughter Act to police forces.

6.32 Progress between the different Trusts had varied but had resulted in the opening of a section 136 mental health suite by Birmingham and Solihull Mental Health NHS Foundation Trust for Birmingham and Solihull residents. Staff in custody suites in Birmingham told us that the opening of the suite (the Oleaster unit) six weeks before the inspection had made a difference to detainee care. Since opening, they had received 52 people. The manager we spoke to commented on the good working relationship with the police and that NHS staff had been impressed with police officers' approach toward detainees, which showed dignity, understanding and respect.

6.33 The unit run by Sandwell Mental Health and Social Care Foundation Trust had been in operation for 18 months and was reviewed every six months for monitoring purposes. In the first seven months of 2010, it had completed assessments on 67 people.

6.34 The suite in Wolverhampton was due to be opened by Wolverhampton PCT within a month of the inspection. Neither Coventry and Warwickshire Partnership Trust nor Dudley and Walsall Partnership Trust had section 136 suites, although discussions were ongoing.

6.35 The policy for the use of the section 136 suites was multi-agency, including the West Midlands Ambulance Service, which sent an ambulance to every section 136 arrest. It included clear instructions for staff about when a detainee should be taken to an A&E department rather than a section 136 suite and when a police custody suite was a suitable venue. However, the policy for the Sandwell unit did not include the involvement of the Ambulance Service, so there was the potential for confusion. NHS and local authority staff and police officers received joint training on the policy and use of the suites, enabling each professional to understand the role of others.

6.36 Only Wolverhampton PCT had a criminal justice liaison team, which worked primarily in the magistrates' and Crown courts. It had previously provided a detainee assessment at point of arrest (DAPA) service to Wolverhampton police station but told us that the scheme had fallen into disrepute, despite the fact that it offered a 30-minute response to custody staff during the working week, with the service covered by their crisis team at other times.

6.37 Wolverhampton was to be a pilot site for youth offending teams and child and adolescent mental health service workers to be based at the police station.

Recommendations

6.38 **The detainee assessment at point of arrest (DAPA) scheme at Wolverhampton custody suite should be resurrected and the model adapted across the force, to ensure that detainees with mental health problems are identified and diverted to appropriate services as soon as possible.**

6.39 **Police custody should only be used as a place of safety for section 136 assessments in exceptional cases.**

Good practice

6.40 *Good work had been undertaken at both the strategic and operational level around the care of detainees arrested under section 136 of the Mental Health Act 1983.*

7. Summary of recommendations

Main recommendations — To West Midlands

7.1 The safety issues concerning ligature points should be addressed as a matter of urgency and, where resources do not allow them to be dealt with immediately, the risks should be carefully managed. The concerns about the Steelhouse Lane custody suite should be prioritised. (2.28)

7.2 A use of force form should be submitted in every appropriate instance and the force should monitor the use of force locally by ethnicity, age, location and officers involved. (2.29)

7.3 Initial risk assessments should be comprehensive and uniform in format. (2.30)

Recommendation — To UK Border Agency

7.4 The UK Border Agency should ensure that immigration detainees are held in police custody suites for the shortest possible time. (5.5)

Recommendations — To West Midlands

Treatment and conditions

7.5 Booking-in desks should allow effective and private communication between detainees and staff. (4.9)

7.6 There should be clear policies and procedures to meet the specific needs of female and juvenile detainees and those with disabilities. (4.10)

7.7 Some cells should be adapted for use by detainees with physical disabilities. (4.11)

7.8 Care planning for detainees at risk of self-harm should be developed. (4.22)

7.9 A schedule of fire evacuation tests should be implemented. (4.31)

7.10 All detainees held overnight, or who require one, should be offered a shower, which they should be able to take with a reasonable level of privacy. (4.37)

7.11 Detainees held for longer periods should be offered outdoor exercise. (4.46)

Individual rights

7.12 Custody staff should ensure that detainees' dependency issues are identified and, where possible, addressed. (5.6)

7.13 Comprehensive risk assessments and, if appropriate, care plans should be completed before release for all vulnerable detainees. (5.7)

7.14 Appropriate adults should be readily available to support vulnerable adults in custody, including out of hours. (5.16)

