Report on an inspection visit to police custody suites in Essex

7–11 January 2013

by

HM Inspectorate of Prisons and

HM Inspectorate of Constabulary

Glossary of terms

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

Senior managers actively oversaw the custody operation in Essex, which was already seeing benefits from the centralising of its management and organisation less than a year earlier. There was still progress to make in some areas, such as optimising the use of the estate through rationalisation, refurbishment, addressing inadequate staffing levels and effective daily allocation of staff and detainees to suites. The role of middle managers in raising standards was not always evident.

Privacy in the booking-in areas was poor and detainees sometimes stayed in handcuffs for too long after arrival. The support offered around diversity and to more vulnerable detainees was mixed, and it was concerning that staff were not always mindful of child safeguarding issues. Sergeants were skilful in assessing and managing risk while detainees were in custody, but arrangements to ensure their safety on release were variable. Staff handover arrangements needed to be improved to ensure all key information was communicated to the incoming shift. The three suites that had been refurbished were in good condition, but the majority of suites were tired and run down, and some looked neglected.

Although staff treated detainees with kindness, the actual care offered was inconsistent. Provision of food and clothing was reasonable, but detainees had limited access to handwashing and shower facilities and little genuine opportunity for time in the open air for those staying for longer periods.

There was an appropriate focus on the requirements of the Police and Criminal Evidence Act (PACE). Provision of appropriate adults for young and vulnerable people was reasonable, although young people did not always see one promptly. When we inspected Essex, the force adhered to the PACE definition of a child, treating 17-year-olds as adults, whereas in all other UK law and treaty obligations 17-year-olds 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.

Where bail for children and young people was considered inappropriate, there was no local authority safe accommodation available to place them while awaiting a court appearance, which resulted in overnight detention in police cells. As a result of early court cut-off times, some detainees were held far longer in police custody than would otherwise be necessary, and we were not reassured that the complaints process was robust or consistent.

There was a reasonable primary health care service, with prompt response to call-outs, and the management of medicines was generally sound. Most medical rooms and/or their equipment were not up to standard, although the one at Chelmsford was good. Substance misuse services were appreciated by detainees. In an area with a relatively high level of mental health need, reasonably regular diversion services were provided and more were planned. Far too many people were brought into police custody under section 136 of the

Mental Health Act, 1983. In our view, police custody is usually inappropriate as a place of safety for people with acute mental health issues.

In summary, the force has begun to take the opportunities presented by central management, but staffing levels were not always adequate to ensure safe and decent management of detainees. The refurbishment programme needed to continue to bring all the suites up to an acceptable standard. The 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
April 2013

Nick Hardwick
HM Chief Inspector of Prisons

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 *Safer Detention and Handling of Persons in Police Custody* 2011 (SDHP) 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 There were nine full-time and one part-time designated custody suites in the Essex Police force area, with a total cell capacity of 144. The force had held 37,946 detainees in 2012, and 447 detainees had been held for immigration matters during that year.

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

Custody suite	Number of cells	Custody suite	Number of cells
Basildon	20	Grays	17
Braintree	8	Harlow	14
Chelmsford	15	Rayleigh	13
Clacton	12	Southend	25
Colchester	17	Stansted Airport (part-time)	3

The Braintree, Chelmsford, Clacton, Colchester and Harlow suites were in the north of the county structure, with the rest in the south.

2.5 A survey of prisoners at HMP Chelmsford who had formerly been detained in the Essex custody suites was conducted by an HM Inspectorate of Prisons researcher and inspector (see Appendix II).[2]

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

[2] 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

Strategy

2.6 The management of custody had been centralised in early 2012. A refurbishment programme had proceeded slowly, with three suites completed and two to come. There was still room for progress towards a planned, efficient and integrated custody operation across the force area. Suites were staffed from the custody group, but at the time of inspection the inefficient deployment of resources in custody suites resulted in inadequate staffing.

2.7 There was evidence of inefficient teamworking. Detainees were generally taken to the nearest suite, which led to uneven numbers held in locations across the force area. A sizeable number of inspectors did not have the expected impact on standards and morale in the individual suites. Better communication would have led to an even burden of responsibility across the custody suites.

