Report on an unannounced inspection visit to police custody suites in

Cheshire

by HM Chief Inspector of Prisons
and HM Inspectorate of Constabulary

16–20 April 2013

Glossary of terms

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HM Inspectorate of Constabulary at 6th Floor, Globe House, 89 Eccleston Square, London SW1V 1PN, or haveyoursay@hmic.gsi.gov.uk

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

Contents

Section 1. Introduction 5

Section 2. Background and key findings 7

Section 3. Strategy 11

Section 4. Treatment and conditions 15

Section 5. Individual rights 21

Section 6. Health care 27

Section 7. Summary of recommendations 31

Section 8. Appendices 35

Appendix I: Inspection team 35

Appendix II: Summary of detainee questionnaires and interviews 37

Section 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. The inspections look at strategy, treatment and conditions, individual rights and health care.

The inspection of Cheshire police indicated a generally good approach to the provision of custody services. Some improvements were identified, but staff were engaged and detainee welfare was good. Senior managers were actively involved in the management of risk and there were some good policies for the care of young people. Managers routinely monitored local authority provision of bed spaces for young people in custody and there were other positive initiatives, such as a targeted information leaflet for young people, although some staff on the frontline did not always know about these. The force needs to review how these good initiatives can be better promoted, sustained and translated into practice.

Cheshire provided three modern purpose-built custody suites across the county. They were among the best structures we have inspected. The suites were clean, had little graffiti and were well maintained. Safety checks were undertaken but not always recorded. There was good evidence of team and individual working, and positive staff morale relating to detainee care. Staff required little direction and often anticipated and responded to custody demands.

Detainees were treated with respect and courtesy. The risk assessments we observed were thorough and normally coherent, identifying need and welfare issues. However, we also observed some practice that remained risk averse, with disproportionate outcomes that took too little account of individual circumstance. Arrangements for the management of shift handovers were weak. Insufficient time had been allocated and, critically, often excluded the detention officers.

Video-enabled courts were in operation and worked well, ensuring detainees could be dealt with quickly. It was concerning, however, that some detainees, ostensibly for risk management reasons, were presented to the court inappropriately in rip-proof clothing rather than being properly dressed. This was disproportionate and disrespectful.

The force adhered to the Police and Criminal Evidence Act (PACE) definition of a child, treating 17-year-olds as adults, whereas in all other UK law and treaty obligations they are treated as children. We therefore made our standard recommendation, calling for appropriate adults to be available to support 17-year-olds, as well as other children and young people. In April 2013, the High Court ruled that the PACE definition was incompatible with human rights law, and the government announced that it would accept this judgment. We welcome this move, but will continue to include this recommendation until there is a change in the law.

Health care provision was generally good, with good contract management arrangements, although these were due to change. It was easy for detainees to see a health care professional as there was usually a nurse in each of the three suites at all times. Detainees told us that they were treated respectfully.

Overall, Cheshire provides a good quality custody service in very good purpose-built facilities. This report provides a number of recommendations to assist the force and the Police and Crime

Commissioner to improve provision further. We expect our findings to be considered in the wider context of priorities and resourcing, and for an action plan to be provided in due course.

Thomas P Winsor
HM Chief Inspector of Constabulary

Nick Hardwick
HM Chief Inspector of Prisons

June 2013

Section 2. Background and key findings

2.1 This report is one in a series relating to inspections of police custody carried out jointly by HM Inspectorates of Prisons and Constabulary. These inspections form part of the joint work programme of the criminal justice inspectorates and contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorates of Prisons and Constabulary are two of several bodies making up the NPM in the UK.

2.2 The inspections of police custody look beyond the implementation of the Police and Criminal Evidence Act 1984 (PACE) codes of practice and the Association of Chief Police Officers (ACPO) *Authorised Professional Practice - Detention and Custody* at force-wide strategies, treatment and conditions, individual rights and health care. They are also informed by a set of *Expectations for Police Custody*[1] about the appropriate treatment of detainees and conditions of detention, developed by the two inspectorates to assist best custodial practice.

2.3 Cheshire Police had three full-time designated custody suites, with a total cell capacity of 90. The force had held 21,759 detainees in the 12 months to March 2013, and 128 detainees had been held for immigration matters during that year. There was also a stand-by suite, which had been used once in the previous 12 months.

2.4 The designated custody suites and cell capacity of each were as follows:

Custody suite	Number of cells
Blacon, Chester	20
Middlewich	35
Runcorn	35

2.5 A survey of prisoners at HMP Altcourse who had formerly been detained in the Cheshire custody suites was conducted by an HM Inspectorate of Prisons researcher and inspector (see Appendix II).

Strategy

2.6 All custody sergeants had received adequate initial training and regular refresher training. The situation for detention officers (DOs) was less effective; recently recruited staff had not been provided with initial training and no DOs received regular refresher training.

2.7 Senior officers were active in the management of custody through regular meetings and monitoring of performance indicators. Partnership arrangements were particularly effective, with a number of initiatives being driven through these multi-agency fora. This included strict

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

monitoring of the local authority's ability to accommodate young people when remanded in custody. However, some strategic policies relating to young people were not being delivered in practice.

2.8 There were good systems for reporting successful interventions in custody. Quality assurance of custody records was systematic, but did not include person escort record (PER) forms or cross-referencing to closed-circuit television (CCTV). There was no effective monitoring of shift handovers. Policies and Independent Police Complaints Commission (IPCC) documents were accessible on the force intranet.

Treatment and conditions

2.9 All custody staff dealt with detainees positively and professionally, with due attention to vulnerabilities and risks. Sergeants tried to manage staff and detainee movement within the suites, but this was not always effective and there was a general lack of privacy when booking-in detainees.

2.10 Female detainees were generally dealt with by a female member of staff. There were good initiatives for dealing with children and young people, but custody staff appeared to be unaware of some of them.

2.11 There was no systematic approach to the handover of information during shift changes. Contrary to our expectation, which is that there should be a whole team handover, there were one-to-one briefings which excluded DOs, and not all handover information was comprehensive.

2.12 All risk assessments were carried out thoroughly. Sergeants asked supplementary questions, paid attention to detainees' individual circumstances, and were well attuned to specific needs, such as self-harm and health care requirements. Appropriate levels of observations were set, based on risk, and reviewed and amended. Shoes and clothes with cords were removed routinely, rather than on the basis of a risk assessment. Prior to release, staff completed a risk assessment but sometimes they were poorly completed.

2.13 There was effective communication and team working between sergeants and DOs regarding the ongoing care of detainees. The use of safety clothing was inconsistent, the rationale for its use was not always clearly recorded in the custody record and its continued need was not reviewed.

2.14 Not all staff carried anti-ligature knives, and some said that they had not been trained in their use, leading to a lack of confidence in carrying them. Staff also commented on the fragility of the knives issued.

2.15 Although staff had to complete a form when force was used outside the custody suite, there was no systematic process for recording the use of force in the custody environment. Data on use of force in custody were therefore not retrievable or analysed to identify trends or learning.

2.16 The physical conditions of the custody suites were good, with little dirt and almost no graffiti. At Runcorn and Middlewich, cell keys were inappropriately routinely handed to non-custody staff, to collect detainees for interview or to bring them to the custody desk for processing.

2.17 There were exercise facilities at each of the custody suites. We observed good use of the exercise yards during the inspection, but this was not reflected in our custody record

analysis, which showed that detainees being held for over 41 hours had not been offered outside exercise.

Individual rights

2.18 Custody sergeants ensured that there were appropriate grounds for detention, and custody sergeants were clear about their obligations to ensure that cases proceeded quickly. Detainees were offered a copy of PACE codes of practice but they were out of date.

2.19 The force adhered to the PACE definition of a child instead of that in the Children Act 1989.[2] The attendance of appropriate adults (AAs) was generally timely, other than between 4pm and 6pm, during the handover period from day to night services.

2.20 Posters on display at Middlewich and Runcorn, but not at Blacon, advised detainees of their right to free legal advice. All detainees were told that they could inform someone of their arrest The management of DNA samples was good.

2.21 Reviews of detainees in custody were undertaken by dedicated PACE inspectors, who were based across the three custody suites. Few face-to-face PACE reviews were carried out, whereby detainees could make representations about their continued detention.

2.22 Court cut-off times were reasonable, with some flexibility from day to day. Staff reported no major issues with these cut-off times because of the availability of the video-enabled courts (VECs) as these were held beyond the cut-off times. VECs were conducted professionally. However, we saw two detainees being presented to the court while still wearing rip-proof clothing. Detainees attending court who were subsequently discharged were given travel warrants to make their way home but those discharged from VECs were not, resulting in a difference of treatment that impacted negatively.