7.15 All evidential samples taken from suspected drunk drivers should be submitted for analysis in a timely fashion. (5.17)

7.16 The force should instigate discussions with the court service to extend court cut-off times. (5.18)

7.17 Detainees should be told how to make a complaint and should be facilitated to do so before they leave custody. (5.22)

Health care

7.18 There should be robust infection control procedures for all the clinical rooms, which should be clean and capable of being used for the taking of forensic samples. (6.9)

7.19 Custody staff should have access to a full range of appropriate first-aid and resuscitation equipment. (6.10)

7.20 The detainee assessment at point of arrest (DAPA) scheme at Wolverhampton custody suite should be resurrected and the model adapted across the force, to ensure that detainees with mental health problems are identified and diverted to appropriate services as soon as possible. (6.38)

7.21 Police custody should only be used as a place of safety for section 136 assessments in exceptional cases. (6.39)

Housekeeping points

Treatment and conditions

7.22 Female detainees should be routinely offered hygiene products. (4.12)

7.23 Portable hearing loops should be available in the designated custody suites and staff should be trained to operate them. (4.13)

7.24 Arresting officers should always provide custody sergeants with all of the available background information when a detainee is being brought into custody suites. (4.23)

7.25 Nicotine replacement items should be introduced. (4.32)

7.26 Pillows and blankets should be offered to detainees. (4.38)

7.27 Mattresses should be wiped clean after each use. (4.39)

7.28 All cells should contain a supply of toilet paper. (4.40)

7.29 Replacement underwear should be available in all custody suites. (4.41)

7.30 A range of reading material should be provided. (4.47)

Individual rights

7.31 When the investigation allows, detainees should be able to make telephone calls with some degree of privacy. (5.8)

7.32 Information leaflets should be given to detainees when being released. (5.9)

Health care

7.33 Medical information, such as the *British National Formulary*, should be up to date. (6.11)

7.34 Patient information leaflets should be accessible in all custody suites. (6.12)

7.35 Health services staff at all custody suites should offer clean needles and syringes to injecting drug users who are being released into the community. (6.29)

Good practice

Strategy

7.36 An electronic force-wide 'whiteboard' had been introduced for directing detainees to custody suites which were best able to deal with them, thereby managing risk more effectively. (3.16)

7.37 The introduction of a single electronic file, which interfaced directly with Crown Prosecution Service systems, had reduced the bureaucratic burden of administration in criminal justice units. (3.17)

7.38 Mental health templates had been adopted by the Offender Health Department for use by other forces and agencies. (3.18)

Health care

7.39 The system for recording the administration of medications at Steelhouse Lane, where detainees signed to acknowledge receipt of the medication, was effective and should be replicated in other custody suites. (6.18)

7.40 The drug intervention workers across the West Midlands had well-established services for engaging with prolific or priority offenders and high crime-causing users. (6.30)

7.41 Good work had been undertaken at both the strategic and operational level around the care of detainees arrested under section 136 of the Mental Health Act 1983. (6.40)

Appendix I: Inspection team

Sean Sullivan	HMIP team leader
Vinnett Pearcy	HMIP inspector
Karen Dillon	HMIP inspector
Ian Macfadyen	HMIP inspector
Gordon Riach	HMIP inspector
Paddy Craig	HMIC inspector
Fiona Shearlaw	HMIC inspector
Mark Ewan	HMIC inspector
David Thompson	HMIC inspector
Simon Meegan	HMIC inspector
Cliff Law	HMIC inspector
Elizabeth Tysoe	HMIP health care inspector
Helen Carter	HMIP health care inspector
Jan Fooks Bale	CQC inspector
Adam Altoft	HMIP researcher
Amy Summerfield	HMIP researcher

Appendix II: Summary of detainee questionnaires and interviews

Detainee survey methodology

A voluntary, confidential and anonymous survey of the prisoner population, who had been through a police station in the West Midlands, 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 4 October 2010. A list of potential respondents to have passed through police stations in the West Midlands was created, listing all those who had arrived from Birmingham, Sutton Coldfield, Walsall, Wolverhampton, Coventry, Dudley, Halesowen, Solihull or Warley magistrates' court within the previous two months.