2.8 Senior officers were active in the strategic management of custody through regular meetings and monitoring of performance indicators, and in inter-agency work. Meetings of custody managers were less frequent, and there were no regular opportunities for staff to come together to express their views. Staff had access to a good monthly newsletter on custody matters, but not all were confident in accessing relevant online material.

2.9 There were good systems for reporting incidents and for quality assurance of custody records, with effective feedback to encourage learning. Further communication could ensure that future training takes account of this learning. There was not such effective monitoring of shift handovers. Policies and Independent Police Complaints Commission (IPCC) documents were accessible on the force intranet.

2.10 There was active strategic engagement with relevant criminal justice partners, including a new regional forum on criminal justice issues, and with the regional health board. There was an active independent custody visiting (ICV) scheme, with regular visits by well-supported volunteers. The force engaged well with the volunteers, who had seen improvement since the centralisation of custody management.

2.11 All staff had received adequate initial training, but there were no opportunities for regular refresher training for sergeants and detention officers. Staff had used online training packages to learn about, for example, the changes to PACE code G.

Treatment and conditions

2.12 Staff, especially sergeants, dealt with detainees in a positive and professional manner, with due attention to vulnerabilities and risks. Shortages of staff were creating pressures, and the sergeants did not always have firm control over the suite, with arresting officers and others going to cells without any advice or instructions, including taking first-time detainees to their cell. There were some long waits of one or occasionally two hours before detainees were booked in, and some suites lacked proper holding areas.

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 Towel et al (eds), Dictionary of Forensic Psychology.)

2.13 Most suites had appropriately located detention rooms for children and young people, but the one at Braintree was grim, and we were not assured that the specific needs of children and young people were always identified and met. Female detainees were asked if they wished to speak with a female member of staff, but on some shifts it was difficult to find a female officer to help. All detainees were asked, with appropriate explanations, whether any dependants were affected by their detention. Not all staff were aware of the proper approach to searching transgender detainees.

2.14 All suites had ramps for access, and some had a wheelchair (the one at Colchester was dirty), but not all were adequately equipped for those with mobility difficulties. There were no hearing loops, although some suites had posters about signers. There were Bibles, a Qur'an and prayer mat (with compass) in a box at all suites, but these were not always stored respectfully. There was little privacy for the booking-in process at several suites.

2.15 Risk assessments were carried out thoroughly. Sergeants asked supplementary questions and paid attention to the individual circumstances of the detainee, and they were well attuned to specific needs, such as drugs and alcohol. The routine removal of shoes meant that detainees sometimes walked through the open areas barefoot, although plimsolls were available.

2.16 Staff knew the proper procedures for rousing (checking on people who are under the influence of drugs or alcohol) and used rousing often, and observations were carried out on time in almost all cases. At some suites, but not all, sergeants briefed and supervised PCs carrying out constant watch duties. There was evidence that levels of observations were changed appropriately with a change in the detainee's circumstances.

2.17 A minority if staff carried a personal anti-ligature knife and all suites had them available at the desk, except for Harlow where all knives had been withdrawn on the grounds of being too fragile. At most suites, shift handovers took place one-to-one between sergeants, or between detention officers (DOs).

2.18 Pre-release risk assessments were of variable standard, with some weaknesses in cases where there was clear vulnerability. Some money was available for fares, and travel warrants for detainees being released at some suites, but these were rarely given; if a detainee needed help getting home, normally a police vehicle would take them. Leaflets about agencies providing support in the community were given out frequently.

2.19 A minority of detainees who we saw arrived in handcuffs. In some cases, we saw detainees remaining handcuffed in the holding rooms before booking in although they were fully compliant. Staff filled in a use of force form online in relevant cases, but most did not know where it went or its purpose.