2.23 The notice of rights and entitlements, which was given to all detainees being booked in, detailed the processes for making a complaint. The process for taking complaints was generally sound.

Health care

2.24 Clinical governance working arrangements were robust. The current health care contract was well monitored by the force but was about to change, and communication about the new contract, which involved a more proactive style of working, had not filtered down to nursing staff working in the suites. There was no clinical supervision of nursing staff. Although up-to-date training on resuscitation had been provided, no staff had undertaken safeguarding training or infection control updates. Treatment rooms in the three main suites were reasonable.

2.25 There was usually a nurse based in each of the custody suites at all times. Not all detainees were able to receive previously prescribed medications while in custody. Staff were unclear about the policy regarding opiate substitution medications, and methadone was not generally administered, even when it was appropriate to do so.

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[2] In all other UK law and international treaty obligations, 17-year-olds are treated as children. In April 2013, the High Court ruled that the PACE definition was incompatible with human rights law.

2.26 Clinical records were comprehensive, conformed to professional guidance, were stored appropriately and were regularly audited. However, the process for a detainee or their legal representative to obtain a copy of their clinical records was cumbersome.

Main recommendations

2.27 There should be arrangements to ensure that custody staff understand and comply with policies and initiatives pertaining to young people.

2.28 Handovers should be comprehensive and attended by all detention officers and police custody staff, and take place with appropriate regard for the privacy of detainees.

2.29 All detainees should be able to continue to receive previously prescribed medication while in custody.

National issue

2.30 Appropriate adults should be available at all times to support without undue delay detained young people aged 17, provided that informed consent has been given.

Section 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 well-being of detainees.

Strategic management

3.1 The assistant chief constable (ACC) provided strategic leadership on custody issues, with a centralised custody function delivered through the Criminal Justice and Custody Department (CJCD). The head of the CJCD was a superintendent, and he line-managed the chief inspector, head of custody.

3.2 The force estate had three full-time custody suites. These suites were virtually identical in specification, with the exception of cell capacity. There were no current plans to rationalise the estate further. The design and condition of these suites were excellent.

3.3 Although detainees were generally conveyed to their local custody area, the on-duty PACE inspector provided management oversight of suite capacity. This resulted in the prompt reception of detainees.

3.4 Staffing levels in custody suites during the inspection were adequate. Staffing comprised permanent custody sergeants and police staff DOs, employed by Cheshire Constabulary. Custody sergeants line-managed DOs, who were responsible for the ongoing care and welfare of detainees. DOs were proactive in their duties, requiring minimal direction from custody sergeants. They had specific roles and worked effectively to provide a good standard of care. There was a high degree of uniformity of operation, team working and a positive morale across the suites.

3.5 There were seven dedicated PACE custody inspectors, line-managed by the chief inspector, head of custody, and they provided 24/7 custody coverage, line-managing the custody sergeants. They also provided critical incident management cover for the force after 2am, as well as having specific portfolio areas of responsibility, such as training, health care and young people. PACE inspectors were visible and active in custody.

3.6 There was an effective meeting structure, whereby custody matters were discussed and reviewed. The chief officer group reviewed the organisational risk register, which featured custody, at weekly and monthly meetings. The Deputy Chief Constable (DCC) chaired a monthly force strategic board, where custody performance and issues could be raised by the ACC custody lead. The DCC also chaired the gold group meetings for the Rule 43 Coroners reports,[3] with the subsequent action plan and learning being monitored through the head of the Professional Standards Department.

3.7 The head of custody held a monthly PACE inspectors meeting, which reviewed custody performance. There was no specific custody user forum for practitioners but there were opportunities for custody sergeants to raise issues with managers at the eight weekly training

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[3] Rule 43 of the Coroners Rules 1984 (as amended) provides coroners with the power to make reports to a person or organisation where the coroner believes that action should be taken to prevent future deaths.

days. The shift pattern of DOs did not include these training days, so it was less clear how they could raise issues.

3.8 The meeting structure was underpinned by a comprehensive monthly performance package, which included custody management information.

Partnerships

3.9 There were productive partnership arrangements and active strategic engagement with relevant criminal justice partners. The head of probation had recently taken over from the chief constable as chair of the Local Criminal Justice Board (LCJB), which was also attended by the ACC custody lead. The video-enabled courts (VECs) initiative had been progressed through this forum. A multi-agency Strategic Public Protection Board had been responsible for overseeing some innovative approaches to dealing with young persons, such as using police custody only as a last resort and strict monitoring of the local authority's capacity to accommodate overnight remands (which was reducing the number of young people staying overnight in police cells), although custody staff seemed unaware of some of these initiatives (see section on treatment and conditions).

3.10 Together with the head of custody, the ACC attended the Healthcare Commissioning Board, which was overseeing the transfer to the NHS commissioning of health care services for police custody. The force was in the final stages of this process, and the preferred health care provider, Tascor, was due to start the delivery of services under this initiative from May 2013.

3.11 There was an independent custody visitors (ICV) coordinator in the Police and Crime Commissioner's (PCC) office. The ICV scheme consisted of three panels providing a regular schedule of visits. ICVs told us that they were generally admitted to custody suites quickly and felt able to raise any concerns with custody staff.

Good practice

3.12 *The multi-agency Strategic Public Protection Board monitored the local authority's capacity to accommodate young people remanded overnight, thereby reducing the number of young people staying overnight in police cells.*

Learning and development

3.13 All custody sergeants had undergone a two-week custody-specific training course before undertaking custody duties. The course was linked to the national custody officer learning programme (NCOLP) of the College of Policing. Most DOs had undergone initial custody-specific training while employed by a private company, before transferring across to Cheshire Constabulary when the contract with the company ended. However, a small number of DOs employed by Cheshire Constabulary in the front office, and redeployed to the custody suite, had not been provided with initial training prior to working in the suite. Affected staff told us that they lacked confidence, for example in carrying anti-ligature knives.

3.14 The shift pattern for custody sergeants allowed for a custody refresher training day every eight weeks. DOs had received no formal refresher training but the force was addressing this gap, with six monthly refresher training events due to start imminently.

3.15 The force had a number of custody policies, which were accessible to all staff on the custody intranet site. The IPCC 'learning the lessons' document was also available on the custody intranet site. Staff awareness of the custody intranet site and how to access information was reasonable.

3.16 There were good systems for reporting successful interventions (where the intervention of staff averts a serious incident) in custody. Immediate issues were dealt with via email. Successful interventions were also subject to analysis as part of the monthly performance package, and were reviewed at custody management meetings and the force health and safety meetings.

3.17 There was a quality assurance process for sampling custody records. Each PACE inspector was required to dip-sample two custody records per sergeant per month. In addition, PACE inspectors were required to undertake real-time sampling of custody records during their tour of duty, supplementing the formal dip-sampling.

3.18 The completion of PERs was supervised by custody sergeants but they were not included in the dip-sampling process. Dip-sampling of custody records was not cross-referenced to CCTV. There was no quality assurance of shift handovers.

Recommendation

3.19 **All detention officers (DOs) should be provided with an initial custody training course before being deployed in custody, and regular refresher training thereafter.**

Housekeeping points

3.20 DOs' shift patterns should include training days, to give them opportunities to raise issues.

3.21 Quality assurance processes should include the cross-referencing of dip-sampled custody records to closed-circuit television, and include person escort record forms and shift handovers.

Section 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 Custody staff communicated with each other and with detainees in a professional and respectful manner. Staff, particularly the DOs, demonstrated a proactive approach and worked collaboratively with the custody sergeants. DOs participated in the booking-in of detainees, conducting searches, completing Police National Computer (PNC) checks, often working on their own initiative but liaising appropriately with custody sergeant when required. Custody staff demonstrated a good level of experience, knowledge and understanding of custody.

4.2 The custody suites lacked privacy for detainees being booked in and conversations could often be overheard. There was a separate room at all three suites that could be used to book in detainees if necessary but we were told at all of the suites that this was rarely used.

4.3 At Blacon custody suite, in particular, we observed the suite become crowded with detainees, police officers and other non-custody staff. Although we saw custody sergeants trying to manage this by directing staff away from the booking-in desks, this did not always resolve the issue.

4.4 Custody staff were aware of diversity issues, and the good mix of male and female DOs on each shift made it possible for female DOs primarily to deal with the personal care of women. We saw this happening during the inspection.

4.5 There were two designated cells for children and young people at Runcorn and Middlewich custody suites, and there was one at Blacon. These were situated close to the booking-in desk and were monitored by CCTV, but otherwise did not differ from the other cells. Although the force had made efforts to provide for young people in custody (including an age-appropriate magazine (called FACT2), a private booking-in area and automatic referral to the health care practitioner; see also section on strategy), not all staff were aware of FACT2, or of the facility to take young people to a private booking-in area (see main recommendation 2.27). The FACT2 magazine had been produced in 2009 and was out of date.