Selecting the sample

In total, 129 respondents were approached. Nine reported being held in police stations outside of the West Midlands. On the day, the questionnaire was offered to 120 respondents; there were four refusals, four questionnaires returned blank and five non-returns. All of those sampled had been in custody within the previous two months.

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

Methodology

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

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

- to 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; or
- to seal the questionnaire in the envelope provided and leave it in their room for collection.

Response rates

In total, 107 (89%) respondents completed and returned their questionnaires.

Comparisons

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

Some questions have been filtered according to the response to a previous question. Filtered questions are clearly indented and preceded by an explanation as to which respondents are included in the filtered questions. Otherwise, percentages provided refer to the entire sample. All missing responses were 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 33 police areas since April 2008.

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

Summary

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

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

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

Police custody survey

Section 1: About you

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

Wolverhampton central – 11; Wednesfield – 1; Walsall – 5; Bloxwich – 4; West Bromwich – 9; Smethwick – 5; Sutton Coldfield – 11; Aston – 5; Steelhouse Lane – 1; Handsworth – 3; Stechford – 1; Kings Heath – 4; Bournville – 3; Harborne – 4; Coventry central – 13; Brierley Hill – 11; Halesowen – 4; Solihull – 6; Stourbridge – 2.

No respondents had been through Wednesbury, Erdington, Digbeth, Edgbaston, Solihull North or Willenhall.

Four respondents did not identify the police stations they had been through.

Q3 **How old are you?**

16 years or younger	0 (0%)	*40-49 years*	14 (13%)
17-21 years	2 (2%)	*50-59 years*	2 (2%)
22-29 years	47 (44%)	*60 years or older*	0 (0%)
30-39 years	42 (39%)		

Q4 **Are you:**

Male	107 (100%)
Female	0 (0%)
Transgender/transsexual	0 (0%)

Q5 **What is your ethnic origin?**

White - British	74 (70%)
White - Irish	3 (3%)
White - other	3 (3%)
Black or black British - Caribbean	6 (6%)
Black or black British - African	2 (2%)
Black or black British - other	0 (0%)
Asian or Asian British - Indian	4 (4%)
Asian or Asian British - Pakistani	7 (7%)
Asian or Asian British - Bangladeshi	1 (1%)
Asian or Asian British - other	0 (0%)
Mixed heritage - white and black Caribbean	5 (5%)
Mixed heritage - white and black African	0 (0%)
Mixed heritage- white and Asian	0 (0%)
Mixed heritage - Other	1 (1%)
Chinese	0 (0%)
Other ethnic group	0 (0%)

Q6 **Are you a foreign national (i.e. you do not hold a British passport, or you are not eligible for one)?**

Yes	7 (8%)
No	83 (92%)

Q7 What, if any, would you classify as your religious group?

None	29 (29%)
Church of England	40 (40%)
Catholic	12 (12%)
Protestant	0 (0%)
Other Christian denomination	2 (2%)
Buddhist	1 (1%)
Hindu	0 (0%)
Jewish	0 (0%)
Muslim	13 (13%)
Sikh	4 (4%)

Q8 How would you describe your sexual orientation?

Straight/heterosexual	106 (99%)
Gay/lesbian/homosexual	0 (0%)
Bisexual	1 (1%)

Q9 Do you consider yourself to have a disability?

Yes	23 (21%)
No	84 (79%)

Q10 Have you ever been held in police custody before?

Yes	104 (98%)
No	2 (2%)

Section 2: Your experience of this custody suite

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

Q11 How long were you held at the police station?

Less than 24 hours	32 (30%)
More than 24 hours, but less than 48 hours (2 days)	43 (41%)
More than 48 hours (2 days), but less than 72 hours (3 days)	24 (23%)
72 hours (3 days) or more	6 (6%)

Q12 Were you given information about your arrest and your entitlements when you arrived there?

Yes	87 (82%)
No	14 (13%)
Don't know/Can't remember	5 (5%)

Q13 Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')?

Yes	68 (64%)
No	30 (28%)
I don't know what this is/I don't remember	9 (8%)

Q14 If your clothes were taken away, were you offered different clothing to wear?