2.20 The refurbished suites – in Basildon, Grays and most recently Chelmsford – were in good condition, although Basildon was already showing signs of wear. At the other end of the spectrum, although the suites were kept clean from day to day, Southend was showing its age with ingrained dirt and considerable graffiti on the cell doors, and the holding room was in poor condition. Clacton and Colchester (which had offensive graffiti) and especially Rayleigh (with no natural light) were also showing their age, and Braintree, while relatively spacious, had a significant crack in the medical room wall. At Harlow the whole environment was not well cared for, with posters hanging down, and there were some ligature points and graffiti outside as well as inside cells.

2.21 Staff carried out informal daily checks of the fabric in most suites, but this was not recorded or monitored. Each suite had an evacuation box with sufficient handcuffs and the required forms.

Staff were aware of their role in an evacuation, but in some suites did not know of any practice evacuations. Call bells were responded to promptly, although those at Basildon and Southend had no audible signal at the time of inspection.

2.22 All cells had mattresses but at several suites they were very thin and worn. Each had a pillow. There were good stocks of standard and rip-resistant blankets at most suites, and cotton towels. Blankets were not issued during the day unless requested.

2.23 Showers were generally in good condition, but were relatively little used. Finding a staff member of the right gender to supervise detainees was sometimes a problem. There were no handwashing facilities in any cells with toilets. All toilets were obscured on the CCTV at all suites. All suites had supplies of tracksuits but no underwear, other than paper items in some suites.

2.24 Staff gave detainees an adequate range of drinks, microwave meals and cereal bars. Staff said that they had been instructed to limit food issue to one item, but they showed sensible flexibility.

2.25 The 'exercise yards' at Colchester, Basildon, Grays and Braintree were indoor rooms, with air flow through grilles. The yard at Chelmsford was open to the air at the top. Stansted had no exercise yard. Exercise was given, but not frequently. All suites had a box of reading matter, mainly old and worn magazines and books provided by staff, with nothing suitable for young people or those not able to read English. Staff at several suites said that no visits would be facilitated, but staff at Clacton said they could take place under exceptional circumstances, and had happened within the last year.

Individual rights

2.26 Individual custody sergeants must be satisfied there is a case and require police officers to demonstrate the cause and necessity for arrest. Most sergeants were prepared to query and even refuse detention in some cases, although several were aware of a renewed emphasis on reversing the decline in the numbers of arrests. Many staff, and some solicitors, said that there were sometimes long waits for investigation teams, although the structure of having investigating teams was changed during the inspection to address this issue.

2.27 In most suites, the charity Catch22 provided appropriate adults (AAs) between 7am and 11pm. We saw some prompt attendance by AAs. They said that they had often been kept waiting before entry to a suite, but managers had given attention to this problem. There were a few cases of young people arriving in the early evening and not receiving an AA until the following morning. No children had been brought to any custody suite as a place of safety. At the time of the inspection, the force adhered to the PACE definition of a child instead of that in the Children Act 1989,[3] which meant those aged 17 were not provided with an AA.

2.28 There was good use of telephone interpreting and interpreters in person for booking in, but several suites did not have the relevant double-handset telephones. All suites used a good local rights and entitlements leaflet, which was available in several languages, although not in Braille or in easy-read format.

[3] 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.

2.29 Reviews were carried out within the required period, although sometimes quite early, and generally by the inspector in person. There was no clear evidence that detainees were reminded of their rights when they woke up after a night-time review.

2.30 There was no direct evidence of delays in the Border Force collecting immigration detainees from police custody, although managers told us of some past cases. The UK Border Agency was prompt in issuing forms authorising detention. Arrangements for managing DNA and forensic samples were sound in all suites.

2.31 Solicitors were very positive about the police in the suites. Some suites had cordless telephones to enable detainees to speak to their solicitor in private. PACE codes of practice were available in most suites, but not all were up to date.

2.32 We were told that the courts offered some flexibility in court cut off times and would accept detainees into court any time up to 5pm. However, many custody staff believed that 1pm was usually the norm on weekdays and 10am at weekends, and these were the times they worked to. Hearings involving remanded defendants were restricted to two courthouses, which had made it more difficult for some other suites to get detainees to court. Although this decision was due to be reversed, it resulted in detainees spending longer periods of time in custody.