4.6 Each of the custody suites had a cell with a lowered cell call bell so that a detainee could press the button from a seated position. A section of the booking-in desk had been lowered to enable detainees using a wheelchair to communicate with the custody sergeant with a good line of sight. Wheelchairs, an adapted toilet and step-free access to all the custody suites were available. Each suite also had a parent and baby room but staff told us that these were rarely used because of a lack of need. None of the staff knew if hearing loops were installed at the booking-in desks, although we found these at both Blacon and Runcorn. These facilities had been provided when the suites had been built, but staff had not been made aware of them.

4.7 Detainees were asked during booking-in if they had any religious or dietary needs. Prayer mats, a compass, a Qur'an, several Bibles and other religious books were available at all three custody suites and there were instructions about their handling. Custody staff told us

that they were rarely used. The custody suites also contained some information about Muslim prayers, including the times they were conducted and what was required.

4.8 Custody sergeants and DOs were aware of the needs of transgender detainees in relation to searching. One DO gave a good account of how she had treated a transgender detainee in this regard.

Recommendation

4.9 Booking-in desks should allow private communication between custody staff, detainees and their legal representatives.

Housekeeping points

4.10 Custody sergeants at Blacon should maintain better control of the number of staff waiting in the booking-in area.

4.11 Staff should familiarise themselves with the use of equipment such as hearing loops.

Safety

4.12 Custody sergeants carried out the initial risk assessment and explained its purpose to detainees. They asked probing questions if detainees divulged that they had harmed themselves in the past or if there were health concerns. We saw a custody sergeant checking marks on a detainee's wrist and asking how they had been caused. DOs checked the PNC for all of the detainees we saw being booked in, and warning markers were noted.

4.13 At Runcorn we saw a detainee arrive handcuffed after being arrested during a drugs warrant search. He was kept in a holding area for approximately 20 minutes until being brought before the custody sergeant. During booking-in, the arresting officers told the custody sergeant that they suspected that the detainee had swallowed class A drugs in an effort to hide evidence. The custody sergeant directed the arresting officers to take the detainee to hospital, but it was concerning that this had not been done in the first instance.

4.14 The custody record analysis showed that detainees were generally placed on appropriate levels of observation. It was evident that DOs were carrying out cell visits; each was allocated a few hours during their shift when they only conducted cell visits, and diligently recorded them. Children and young people were automatically placed on 30-minute observations.

4.15 We saw DOs conducting rousing checks on detainees who were under the influence of alcohol. They elicited an acceptable response from such detainees and told the custody sergeant the outcome of these checks. In the sample of records we reviewed, rousing had generally been recorded where necessary. Care plans were reviewed and levels of observation were amended as appropriate. Custody sergeants and DOs worked well together in conducting, revising and reviewing observations and ending checks when detainees became sober.

4.16 Custody sergeants routinely removed detainees' shoes or clothes with cords attached; this should be based on an individual risk assessment, rather than routine. They were also inconsistent in their use of safety clothing. For detainees who could not, or would not, cooperate with the risk assessment, some sergeants said that they would use safety clothing,

whereas others said that location in a CCTV cell without the use of clothing would be sufficient. Once detainees were placed in safety clothing, this did not appear to be reviewed.

4.17 Ten of the 35 cells at Middlewich and Runcorn, and seven of the 20 cells at Blacon were monitored by CCTV. Although the monitors could be seen from the booking-in area, they were not used in place of personal checks. At Runcorn, we saw police officers tasked with close proximity supervision of a detainee who was suspected of swallowing drugs (see paragraph 4.13) but had refused hospital intervention. The first officer to conduct the supervision was briefed on the circumstances and subsequently handed over to another two officers. None of the interactions between the officers and the detainee were recorded. We saw one of the officers using his mobile telephone, and not observing the detainee, as he had been instructed. After we intervened, the custody sergeant instructed the officer not to use his telephone during close proximity supervision.

4.18 Not all staff carried anti-ligature knives. Some staff commented on the fragility of the knives issued, and some said that they had not been trained in their use and therefore did not feel confident to carry them (see paragraph 3.13).

4.19 Handovers were poorly conducted. The shift patterns did not allow time for a formal handover; rather than an overall team handover, there were one-to-one briefings, during which normal activities continued. We observed that the first sergeant to come on shift received the handover. No DOs were included and not all handovers were comprehensive (see main recommendation 2.28).

4.20 Not all detainees released were given a leaflet describing support organisations; this was usually distributed at Blacon but not at the other two suites. Our custody record analysis showed that pre-release risk assessments (PRRAs) were always completed but often lacked detail; for example, for two young people the PRRA did not acknowledge vulnerability due to age. Custody staff routinely considered how detainees would get home. In some cases they were taken home, although sometimes after a considerable wait. They were also offered the opportunity to call relatives or friends to provide transport home.

Recommendations

4.21 **Arrested persons suspected of swallowing class A drugs should be taken directly to hospital and not initially to the custody suite.**

4.22 **All custody staff should carry anti-ligature knives and be briefed on their use to protect vulnerable detainees.**

Housekeeping points

4.23 Shoes and clothes with cords attached should only be removed if indicated by a risk assessment.

4.24 Custody records should clearly record the reasons for placing detainees in safety clothing, and custody staff should regularly review whether a detainee needs to continue wearing this throughout their detention.

Use of force

4.25 Most detainees arrived at the custody suite in handcuffs but, from discussions with staff, we were satisfied that police officers considered the necessity and proportionality of handcuffing. However, some detainees were not promptly released from these handcuffs, having to wait until they were brought before the custody sergeant.

4.26 It was a requirement of Cheshire Constabulary to record uses of force. However, although staff had to complete a form when force was used outside the custody suite, uses of force in the custody setting were recorded simply by adding a note on the detention log. It was therefore not possible to search Niche (police custody computer database) for incidents of use of force in custody, which meant that these were not collated or analysed by the force to identify trends or practice points. All staff had been trained in approved safety techniques and received annual refresher training.

4.27 In our custody record analysis sample, only one individual had been placed in restraints during their detention. This individual had been restrained using handcuffs, leg restraints and a head guard after repeatedly banging his head against his cell wall. The individual had been released nearly 14 hours after this event but there was no record in the detention log of when the restraints had been removed.

4.28 During the inspection, four detainees were strip-searched because they had been arrested for possession of drugs with intent to supply. The searches took place privately in a cell, and those we examined were conducted appropriately.

Recommendation

4.29 **Cheshire Constabulary should collate use of force data in accordance with Association of Chief Police Officers' policy and College of Policing guidance, to identify trends, patterns and learning arising out of these incidents.**

Housekeeping point

4.30 Detainees should only be handcuffed in holding areas when a risk assessment indicates that this is necessary for the safety of staff and others.

Physical conditions

4.31 The physical conditions of Runcorn and Middlewich custody suites was good, with the booking-in area light, clean and well ordered. The communal areas and corridors were clean and well maintained, and the cells were in good condition. There was little dirt in the cells and almost no graffiti at either of the suites. The Blacon custody suite was airy, light and clean, and all the cells were in a good condition. The cells in all three suites had very little natural light but staff turned on the lights when they were occupied. During the inspection, some detainees complained that it was cold in the cells; the custody staff had no control of the heating of the building, so gave such detainees blankets or a jumper. Staff did not express any concerns about emergency repairs being carried out.

4.32 Two cleaners attended all the custody suites daily, thoroughly cleaning the walls and doors of each of the vacant cells and recording which cells had been cleaned. Cells that were vacated after the cleaners had left the building were cleaned by the DOs.

4.33 We saw detention staff making daily checks of the cells, and also the emergency resuscitation equipment. This included checking cell call bells, the quality of mattresses and pillows, lighting and ligature points. Although we were satisfied that these checks were being done, they were not always recorded correctly and the electronic forms were not checked for quality.

4.34 When a cell call bell was rung, a sign was illuminated in the cell corridors and also at the booking-in desk, identifying the cell concerned; it was also audible in the booking-in area and the back office. DOs could speak to detainees in their cell via an intercom and we observed a prompt response when call bells were rung.

4.35 Although custody staff should keep control of keys and accompany staff collecting detainees, at both Runcorn and Middlewich we saw cell keys handed to non-custody staff to collect detainees for interview or to bring them to the custody desk for charging or release.