My clothes were not taken	59 (60%)
I was offered a tracksuit to wear	23 (23%)
I was offered an evidence/ paper suit to wear	4 (4%)

I was offered a blanket 8 (8%)
Nothing 4 (4%)

Q15 Could you use a toilet when you needed to?
Yes 90 (87%)
No 12 (12%)
Don't know 2 (2%)

Q16 If you have used the toilet there, was toilet paper provided?
Yes 57 (56%)
No 45 (44%)

Q17 Did you share a cell at the police station?
Yes 2 (2%)
No 105 (98%)

Q18 How would you rate the condition of your cell:

	Good	*Neither*	*Bad*
Cleanliness	39 (37%)	29 (28%)	37 (35%)
Ventilation/air quality	25 (26%)	24 (24%)	49 (50%)
Temperature	20 (21%)	20 (21%)	56 (58%)
Lighting	44 (46%)	30 (32%)	21 (22%)

Q19 Was there any graffiti in your cell when you arrived?
Yes 56 (53%)
No 49 (47%)

Q20 Did staff explain to you the correct use of the cell bell?
Yes 13 (12%)
No 93 (88%)

Q21 Were you held overnight?
Yes 99 (93%)
No 8 (7%)

Q22 If you were held overnight, which items of clean bedding were you given?
Not held overnight 8 (7%)
Pillow 5 (5%)
Blanket 74 (67%)
Nothing 24 (22%)

Q23 Were you offered a shower at the police station?
Yes 6 (6%)
No 100 (94%)

Q24 Were you offered any period of outside exercise while there?
Yes 3 (3%)
No 103 (97%)

Q25 Were you offered anything to:

	Yes	*No*
Eat?	77 (73%)	29 (27%)
Drink?	87 (89%)	11 (11%)

Q26 What was the food/drink like in the police custody suite?

Very good	*Good*	*Neither*	*Bad*	*Very bad*	*N/A*
1 (1%)	5 (5%)	19 (18%)	24 (23%)	46 (45%)	8 (8%)

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

I did not have any food or drink	9 (9%)
Yes	34 (36%)
No	52 (55%)

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

I do not smoke	11 (10%)
I was allowed to smoke	6 (6%)
I was not offered anything to cope with not smoking	87 (83%)
I was offered nicotine gum	1 (1%)
I was offered nicotine patches	0 (0%)
I was offered nicotine lozenges	0 (0%)

Q29 Were you offered anything to read?

Yes	4 (4%)
No	102 (96%)

Q30 Was someone informed of your arrest?

Yes	49 (47%)
No	36 (35%)
I don't know	5 (5%)
I didn't want to inform anyone	14 (13%)

Q31 Were you offered a free telephone call?

Yes	58 (55%)
No	48 (45%)

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

My telephone call was not denied	64 (65%)
Yes	6 (6%)
No	29 (29%)

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

	Yes	*No*
Who was taking care of your children	5 (6%)	75 (94%)
Contacting your partner, relative or friend	42 (45%)	52 (55%)
Contacting your employer	3 (4%)	72 (96%)
Where you were going once released	18 (22%)	63 (78%)

Q34 Were you interviewed by police officials about your case?

Yes	86 (82%)	
No	19 (18%)	If No, go to Q36

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

	Yes	*No*	*Not needed*
Solicitor	57 (66%)	19 (22%)	10 (12%)
Appropriate adult	0 (0%)	20 (42%)	28 (58%)
Interpreter	1 (2%)	19 (40%)	28 (58%)

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

I did not request a solicitor	34 (36%)
2 hours or less	15 (16%)
Over 2 hours but less than 4 hours	12 (13%)
4 hours or more	34 (36%)

Section 3: Safety

Q38 **Did you feel safe there?**

Yes	64 (62%)
No	39 (38%)

Q39 **Did another detainee or a member of staff victimise (insult or assault) you there?**

Yes	42 (40%)
No	63 (60%)

Q40 **If you have felt victimised, what did the incident involve? (Please tick all that apply to you.)**