2.33 Arrangements for taking detainees' complaints were variable, but generally poor.

Health care

2.34 G4S Medical Services was the main health service provider with a busy caseload of around 1,800 calls a month, and the service was generally well regarded by the police. Over 90% of call-outs arrived within 60 minutes. Not all G4S health staff received regular clinical supervision. Health care professionals were not immediately recognisable as they were not in uniform.

2.35 Medicines management was generally good, although patient group directions were out of date. Stock was securely stored at most suites. Some medical reference materials were out of date, representing a risk. There was improper secondary prescribing of the medicines. The dispensing of medicines by custody officers from the telephone advice safes, while at the request of health care professionals, was poor practice. Police officers visited the detainee's home to get medication as necessary.

2.36 The quality of medical rooms was very variable. Cleanliness was of the required standard at Chelmsford, but there was an urgent requirement for deep cleaning elsewhere. Some fixtures and fittings did not meet infection control standards. Auditing in preparation for the move to NHS commissioning had provided guidance on infection control, and remedial actions had begun.

2.37 Resuscitation equipment was standardised and included automatic external defibrillators. Equipment checks were regular, although not always documented, and staff were appropriately trained. There was needless duplication of some resuscitation equipment at some suites, and suction equipment was not assembled for use and therefore not ready. The content of several first aid kits was out of date, although prompt action was taken to rectify this.

2.38 Custody staff were generally content with the working relationships with the health staff, and clinical records indicated that treatment was appropriate to assessment. We were concerned to see CCTV cameras in some medical rooms, as they were a potential risk to medical

confidentiality. All medical rooms had switches to turn off the CCTV, although the one at Stansted was outside rather than within the room.

2.39 G4S staff inputted clinical records directly on to the NSPIS (national strategy for police information systems) IT case record system, which was good practice. Custody staff said that they received useful information and guidance from medical staff. Medical records were securely stored.

2.40 Westminster Drug Project provided services at most suites (through Inside Out and other projects), and custody staff were satisfied with the services. There were projects to introduce high intensity programmes alongside the low intensity ones that were run. Substance misuse workers visited most suites daily, and police could make appointments for detainees at other times. Methadone therapy and needle exchange were not available to detainees while in custody but symptomatic relief was. Children and young people were seen by drugs workers, who signposted them to appropriate services.

2.41 In our survey, more respondents than the comparator said they had mental health needs (40% against 23%). North and South Essex Partnership NHS Trusts provided services to police custody suites through criminal justice liaison teams. The team workers visited most suites daily and were available by telephone at other times. Custody staff were generally content with the support they received to work with detainees with mental health care needs. Most custody staff had received some mental health awareness training within the last year.

2.42 The suites had been used frequently for detention under section 136 of the Mental Health Act[4] with an average of 286 times a year in the last three years, which was high. Work was in hand to capture NHS data on the use of section 136. There were five NHS section 136 suites available throughout the county, and also one facility for children and adolescents. There were problems in getting the NHS to take detainees who were intoxicated, and delays for police officers waiting for NHS staff and beds to be available. These problems had been brought to the attention of the mental health trust and a revised protocol had been agreed.

Main recommendations

2.43 **The force should ensure that the custody staff and suites provide for a respectful and suitable environment for detainees.**

2.44 **Sufficient officers should be deployed in custody to provide safe and decent management of detainees at all times.**

2.45 **Police custody suites should not be used routinely as places of safety for detainees under section 136 Mental Health Act.**

National issues

2.46 **Appropriate adults should be available out of hours, given informed consent where necessary, to support children and young people aged 17 and under and vulnerable adults in custody.**

[4] Section 136 of the Mental Health Act 1983 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.

Strategic management

3.1 An assistant chief constable (ACC) provided strategic leadership on custody issues, with a centralised custody function delivered through the criminal justice and offender management (CJOM) department. There was a police staff head of CJOM, and a chief inspector head of custody in the CJOM.