4.36 All three custody suites had a fire evacuation policy, and staff showed a good knowledge of it. An emergency evacuation safe was available at all suites, containing the policy, handcuffs and paperwork, and all custody staff were aware of its location. Staff at all suites told us that there were annual fire evacuation drills but we found no record of any drills being carried out. A no-smoking policy was strictly enforced.

Recommendations

4.37 Visits to cells should be undertaken only by custody staff, or if necessary accompanied by them.

4.38 Fire evacuation drills should be carried out regularly and records kept.

Housekeeping point

4.39 Cell checks should always be recorded correctly, and the electronic forms should be checked for quality.

Detainee care

4.40 All cells contained a mattress and pillow, which were wiped clean between uses. There was a good stock of clean non-rip blankets, which were distributed throughout the day and night. All cells, except the one dry cell in each suite, contained hand washbasins. Toilet paper was given to detainees on entry to the cells, subject to a risk assessment. Images of toilet areas on CCTV monitors were obscured.

4.41 In our custody record analysis, no detainees in the sample had had access to washing facilities while in custody, even though three detainees (two from Runcorn and one from Middlewich) had been transferred to court after long periods in detention. At Runcorn, we saw one detainee being taken to a sink to have a wash, and given soap and a cotton towel. The showers at all suites were clean and dry, indicating that they were not used daily. Custody staff told us that showers were usually facilitated by the night staff if there were enough DOs to facilitate this.

4.42 Toiletries such as toothpaste and soaps were available, and also a variety of sanitary products for women, although these were not routinely offered. There were stocks of replacement clothing, including tracksuit bottoms, T-shirts, paper suits and plimsolls, and we saw some

detainees in replacement clothing and shoes. However, there was no replacement underwear. Detainees could have clothing brought in by family members.

4.43 Cereal bars were offered to detainees for breakfast, and a wide variety of microwave meals was available. These met a range of dietary and religious needs. We saw these meals being provided to detainees throughout the day and night. Custody staff told us that they provided detainees with meals on request, outside of recognised mealtimes. This was supported by our custody record analysis, in which 20 (67%) detainees in our sample had been offered at least one meal while in custody. The kitchen at both Runcorn and Middlewich was clean and appropriately equipped. Tea, coffee, water and orange juice were available and offered regularly.

4.44 At each of the custody suites there were two exercise yards, which were monitored by CCTV but did not contain call bells, so detainees had to knock on the window if they wanted to come inside. We saw detainees being offered time in the open air; however, in our custody record analysis only one (3%) detainee in our sample, who had been held for over 19 hours at Runcorn, had received outside exercise. Three detainees who had been held for over 41 hours did not appear to have been offered outside exercise. The exercise yards were better than those we have seen in other force custody suites.

4.45 There was reading material available, and nothing in languages other than English, in easy-read formats or for young people. Magazines had recently been removed from the custody suites as there was a fear that staples in them might be used to self-harm or as a weapon. This approach did not assess individual risk and was unnecessary as a standard approach. At all custody suites we saw detainees being offered reading material. A closed visits room was available at each suite and used for vulnerable detainees and young people who might benefit from a visit by a family member.

Recommendations

4.46 **All detainees held overnight should be offered a shower.**

4.47 **Detainees, particularly those held for more than 24 hours, should be offered exercise.**

Housekeeping points

4.48 Hygiene packs should be routinely offered to female detainees.

4.49 Replacement underwear should be available at all suites.

4.50 There should be a suitable range of reading material for detainees, including young people, non-English speakers and those with limited literacy.

Section 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 the reasons for detention with arresting officers to ensure that there were appropriate grounds for detention. Sergeants told us that they were confident in refusing detention when the circumstances did not merit arrest and were able to provide us with historical details of such cases. We observed one custody sergeant at Runcorn refusing to accept a detainee who had been brought to the custody suite under the terms of section 136 of the Mental Health Act 1983.[4] He rightly instructed the arresting officers to take the detainee instead to the local accident and emergency unit. Alternatives to custody were available, such as street bail and voluntary attendance. There was evidence that increasing use was being made of voluntary attendance. Sergeants told us that they had seen an increase in the number of officers seeking advice before making an arrest, and we saw this taking place on a number of occasions.

5.2 All staff were aware of the need to keep detention periods to a minimum, and custody sergeants were clear about their obligations to ensure that cases proceeded quickly. In our custody record analysis of 30 cases, the average length of detention had been 12 hours and 51 minutes. Three (10%) detainees had been held for more than 40 hours, the longest for 46 hours 29 minutes. Fifteen (50%) detainees had been in custody overnight, including those who had arrived during the night (up until 3am) and not released until the morning.

5.3 An initiative had been launched in Blacon in November 2012 to remind custody sergeants of their need to minimise the detention of young people in police cells unnecessarily. This had been instigated following the introduction of the new PACE code G amendments, which strengthened the necessity criteria for any arrest, and staff were aware of the need to justify the detention of all young people in custody. The initiative reminded staff of the need to approach the local authority emergency duty team (EDT) in every case involving the overnight detention of a young person, with a request to provide either secure or non-secure accommodation, depending on the circumstances. Such requests, and the outcomes, were recorded on individual detainee custody records, and the details of all such cases were reported to the Local Safeguarding Children Boards for their scrutiny.

5.4 During booking-in, staff provided detainees with a detailed and informative leaflet summarising their rights and entitlements. A similar version could be downloaded and printed for non-English-speaking detainees in their own language, and we saw this being printed off for a Bengali-speaking detainee. None of the custody staff was aware that an easy-read pictorial format version was also available on the same website. At Blacon, a pictorial leaflet containing information for detainees with learning disabilities was available, and also an ICV guide in various languages. These were not available at either Middlewich or Runcorn. The rights and entitlements documentation was available in Braille at all three custody suites.

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

5.5 Staff reported a good relationship with UK Border Agency (now known as Home Office Immigration Enforcement) staff, and most immigration detainees were collected within a short time. At Middlewich, we saw one detainee, who had been arrested on behalf of Home Office Immigration Enforcement, being collected within four hours for onward transportation to a residential short-term holding centre.

5.6 In our custody record analysis, there was one (3%) foreign national in the sample. There was no specific field on Niche to record that the detainee had had their rights as a foreign national explained, so we were unable to ascertain that this had taken place. In the field designated for officers to indicate whether the detainee wanted their high commission, embassy or consulate to be informed, this had been marked as 'not applicable'.

5.7 A professional telephone interpreting service was used during the booking-in process. Although a double-handset telephone was available at all three custody suites, staff told us that they did not use these to facilitate three-way conversations due to the poor quality of audio reception while using the telephone. As an alternative, staff spoke to the interpreting service and then passed the telephone handset back and forth between themselves and the detainee, prolonging the time taken to complete the process. A good face-to-face interpreting service was available for interviews, but delays could be experienced, depending on the language involved.

5.8 Staff assured us that the custody suites were never used as a place of safety for children under Section 46 of the Children Act 1989.

5.9 At the time of the inspection, the force 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 they were otherwise deemed vulnerable (see recommendation 2.30).[5] Family members or friends were usually contacted in the first instance to act as an AA. When this was not possible, a scheme operated by social services provided cover for children and young people and vulnerable adults 24 hours a day, seven days a week. During office hours, depending on the needs involved, these calls were covered by a member of the youth offending team, approved mental health professionals or mainstream social workers. Outside these hours the calls were covered by the social services EDT. No delays in attendance were reported, other than some difficulties that had been experienced during the handover from day to night services between 4pm and 6pm. We observed the prompt arrival of two social workers at Runcorn custody suite at 11.30pm to support a vulnerable adult while his rights and entitlements were being explained to him and his fingerprints taken.

5.10 In our custody record analysis, there were five (17%) young people in the sample aged less than 17 years of age, three of whom had also reported mental health problems. They all had an AA present while their rights and entitlements were being explained, and also during any interviews. In one case, a young person had been detained for approximately 10 hours with no AA. Initially, the individual's mother had been contacted to be her AA, but it had subsequently come to light that the young person was in custody for stealing her mother's car, which meant that, as a victim, it would have been inappropriate for her parent to act as an AA. An alternative AA had then been contacted for the young person.

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[5] In all other UK law and international treaty obligations, 17-year-olds are treated as children. In April 2013, the High Court ruled that the PACE definition was incompatible with human rights law.

Housekeeping points

5.11 Staff should be made aware of the different formats of the rights and entitlement information.

5.12 Suitable-quality double-handset telephones should be provided in all suites to facilitate telephone interpreting services.

Rights relating to PACE

5.13 We observed detainees being told that they could read the PACE codes of practice during the booking-in process. Staff were not aware that their copies of the code were out of date, having been superseded by a newer edition (2012). The new version of PACE code C was available only at Middlewich, but staff there were also still issuing detainees with the 2006 version.