I have not been victimised	63 (48%)	*Because of your crime*	15 (11%)
Insulting remarks (about you, your family or friends)	21 (16%)	*Because of your sexuality*	1 (1%)
Physical abuse (being hit, kicked or assaulted)	5 (4%)	*Because you have a disability*	1 (1%)
Sexual abuse	1 (1%)	*Because of your religion/religious beliefs*	0 (0%)
Your race or ethnic origin	2 (2%)	*Because you are from a different part of the country than others*	3 (2%)
Drugs	19 (15%)		

Q41 **Were your handcuffs removed on arrival at the police station?**

Yes	73 (70%)
No	18 (17%)
I wasn't handcuffed	13 (13%)

Q42 **Were you restrained while in the police custody suite?**

Yes	14 (14%)
No	89 (86%)

Q43 **Were you injured while in police custody, in a way that you feel was not your fault?**

Yes	15 (14%)
No	89 (86%)

Q44 **Were you told how to make a complaint about your treatment if you needed to?**

Yes	11 (11%)
No	92 (89%)

Section 4: Health care

Q46 **Did you need to take any prescribed medication when you were in police custody?**

Yes	73 (71%)
No	30 (29%)

Q47 **Were you able to continue taking your prescribed medication while there?**

Not taking medication	30 (30%)
Yes	33 (33%)
No	36 (36%)

Q48 **Did someone explain your entitlements to see a health care professional if you needed to?**

Yes	54 (53%)
No	42 (42%)
Don't know	5 (5%)

Q49 **Were you seen by the following health care professionals during your time there?**

	Yes	*No*
Doctor	67 (70%)	29 (30%)
Nurse	42 (56%)	33 (44%)
Paramedic	3 (6%)	44 (94%)
Psychiatrist	2 (4%)	46 (96%)

Q50 **Were you able to see a health care professional of your own gender?**

Yes	38 (38%)
No	43 (43%)
Don't know	20 (20%)

Q51 **Did you have any drug or alcohol problems?**

Yes	76 (74%)
No	27 (26%)

Q52 **Did you see, or were offered the chance to see, a drug or alcohol support worker?**

I didn't have any drug/alcohol problems	27 (26%)
Yes	51 (50%)
No	25 (24%)

Q53 **Were you offered relief or medication for your immediate symptoms?**

I didn't have any drug/alcohol problems	27 (27%)
Yes	41 (41%)
No	31 (31%)

Q54 **Please rate the quality of your health care while in police custody:**

I was not seen by health care staff	*Very good*	*Good*	*Neither*	*Bad*	*Very bad*
23 (23%)	3 (3%)	28 (28%)	11 (11%)	21 (21%)	15 (15%)

Q55 **Did you have any specific <u>physical</u> health care needs?**

No	74 (71%)
Yes	30 (29%)

Q56 **Did you have any specific mental health care needs?**

No	83 (81%)
Yes	20 (19%)

Thank you for your time.

Prisoner survey responses for West Midlands 2010

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

Key to tables

		2010 West Midlands	Police custody comparator
	Any percentage highlighted in green is significantly better		
	Any percentage highlighted in blue is significantly worse		
	Any percentage 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		107	1098
SECTION 1: General information			
3	Are you under 21 years of age?	**2%**	**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)?	**25%**	**34%**
6	Are you a foreign national?	**8%**	**16%**
7	Are you Muslim?	**13%**	**12%**
8	Are you homosexual/gay or bisexual?	**1%**	**2%**
9	Do you consider yourself to have a disability?	**22%**	**20%**
10	Have you been in police custody before?	**98%**	**90%**
SECTION 2: Your experience of this custody suite			
For the most recent journey you have made either to or from court or between prisons:			
11	Were you held at the police station for over 24 hours?	**70%**	**65%**
12	Were you given information about your arrest and entitlements when you arrived?	**82%**	**73%**
13	Were you told about PACE?	**64%**	**51%**
14	If your clothes were taken away, were you given a tracksuit to wear?	**59%**	**44%**
15	Could you use a toilet when you needed to?	**87%**	**90%**
16	If you did use the toilet, was toilet paper provided?	**56%**	**50%**
17	Did you share a cell at the station?	**2%**	**3%**
18	Would you rate the condition of your cell, as 'good' for:		
18a	Cleanliness?	**37%**	**30%**
18b	Ventilation/air quality?	**26%**	**21%**
18c	Temperature?	**21%**	**14%**
18d	Lighting?	**46%**	**44%**
19	Was there any graffiti in your cell when you arrived?	**53%**	**56%**
20	Did staff explain the correct use of the cell bell?	**12%**	**22%**
21	Were you held overnight?	**93%**	**92%**
22	If you were held overnight, were you given **no** clean items of bedding?	**23%**	**30%**
23	Were you offered a shower?	**6%**	**9%**
24	Were you offered a period of outside exercise?	**3%**	**7%**
25a	Were you offered anything to eat?	**73%**	**80%**
25b	Were you offered anything to drink?	**89%**	**82%**
	For those who had food:		
26a	Was the quality of the food and drink you received 'good'/'very good'?	**6%**	
26b	Was the food/drink you received suitable for your dietary requirements?	**40%**	**45%**
27	For those who smoke: were you offered **nothing** to help you cope with the ban there?	**83%**	**77%**
28	Were you offered anything to read?	**4%**	**14%**
29	Was someone informed of your arrest?	**47%**	**43%**
30	Were you offered a free telephone call?	**55%**	**51%**