3.2 The force estates strategy had led to the reduction to the current nine full-time and one part-time suites. A review of the custody estate in 2003 had resulted in a seven-year programme to refurbish or replace most of the custody suites in the force. Priorities had changed in the intervening period and a revised plan was now being developed. The refurbishment of three suites had been completed since 2003 and the plan to refurbish Southend and Harlow was still relevant. The Police and Crime Commissioner (PCC) had agreed to fund these developments.

3.3 Essex Police had nine full-time designated custody suites and a part-time designated custody suite at Stansted Airport. Since the reduction to the current nine full-time suites, there had been no occasions that had required the unplanned use of other suites or neighbouring forces' custody facilities.

3.4 Staffing levels in custody suites during the inspection was not always adequate, and the shortfall was not made up from operational resources. Staffing comprised permanent custody sergeants and police staff detention officers (DOs), employed by Essex Police. 'Acting sergeants' were not used to undertake custody duties. The role of DOs in looking after the ongoing care and welfare of detainees was sometimes compromised due to shortfalls in staffing levels, resulting in operational staff often assisting in taking detainees to and from the cells (see paragraph 4.49). There were 10 vacancies for DOs and recruitment to address this had started. Although designated in their role, DOs often did not search detainees. Some DOs were trained to take fingerprints and photographs, while some were not. Consequently, working practices differed from suite to suite.

3.5 Staff viewed the roles of custody sergeants and DOs as separate and there was a lack of a team approach with clear roles and responsibilities. This had a consequent effect on corporate approach to custody delivery – for example, during the shift handover, where standardisation would improve the effectiveness of custody provision and minimise risk. There was no evidence of a centralised cell allocation process, and detainees were generally taken to the nearest police station that had a custody facility.

3.6 There were 10 dedicated PACE custody inspectors, two per shift in the north and south of the county (see paragraph 2.4), line managing the custody sergeants, who in turn line managed the DOs. In addition, there were two custody managers (inspectors, north and south) with no line management responsibilities. However, other than their PACE duties, identification process management and quality assurance feedback, there was little evidence of these inspector resources positively impacting on the outcomes for detainees within the custody suites. This was a significant resource with scope to provide leadership, oversight and

corporacy. All inspectors were line managed by the chief inspector head of custody who also had another inspector as his deputy.

3.7 The assistant chief constable (ACC) lead for custody held a fortnightly meeting with the head of CJOM, where outstanding custody matters could be raised for resolution. The ACC held a bimonthly CJOM board meeting, attended by the head of custody, to review performance, which included near misses, bail and constant watches. The head of CJOM's fortnightly senior management team meeting, attended by the head of custody, also covered custody issues. There was a six-monthly custody inspectors meeting chaired by the head of custody. This was not often enough to address the changes that were happening and to engage managers, but the force was due to make the meetings more frequent.

3.8 There were no formal custody user group meetings, although staff could express views in team meetings held on training days. Staff reported that the PACE shift inspectors were visible around the suites, but the custody managers and chief inspector in custody were less so.

Partnerships

3.9 There were satisfactory partnership arrangements and active strategic engagement with relevant criminal justice partners. The chief constable chaired the local criminal justice board (LCJB), which was attended by the ACC custody lead who also deputised for the chief constable when needed. The ACC also chaired the criminal justice reform board attended by criminal justice partners. The PCC had also recently attended the LCJB. A regional forum on criminal justice issues was due to be established with Kent Police, which the head of CJOM was to attend. The head of custody represented Essex Police on a regional health care board as part of the NHS commissioning of health services in police custody. Essex Police was in the second wave of this programme

3.10 The PCC's office had recently appointed a coordinator for the independent custody visitors (ICV) scheme. There were two ICV coordinators and the scheme was active, with a single panel covering the force area, providing a regular schedule of visits. ICVs said that they were generally admitted to custody suites quickly and were confident in challenging staff. ICVs had identified trends in the slow response to requests for repairs in custody suites. There was an annual training event and meeting for ICVs, and consistent police representation from the CJOM department at coordinator meetings. Feedback from the police was generally good, but the monthly feedback reports had recently ceased, although ICVs commented on the greater professionalism and consistency of provision since the centralisation of the force.