5.14 There were posters on display at Middlewich and Runcorn, in a range of languages, advising detainees of their right to free legal advice; these posters were not available at Blacon. Solicitors we spoke to were positive about how they and their clients were dealt with, and told us that custody staff adhered to PACE. A cordless telephone was available in all three custody suites, which was taken to a detainee's cell, thus allowing a private telephone consultation to take place with their solicitor. We saw solicitors routinely being offered either the front sheet or full printout of their client's custody record without having to request this.

5.15 In our custody record analysis, all detainees had been routinely offered legal advice and 10 (33%) had accepted this offer. In all but one instance, it appeared that solicitors had been contacted promptly and stayed in close communication with custody staff. In one case involving a 13-year-old detainee, the individual had accepted the offer of a solicitor at 1.17am but the notification to a solicitor had not taken place until 5.25am; no reason had been recorded for this delay. Staff told us that delays were sometimes experienced when duty solicitors were not available, owing to high demand.

5.16 We saw staff telling detainees that they could inform someone of their arrest, and this was reflected in our custody record analysis.

5.17 Reviews of detainees in custody were undertaken by one of the seven dedicated PACE inspectors, who were based across the three custody suites. Few face-to-face PACE reviews were carried out, whereby detainees could make representations about their continued detention, because PACE inspectors usually did not travel from the custody suites where they were based; this resulted in many reviews being carried out by telephone. In our custody record analysis, inspector reviews had been necessary in 25 (83%) cases, of which 11 had taken place on time, 13 early and one late. Custody logs showed that only six of these 25 reviews had been carried out face to face with the detainee. Eleven had taken place while the detainees had been asleep and there was no record of whether they had subsequently been informed or that they had been reminded of their rights and entitlements. Six reviews had been conducted over the telephone, but the records showed that in all of these cases the inspector had spoken directly to the detainee.

5.18 All DNA samples were handled effectively, with regular collection from custody. Freezers were clearly labelled for their purpose.

5.19 Video-enabled courts (VECs) were in operation at all three custody suites. A maximum of five detainee hearings were available from Monday to Friday (they did not operate on

Saturdays). We observed the VECs in operation and found they were conducted correctly. However, we saw two detainees (one female at Blacon and one male at Runcorn) being presented to the court while still wearing safety clothing. When we asked custody staff if they had considered reviewing the detainees' risk levels and considered the use of alternative clothing, they had not, although the escorting DO had allowed the female detainee to wear a pair of trousers and boots, as she had been wearing a short rip-proof smock.

5.20 Detainees who were not suitable for the VECs were transported to court in a timely manner. Court cut-off times varied from 1pm at Blacon Magistrates' Court to 2.30pm at Halton Magistrates' Court, with some flexibility from day to day. Staff reported no major issues with these cut-off times due to the availability of the VECs, which could accept detainees at any time during the working day, depending on the availability of slots and court staff to operate the equipment. A prisoner escort contractor (PEC) was available for transportation for both morning and afternoon courts. If the PEC was unable to meet their contractual requirements for transportation to afternoon courts, police officers took the detainees in police vehicles, to ensure that they did not remain in custody longer than necessary, although we were told that this occurred very infrequently.

5.21 If a detainee appeared at court and had no means of getting home, court custody staff issued travel warrants or petty cash. However, for those who appeared before VECs and were released by the court while still in police custody, the force was unable to issue travel warrants or petty cash. Such detainees had to source an alternative means of transport or rely on the goodwill of police custody staff to make arrangements on their behalf. Staff told us that they did not put eligible detainees before the VEC if they knew that subsequent transport arrangements for them might be problematic.

Recommendation

5.22 **Detainees should not be presented to the video-enabled courts while wearing rip-proof clothing.**

Housekeeping points

5.23 Staff should be made aware of the existence of up-to-date copies of the PACE codes of practice, which should be made available at all custody suites.

5.24 Posters advising detainees of their right to free legal advice, in a range of languages, should be displayed at Blacon.

5.25 PACE reviews should be carried out on time.

5.26 Detainees should be informed of any reviews carried out while they were sleeping, and a record to that effect should be made in the custody record.

Rights relating to treatment

5.27 The notice of rights and entitlements, which was given to all detainees being booked in, detailed the processes for making a complaint. Custody staff told us that if a detainee wished to make a complaint, they would immediately advise the duty PACE inspector. PACE inspectors confirmed that they would take complaints from detainees while they were still in custody or would instruct a custody sergeant to take the complaint on their behalf; if no one

was available to take the complaint, they made an appointment to see the detainee at a later date.

5.28 Custody staff at both Blacon and Runcorn had access to copies of the IPCC literature for dissemination to detainees if they were undecided as to whether they wished to proceed with a complaint. These were not available at Middlewich, but when staff there discovered this, they immediately placed an order to replenish their stock.

5.29 The force collected data on complaints, which were shared with staff through the distribution of a monthly management information pack.

Section 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.

Governance

6.1 Health services were provided by several different providers across the force area, but primary care was provided by Tascor. Overall, there were good working relationships between the police and health care providers. Cheshire Constabulary was an 'early adopter' site for the NHS commissioning of health services for detainees in police custody, and the new contract was due to start imminently. There was an established Police Healthcare Partnership Board, and a health needs assessment had been completed.

6.2 The current contract was well monitored by the force, and 'service credits' were used appropriately when the provider failed to meet the contract specification. Tascor provided a team of nurses and forensic medical examiners (FMEs). Clinical governance arrangements were robust but not all were carried out locally, and some of the policies, protocols and working arrangements for the new contract, which involved a more proactive style of working, had not filtered down to nursing staff working in the suites. Tascor staff had not received sufficient training. All staff were up to date with resuscitation training but none had undertaken safeguarding training or infection control updates. One member of staff described access to training as 'atrocious'. Nursing staff did not have clinical supervision. Staff attended monthly meetings, chaired by the lead doctor; these included discussions about the new contract, untoward incidents and advice. Tascor also had company clinical governance meetings, and the minutes were available to staff electronically.

6.3 Treatment rooms in the three main suites were reasonable but needed some minor alterations to ensure that they all met infection control guidance. Sharps bins were not signed or dated. Resuscitation equipment, including automated external defibrillators (AEDs), suction equipment and oxygen, was located behind each custody desk, and health services staff had suction and pulse oximetry equipment in the treatment rooms. Custody staff were trained in the use of resuscitation equipment, including AEDs.

Recommendation

6.4 **All staff should have access to clinical supervision and training/continuing professional development relevant to their role.**

Patient care

6.5 It was easy for detainees to see a health care professional (HCP) as there was usually a nurse based in each of the three suites at all times. Our custody record analysis revealed that the average wait for an HCP was 22 minutes. Detainees could potentially see an HCP of their own gender but were not told that they could do so. Detainees we spoke to told us that they were treated respectfully.

6.6 Clinical records were comprehensive, conformed to professional guidance, were stored appropriately and were regularly audited by Tascor. Entries in the custody record contained

a good level of detail about the consultation, medications that were issued and any medical issues that might have affected the detainee during their detention. However, the process for a detainee or their legal representative to obtain a copy of their clinical records was cumbersome.

6.7 Not all detainees were able to receive previously prescribed medications while in custody. Eleven (37%) detainees in our custody record analysis reported being on medication on arrival, seven of whom needed to take it while in custody. However, none received their medication, despite some spending long periods in custody. In three cases, custody staff had not referred detainees to HCPs. Staff were unclear about the policy for opiate substitution medications, and it had become customary practice not to administer methadone unless the detainee was pregnant or was charged with murder. During the inspection, we came across a detainee on a known methadone maintenance programme who was in custody for 24 hours, with no efforts made to ensure that he received it while in custody. Nurses used patient group directions to administer most medications and rarely deferred to the FME.

6.8 Comments from prisoners who completed our survey included:

'*They never give you medication for withdrawal, leave you very ill. Very poor, even if you have medication there with you they still won't give it.*'

'*Even though I was on prescribed medication and I was withdrawing from my med, nothing was done. They just simply said that [they] can't prescribe it as they don't stock the medication I was on, even though they had confirmation of what I was prescribed.*'

6.9 Nursing staff were not proactive in their management of detainees' medications; for example, escorting staff had to request that a detainee received symptomatic relief before his attendance at court rather than the nurse anticipating such needs.

6.10 Medications were stored appropriately, although we found out-of-date medications in a cupboard by the custody desk in Blacon custody suite.

6.11 As part of the preparation for the new contract, Tascor staff were in the process of mapping referral pathways for detainees.