Key to tables

		2010 West Midlands	Police custody comparator
	Any percentage highlighted in green is significantly better		
	Any percentage highlighted in blue is significantly worse		
	Any percentage highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
31	If you were denied a free call, was a reason given?	**17%**	**15%**
32	Did you have any concerns about:		
32a	Who was taking care of your children?	**6%**	**16%**
32b	Contacting your partner, relative or friend?	**45%**	**53%**
32c	Contacting your employer?	**4%**	**21%**
32d	Where you were going once released?	**22%**	**31%**
34	If you were interviewed were the following people present:		
34a	Solicitor	**66%**	**73%**
34b	Appropriate adult	**0%**	**8%**
34c	Interpreter	**2%**	**7%**
35	Did you wait over four hours for your solicitor?	**56%**	**66%**
SECTION 3: Safety			
39	Did you feel unsafe?	**38%**	**41%**
40	Has another detainee or a member of staff victimised you?	**40%**	**41%**
41	If you have felt victimised, did the incident involve:		
41a	Insulting remarks (about you, your family or friends)?	**20%**	**20%**
41b	Physical abuse (being hit, kicked or assaulted)?	**5%**	**14%**
41c	Sexual abuse?	**1%**	**2%**
41d	Your race or ethnic origin?	**2%**	**6%**
41e	Drugs?	**18%**	**15%**
41f	Your crime?	**14%**	**17%**
41g	Your sexuality?	**1%**	**1%**
41h	Your disability?	**1%**	**3%**
41i	Your religion/religious beliefs?	**0%**	**3%**
41j	Was it because you are from a different part of the country than others?	**3%**	**4%**
42a	Were your handcuffs removed on arrival at the police station?	**80%**	**76%**
42b	Were you restrained while in the police custody suite?	**14%**	**10%**
43	Were you injured while in police custody, in a way that you feel is not your fault?	**14%**	**25%**
44	Were you told how to make a complaint about your treatment?	**11%**	**14%**
SECTION 4: Health care			
46	Did you need to take any prescribed medication when you were in police custody?	**71%**	**41%**
47	For those who were on medication: were you able to continue taking your medication?	**48%**	**40%**
48	Did someone explain your entitlement to see a health care professional if you needed to?	**54%**	**35%**
49	Were you seen by the following health care professionals during your time in police custody:		
49a	Doctor	**70%**	**49%**
49b	Nurse	**56%**	**16%**
	Percentage seen by either a doctor or a nurse	**77%**	**53%**
49c	Paramedic	**6%**	**4%**
49d	Psychiatrist	**4%**	**3%**
50	Were you able to see a health care professional of your own gender?	**38%**	**28%**
51	Did you have any drug or alcohol problems?	**74%**	**53%**
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?	**67%**	**42%**
53	Were you offered relief medication for your immediate symptoms?	**57%**	**32%**
54	For those who had been seen by health care staff, would you rate the quality as good/very good?	**40%**	**29%**
55	Do you have any specific physical health care needs?	**29%**	**33%**
56	Do you have any specific mental health care needs?	**19%**	**24%**