Recommendation

6.12 **All detainees should be able to continue to receive previously prescribed medication while in custody.**

Housekeeping point

6.13 Detainees should easily be able to obtain a copy of their clinical records before leaving custody.

Substance misuse

6.14 In our survey, 39% of detainees said that they had a drug or alcohol problem on arrest; of these, only 11%, considerably lower than the comparator, had been offered the services of a drug or alcohol support worker. Our analysis of custody records showed that the services of arrest referral workers had routinely been offered to detainees during the initial risk assessment. Three detainees had accepted the offer of a referral, but there was no record of

them being seen while they were detained. Only one detainee at Runcorn had seen an arrest referral worker during their time in custody but it was not clear from the detention log if they had requested to see the worker or if they had been 'picked up' on a cell sweep.

6.15 Substance misuse services varied across the force area. In Blacon and Middlewich, services for adults using class A drugs were provided by Addiction Dependency Solutions (ADS), while the Hospital Alcohol Liaison Service (HALS) saw those with alcohol issues, but only in the Blacon custody suite. ADS staff were not based in the custody suites but visited twice a day during the week. They tried to make sure that detainees were followed up by the drugs worker who had made the initial contact while they were in custody. Custody staff rarely made referrals to ADS, although they asked detainees if they wished to see a drugs worker. ADS staff were able to refer detainees to appropriate services.

6.16 The HALS service was not directly commissioned and had developed from a pilot project in late 2012. HALS was based at the local hospital in Blacon and was available from 8am until 6pm during the week and 9am until 1pm at weekends. When these services were needed, custody staff contacted one of the team, who then visited the detainee in custody if they were able, to provide brief interventions and refer to appropriate services.

6.17 Services for detainees with drug issues in Runcorn were provided by Crime Reduction Initiatives (CRI). Workers visited the suite twice a day during the week but there was no service at weekends. Although there were referral forms for the police to use at other times, CRI staff told us that they did not receive them very often. When they did, they contacted the referred person in the community. CRI offered a prescribing service to detainees who were dependent on opiates. They completed an assessment with the detainee, and the drugs worker followed this up in the community within 48 hours. If the detainee was remanded, they contacted the drugs worker in the relevant prison. There was no service in custody for detainees with alcohol issues at Runcorn, although CRI workers said that they would signpost them to relevant services.

6.18 There were no needle exchange schemes at any of the custody suites but we were told that services were available in the community.

Mental health

6.19 Each of the three main suites had access to a criminal justice liaison team (CJLT) during working hours. At Blacon and Middlewich, services were provided by Cheshire and Wirral NHS Foundation Partnership Trust (CWP). Custody staff were able to contact a member of this team, who assessed the detainee and provided advice and support as required. They could arrange support for the detainee through the criminal justice system, community mental health services or admission to hospital for assessment. If admission was not voluntary, the CWP member of staff could liaise with the local approved mental health professional for a formal assessment under section 136 of the Mental Health Act 1983. At Runcorn, the services were similar but the mental health trust to which detainees were referred depended on where they resided, as the area covered by the local policing teams crossed the borders of the jurisdictions of both 5 Boroughs NHS Partnership Trust and Warrington and Halton Hospitals NHS Foundation Trust (WHFT).

6.20 There was no cover from the CJLT out of normal working hours in any of the suites, and custody staff relied on the emergency duty team (EDT).

6.21 The police had made great efforts to work with the local mental health services; there was a clear conveying policy for the North West to ensure that detainees with mental health problems were conveyed safely.

6.22 There were no specific section 136 suites in the force area. In the east and west of the force area detainees were taken to the local accident and emergency department, and in the north there was a mental health facility but no dedicated suite. In the first three months of 2013, 12 detainees had been taken to the custody suite at Runcorn, and four to Blacon or Middlewich under section 136. Custody sergeants were clear that custody suites were not a suitable environment for someone detained under section 136. We were unable to obtain figures to compare how many detainees had been taken to a medical place of safety in the same period. However, an audit undertaken by the force in 2012 revealed that, of the total of 396 section 136 detentions, 94 of them had been taken to a custody suite – 22 (5%) to Blacon or Middlewich and 72 (18%) to Runcorn.

6.23 The police had final draft policies for section 136 detainees with both CWP and 5 Boroughs Trust, but not with WHFT; however, we were assured that efforts were being made at a strategic level to address this issue.

Section 7. Summary of recommendations

Main recommendations

7.1 There should be arrangements to ensure that custody staff understand and comply with policies and initiatives pertaining to young people. (2.27)

7.2 Handovers should be comprehensive and attended by all detention officers and police custody staff, and take place with appropriate regard for the privacy of detainees. (2.28)

7.3 All detainees should be able to continue to receive previously prescribed medication while in custody. (2.29)

National issue

7.4 Appropriate adults should be available at all times to support without undue delay detained young people aged 17, provided that informed consent has been given. (2.30)

Recommendations

Strategy

7.5 All detention officers (DOs) should be provided with an initial custody training course before being deployed in custody, and regular refresher training thereafter. (3.19)

Treatment and conditions

7.6 Booking-in desks should allow private communication between custody staff, detainees and their legal representatives. (4.9)

7.7 Arrested persons suspected of swallowing class A drugs should be taken directly to hospital and not initially to the custody suite. (4.21)

7.8 All custody staff should carry anti-ligature knives and be briefed on their use to protect vulnerable detainees. (4.22)

7.9 Cheshire Constabulary should collate use of force data in accordance with Association of Chief Police Officers' policy and College of Policing guidance, to identify trends, patterns and learning arising out of these incidents. (4.29)

7.10 Visits to cells should be undertaken only by custody staff, or if necessary accompanied by them. (4.37)

7.11 Fire evacuation drills should be carried out regularly and records kept. (4.38)

7.12 All detainees held overnight should be offered a shower. (4.46)

7.13 Detainees, particularly those held for more than 24 hours, should be offered exercise. (4.47)

Individual rights

7.14 Detainees should not be presented to the video-enabled courts while wearing rip-proof clothing. (5.22)

Health care

7.15 All staff should have access to clinical supervision and training/continuing professional development relevant to their role. (6.4)

7.16 All detainees should be able to continue to receive previously prescribed medication while in custody. (6.12)

Housekeeping points

Strategy

7.17 DOs' shift patterns should include training days, to give them opportunities to raise issues. (3.20)

7.18 Quality assurance processes should include the cross-referencing of dip-sampled custody records to closed-circuit television, and include person escort record forms and shift handovers. (3.21)

Treatment and conditions

7.19 Custody sergeants at Blacon should maintain better control of the number of staff waiting in the booking-in area. (4.10)

7.20 Staff should familiarise themselves with the use of equipment such as hearing loops. (4.11)

7.21 Shoes and clothes with cords attached should only be removed if indicated by a risk assessment. (4.23)

7.22 Custody records should clearly record the reasons for placing detainees in safety clothing, and custody staff should regularly review whether a detainee needs to continue wearing this throughout their detention. (4.24)

7.23 Detainees should only be handcuffed in holding areas when a risk assessment indicates that this is necessary for the safety of staff and others. (4.30)

7.24 Cell checks should always be recorded correctly, and the electronic forms should be checked for quality. (4.39)

7.25 Hygiene packs should be routinely offered to female detainees. (4.48)

7.26 Replacement underwear should be available at all suites. (4.49)

7.27 There should be a suitable range of reading material for detainees, including young people, non-English speakers and those with limited literacy. (4.50)

Individual rights

7.28 Staff should be made aware of the different formats of the rights and entitlement information. (5.11)

7.29 Suitable-quality double-handset telephones should be provided in all suites to facilitate telephone interpreting services. (5.12)

7.30 Staff should be made aware of the existence of up-to-date copies of the PACE codes of practice, which should be made available at all custody suites. (5.23)

7.31 Posters advising detainees of their right to free legal advice, in a range of languages, should be displayed at Blacon. (5.24)

7.32 PACE reviews should be carried out on time. (5.25)

7.33 Detainees should be informed of any reviews carried out while they were sleeping, and a record to that effect should be made in the custody record. (5.26)

Health care

7.34 Detainees should easily be able to obtain a copy of their clinical records before leaving custody. (6.13)

Section 8. Appendices

Appendix I: Inspection team

Maneer Afsar	HMIP team leader
Gary Boughen	HMIP inspector
Fiona Shearlaw	HMIP inspector
Vinnett Pearcy	HMIP inspector
Paul Davies	HMIC lead staff officer
Mark Ewan	HMIC staff officer
Elizabeth Tysoe	HMIP health services inspector
Kathleen Byrne	Care Quality Commission inspector
Rachel Murray	HMIP researcher
Helen Ranns	HMIP researcher

Appendix II: Summary of detainee questionnaires and interviews

Prisoner survey methodology

A voluntary, confidential and anonymous survey of the HMP Altcourse prisoner population who had been through a police station in the Cheshire police force area 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 8 April 2013. A list of potential respondents to have passed through Runcorn, Middlewich, Chester or Wilmslow police stations was created, listing all those who had arrived from South Cheshire, Warrington, Chester, Runcorn (Halton) and Macclesfield Magistrates Courts or Chester, Knutsford and Warrington Crown Courts court within the past two months.

Selecting the sample

In total 67 respondents were approached. Thirteen respondents reported being held in police stations outside of Cheshire and two had last been held in police custody outside the survey period. On the day, the questionnaire was offered to 52 respondents; there were four refusals, three questionnaires were returned blank and three non-returns. All of those sampled had been in custody within the last two months.

Completion of the questionnaire was voluntary. Interviews were carried out with any respondents with literacy difficulties. 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;
- to 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, 42 (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 63 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 for certain responses within the summary, for example 'not held overnight' 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 those shown in the comparison data as the comparator data have been weighted for comparison purposes.

Survey results

Section 1: About you

Q2 Which police station were you last held at?

Chester - 8
Middlewich - 15
Runcorn – 19

Q3 How old are you?

16 years or younger	0 (0%)	*40-49 years*	7 (17%)
17-21 years	5 (12%)	*50-59 years*	2 (5%)
22-29 years	21 (50%)	*60 years or older*	0 (0%)
30-39 years	7 (17%)		

Q4 Are you:

Male	42 (100%)
Female	0 (0%)
Transgender/Transsexual	0 (0%)

Q5 What is your ethnic origin?

White - British	39 (93%)
White - Irish	0 (0%)
White - other	2 (5%)
Black or black British - Caribbean	0 (0%)
Black or black British - African	0 (0%)
Black or black British - other	0 (0%)
Asian or Asian British - Indian	0 (0%)
Asian or Asian British - Pakistani	0 (0%)
Asian or Asian British - Bangladeshi	0 (0%)
Asian or Asian British - other	0 (0%)
Mixed heritage - white and black Caribbean	0 (0%)
Mixed heritage - white and black African	0 (0%)
Mixed heritage- white and Asian	0 (0%)
Mixed heritage - other	1 (2%)
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	3 (8%)
No	37 (93%)

Q7 What, if any, is your religion?

None	16 (38%)
Church of England	18 (43%)
Catholic	7 (17%)
Protestant	0 (0%)
Other Christian denomination	1 (2%)
Buddhist	0 (0%)
Hindu	0 (0%)
Jewish	0 (0%)
Muslim	0 (0%)

	Sikh	0 (0%)
Q8	**How would you describe your sexual orientation?**	
	Straight/heterosexual	40 (98%)
	Gay/lesbian/homosexual	0 (0%)
	Bisexual	1 (2%)
Q9	**Do you consider yourself to have a disability?**	
	Yes	9 (21%)
	No	33 (79%)
Q10	**Have you ever been held in police custody before?**	
	Yes	40 (95%)
	No	2 (5%)

Section 2: Your experience of the police custody suite

Q11	**How long were you held at the police station?**	
	Less than 24 hours	11 (28%)
	More than 24 hours, but less than 48 hours (2 days)	18 (46%)
	More than 48 hours (2 days), but less than 72 hours (3 days)	5 (13%)
	72 hours (3 days) or more	5 (13%)
Q12	**Were you told your rights when you first arrived there?**	
	Yes	28 (68%)
	No	8 (20%)
	Don't know/Can't remember	5 (12%)
Q13	**Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')?**	
	Yes	25 (63%)
	No	13 (33%)
	I don't know what this is/I don't remember	2 (5%)
Q14	**If your clothes were taken away, what were you offered instead?**	
	My clothes were not taken	16 (40%)
	I was offered a tracksuit to wear	6 (15%)
	I was offered an evidence/ paper suit to wear	12 (30%)
	*I was **only** offered a blanket*	4 (10%)
	Nothing	2 (5%)
Q15	**Could you use a toilet when you needed to?**	
	Yes	37 (90%)
	No	4 (10%)
	Don't know	0 (0%)
Q16	**If you used the toilet there, was toilet paper provided?**	
	Yes	12 (31%)
	No	27 (69%)

Q17 How would you rate the condition of your cell:

	Good	*Neither*	*Bad*
Cleanliness	14 (34%)	9 (22%)	18 (44%)
Ventilation/air quality	14 (37%)	5 (13%)	19 (50%)
Temperature	7 (18%)	7 (18%)	24 (63%)
Lighting	15 (39%)	10 (26%)	13 (34%)

Q18	**Was there any graffiti in your cell when you arrived?**	
	Yes	28 (68%)
	No	13 (32%)
Q19	**Did staff explain to you the correct use of the cell bell?**	
	Yes	8 (20%)
	No	33 (80%)
Q20	**Were you held overnight?**	
	Yes	35 (90%)
	No	4 (10%)
Q21	**If you were held overnight, which items of bedding were you given? (Please tick all that apply)**	
	Not held overnight	4 (10%)
	Pillow	14 (34%)
	Blanket	33 (80%)
	Nothing	2 (5%)
Q22	**If you were given items of bedding, were these clean?**	
	Not held overnight/ Did not get any bedding	6 (15%)
	Yes	16 (40%)
	No	18 (45%)
Q23	**Were you offered a shower at the police station?**	
	Yes	2 (5%)
	No	39 (95%)
Q24	**Were you offered any period of outside exercise while there?**	
	Yes	2 (5%)
	No	38 (95%)

Q25 Were you offered anything to:

	Yes	*No*
Eat?	31 (79%)	8 (21%)
Drink?	32 (84%)	6 (16%)

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

Very good	*Good*	*Neither*	*Bad*	*Very bad*	*N/A*
1 (2%)	2 (5%)	6 (15%)	7 (17%)	23 (56%)	2 (5%)

Q27	**Was the food/drink you received suitable for your dietary requirements?**	
	I did not have any food or drink	2 (5%)
	Yes	14 (36%)
	No	23 (59%)
Q28	**If you smoke, were you offered anything to help you cope with not being able to smoke? (Please tick all that apply)**	
	I do not smoke	13 (32%)
	I was allowed to smoke	1 (2%)
	I was offered a nicotine substitute	1 (2%)
	I was not offered anything to cope with not smoking	26 (63%)
Q29	**Were you offered anything to read?**	
	Yes	9 (22%)

	No	32 (78%)

Q30 Was someone informed of your arrest?

Yes	19 (46%)
No	13 (32%)
I don't know	3 (7%)
I didn't want to inform anyone	6 (15%)

Q31 Were you offered a free telephone call?

Yes	29 (71%)
No	12 (29%)

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

My telephone call was not denied	29 (73%)
Yes	0 (0%)
No	11 (28%)

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

	Yes	*No*
Who was taking care of your children	4 (13%)	28 (88%)
Contacting your partner, relative or friend	21 (51%)	20 (49%)
Contacting your employer	5 (16%)	27 (84%)
Where you were going once released	9 (31%)	20 (69%)

Q34 Were you offered free legal advice?

Yes	36 (88%)
No	5 (12%)

Q35 Did you accept the offer of free legal advice?

Was not offered free legal advice	5 (13%)
Yes	27 (71%)
No	6 (16%)

Q36 Were you interviewed by police about your case?

Yes	35 (85%)
No	6 (15%)

Q37 Was a solicitor present when you were interviewed?

Did not ask for a solicitor/ Was not interviewed	10 (25%)
Yes	23 (57%)
No	7 (18%)

Q38 Was an appropriate adult present when you were interviewed?

Did not need an appropriate adult/ Was not interviewed	22 (54%)
Yes	5 (12%)
No	14 (34%)

Q39 Was an interpreter present when you were interviewed?

Did not need an interpreter/ Was not interviewed	24 (59%)
Yes	0 (0%)
No	17 (41%)

Section 3: Safety

Q41 Did you feel safe there?

Yes	26 (63%)
No	15 (37%)

Q42 Did a member of staff victimise (insulted or assaulted) you there?

Yes	14 (34%)
No	27 (66%)

Q43 If you were victimised by staff, what did the incident involve? (Please tick all that apply to you.)

I have not been victimised	27 (66%)	*Because of your crime*	8 (20%)
Insulting remarks (about you, your family or friends)	9 (22%)	*Because of your sexuality*	0 (0%)
Physical abuse (being hit, kicked or assaulted)	5 (12%)	*Because you have a disability*	2 (5%)
Sexual abuse	0 (0%)	*Because of your religion/religious beliefs*	0 (0%)
Your race or ethnic origin	1 (2%)	*Because you are from a different part of the country than others*	0 (0%)
Drugs	5 (12%)		

Q44 Were your handcuffs removed on arrival at the police station?

Yes	25 (63%)
No	9 (23%)
I wasn't handcuffed	6 (15%)

Q45 Were you restrained whilst in the police custody suite?

Yes	6 (15%)
No	33 (85%)

Q46 Were you injured while in police custody, in a way that was not your fault?

Yes	9 (23%)
No	31 (78%)

Q47 Were you told how to make a complaint about your treatment if you needed to?

Yes	4 (10%)
No	35 (90%)

Q48 How were you treated by staff in the police custody suite?

Very well	*Well*	*Neither*	*Badly*	*Very badly*	*Don't remember*
3 (8%)	7 (18%)	16 (40%)	7 (18%)	7 (18%)	0 (0%)

Section 4: Health care

Q50 Did someone explain your entitlements to see a health care professional, if you needed to?

Yes	13 (32%)
No	25 (61%)
Don't know	3 (7%)

Q51 Were you seen by the following health care professionals during your time there?

	Yes	*No*
Doctor	5 (14%)	30 (86%)
Nurse	17 (49%)	18 (51%)
Paramedic	0 (0%)	28 (100%)

Q52	**Were you able to see a health care professional of your own gender?**	
	Yes	4 (10%)
	No	26 (63%)
	Don't know	11 (27%)
Q53	**Did you need to take any prescribed medication when you were in police custody?**	
	Yes	15 (37%)
	No	26 (63%)
Q54	**Were you able to continue taking your prescribed medication while there?**	
	Not taking medication	26 (63%)
	Yes	3 (7%)
	No	12 (29%)
Q55	**Did you have any drug or alcohol problems?**	
	Yes	16 (39%)
	No	25 (61%)
Q56	**Did you see, or were you offered the chance to see a drug or alcohol support worker?**	
	I didn't have any drug/alcohol problems	25 (61%)
	Yes	2 (5%)
	No	14 (34%)
Q57	**Were you offered relief or medication for your immediate withdrawal symptoms?**	
	I didn't have any drug/alcohol problems	25 (61%)
	Yes	2 (5%)
	No	14 (34%)

Q58 **Please rate the quality of your healthcare while in police custody:**

I was not seen by health care	*Very good*	*Good*	*Neither*	*Bad*	*Very bad*
22 (56%)	1 (3%)	3 (8%)	2 (5%)	8 (21%)	3 (8%)

Q59	**Did you have any specific physical health care needs?**	
	Yes	9 (23%)
	No	31 (78%)
Q60	**Did you have any specific mental health care needs?**	
	Yes	13 (32%)
	No	28 (68%)
Q61	**If you had any mental health care needs, were you seen by a mental health nurse / psychiatrist?**	
	I didn't have any mental health care needs	28 (70%)
	Yes	1 (3%)
	No	11 (28%)

Prisoner survey responses for Cheshire Police 2013

Prisoner survey responses (missing data have 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

		Cheshire Police custody	Police custody comparator
(green)	Any percentage highlighted in green is significantly better		
(blue)	Any percentage highlighted in blue is significantly worse		
(orange)	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		42	2369
SECTION 1: General information			
3	Are you under 21 years of age?	**12%**	**10%**
4	Are you transgender/transsexual?	**0%**	**0%**
5	Are you from a minority ethnic group? (Including all those who did not tick white British, white Irish or white other categories)	**2%** (orange)	**29%**
6	Are you a foreign national?	**8%**	**16%**
7	Are you Muslim?	**0%** (orange)	**10%**
8	Are you homosexual/gay or bisexual?	**2%**	**2%**
9	Do you consider yourself to have a disability?	**22%**	**20%**
10	Have you been in police custody before?	**96%**	**92%**
SECTION 2: Your experience of this custody suite			
11	Were you held at the police station for over 24 hours?	**72%**	**68%**
12	Were you told your rights when you first arrived?	**69%**	**80%**
13	Were you told about PACE?	**63%**	**52%**
For those who had their clothing taken away:			
14	Were you given a tracksuit to wear?	**25%**	**42%**
15	Could you use a toilet when you needed to?	**90%**	**91%**
16	If you used the toilet, was toilet paper provided?	**30%** (blue)	**48%**
17	Would you rate the condition of your cell, as 'good' for:		
17a	Cleanliness?	**35%**	**34%**
17b	Ventilation/air quality?	**37%** (green)	**23%**
17c	Temperature?	**18%**	**17%**
17d	Lighting?	**40%**	**45%**
18	Was there any graffiti in your cell when you arrived?	**69%**	**54%**
19	Did staff explain the correct use of the cell bell?	**20%**	**24%**
20	Were you held overnight?	**89%**	**92%**
For those who were held overnight:			
21	Were you given any items of bedding?	**96%**	**86%**
For those who were held overnight and were given items of bedding:			
22	Were these clean?	**48%**	**61%**
23	Were you offered a shower?	**4%**	**10%**
24	Were you offered a period of outside exercise?	**4%**	**6%**
25a	Were you offered anything to eat?	**79%**	**81%**
25b	Were you offered anything to drink?	**84%**	**84%**
For those who had food/drink:			
26	Was the quality of the food and drink you received good/very good?	**9%**	**13%**
27	Was the food/drink you received suitable for your dietary requirements?	**39%**	**44%**

Key to tables

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(orange)	Any percentage highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
For those who smoke:			
28	Were you offered anything to help you cope with not being able to smoke?	4%	6%
29	Were you offered anything to read?	22%	14%
30	Was someone informed of your arrest?	47%	45%
31	Were you offered a free telephone call?	71%	50%
If you were denied a free telephone call:			
32	Was a reason given?	0%	15%
33	Did you have any concerns about:		
33a	Who was taking care of your children?	13%	13%
33b	Contacting your partner, relative or friend?	51%	52%
33c	Contacting your employer?	16%	18%
33d	Where you were going once released?	31%	30%
34	Were you offered free legal advice?	88%	88%
For those who were offered free legal advice:			
35	Did you accept the offer of free legal advice?	82%	70%
For those who were were interviewed and needed them:			
37	Was a solicitor present when you were interviewed?	77%	81%
38	Was an appropriate adult present when you were interviewed?	26%	29%
39	Was an interpreter present when you were interviewed?	0%	12%
SECTION 3: Safety			
41	Did you feel unsafe?	63%	62%
42	Has another detainee or a member of staff victimised you?	35%	33%
43	If you have felt victimised, what did the incident involve?		
43a	Insulting remarks (about you, your family or friends)	22%	16%
43b	Physical abuse (being hit, kicked or assaulted)	12%	10%
43c	Sexual abuse	0%	2%
43d	Your race or ethnic origin	2%	2%
43e	Drugs	12%	10%
43f	Because of your crime	20%	12%
43g	Because of your sexuality	0%	1%
43h	Because you have a disability	4%	2%
43i	Because of your religion/religious beliefs	0%	1%
43j	Because you are from a different part of the country than others	0%	3%
44	Were your handcuffs removed on arrival at the police station?	73%	73%
45	Were you restrained while in the police custody suite?	15%	19%
46	Were you injured whilst in police custody, in a way that was not your fault?	23%	23%
47	Were you told how to make a complaint about your treatment?	11%	13%
48	Were you treated well/very well by staff in the police custody suite?	25%	36%

Key to tables

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	Percentages which are not highlighted show there is no significant difference		
SECTION 4: Health care			
50	Did someone explain your entitlements to see a health care professional, if you needed to?	**31%**	**35%**
51	Were you seen by the following health care professionals during your time in police custody?		
51a	Doctor	**14%**	**42%**
51b	Nurse	**49%**	**21%**
	Percentage seen by either a doctor or a nurse	**51%**	**50%**
51c	Paramedic	**0%**	**4%**
52	Were you able to see a health care professional of your own gender?	**10%**	**25%**
53	Did you need to take any prescribed medication when you were in police custody?	**37%**	**42%**
For those who were on medication:			
54	Were you able to continue taking your medication while in police custody?	**22%**	**32%**
55	Did you have any drug or alcohol problems?	**39%**	**52%**
For those who had drug or alcohol problems:			
56	Did you see, or were offered the chance to see a drug or alcohol support worker?	**11%**	**42%**
57	Were you offered relief or medication for your immediate withdrawal symptoms?	**11%**	**26%**
For those who were seen by health care:			
58	Would you rate the quality as good/very good?	**25%**	**31%**
59	Did you have any specific physical health care needs?	**23%**	**31%**
60	Did you have any specific mental health care needs?	**31%**	**24%**
For those who had any mental health care needs:			
61	Were you seen by a mental health nurse/psychiatrist?	**7%**	**13%**