Learning and development

3.11 All custody sergeants and DOs had undergone custody-specific training before undertaking custody duties. There was an initial course for custody sergeants followed by a period of mentoring. The course was linked to the national custody officer learning programme (NCOLP) organised by the College of Policing. There was no custody refresher training, although the shift pattern allowed for five annual training days. This was a missed opportunity and a risk to the organisation. Refresher training would also need to be informed by the monitoring and analysis of quality assurance, adverse incidents and complaints. Training in the new code of practice G of PACE had been delivered across the force through a computer-based training package.

3.12 The force had several custody policies based on the *Safer Detention and Handling of Persons in Police Custody* (see paragraph 2.2), which were accessible to all staff on the custody

intranet page. The force was actively consulting on some policies due for review. The Independent Police Complaints Commission (IPCC) 'Learning the Lessons' document was also available on the custody intranet site. A bi-monthly custody newsletter was used effectively to communicate a wide range of custody issues. Staff awareness of the custody intranet site was mixed and could be improved.

3.13 There was a thorough process for reporting adverse incidents with a custody sergeant completing an electronic report form at the time of the incident. These are incidents where some significant danger, risk or harm is averted; the incident is then used to learn lessons to avoid any repeat or worse outcome in the future. The form was forwarded through the inspector to the head of custody and the professional standards department. All adverse incidents were analysed and reported to the quarterly health and safety meeting chaired by the head of CJOM. Immediate issues were dealt with by email and also featured on the custody newsletter.

3.14 There was a quality assurance process for sampling custody records. The corporate development department analysed 20 custody records per suite a month and gave feedback to the head of custody. This process was comprehensive and completed on a corporate template with a joint focus on 'legislation compliance' and 'risk and control', and a clear feedback trail to individual officers. The sampling was overseen by the head of custody. The focus was on the quality of completion and included the person escort record (PER) form. There were no cross-referencing checks to CCTV recordings. The custody manager raised any issues arising from the sampling in person with the relevant staff member, and any trends were communicated through the newsletter. There was no quality assurance of shift handovers.

Recommendations

3.15 **The force should review operating procedures for the custody suites, to include clear and consistent guidance on roles and standards relating to the treatment and conditions of detainees in particular to ensure that inspectors are undertaking the full range of duties relating to custody and fulfilling their obligations in providing care for detainees.**

3.16 **The sampling of custody records should include cross-referencing checks to CCTV, and the quality assurance process should cover shift handovers.**

Housekeeping points

3.17 Scheduled training days should include a structured forum where custody practitioners and managers can discuss custody issues.

3.18 Refresher training should be delivered regularly to all custody staff.

4. Treatment and conditions

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

Respect

4.1 Custody sergeants interacted with detainees in a professional manner, and were respectful and friendly. Most of the many detainees we spoke to told us that they had been treated very well. DOs were generally not involved in the booking-in process nor, quite often, in the initial lodging of detainees in cells, which was left to arresting officers.

4.2 The booking-in areas in most suites, except Rayleigh, offered little privacy for detainees. However, owing to low staffing levels, we very rarely saw any more than one detainee being booked in at a time. At Clacton and Harlow, there was only room at the booking-in desk for one detainee to be booked in at a time, although there were separate offices further away that were occasionally used, but these were not covered by CCTV. Except at Stansted, all booking-in desks were of a reasonable height to facilitate good communication with detainees.

4.3 There was a lack of direct supervision of the DOs at many custody suites. Staff resourcing was a problem and there was often one sergeant or DO less than there should have been. Although relations between custody officers and DOs were not strained, there was no clarity of roles and direction, and working arrangements lacked any team ethos. We saw custody sergeants and arresting officers visiting cells and undertaking duties that we usually see DOs doing, such as taking drinks, answering call bells or removing blankets from cells, and occasionally the taking of fingerprints and photographs.

4.4 We did not see any DOs searching detainees, although we were told that most were trained and authorised to do so. We saw several cases where arresting officers tried to find a female police officer to search a female detainee when there was a female DO in the suite.

4.5 Although staff were professional in their dealings with detainees, the approach to diversity was mixed. Young people were mainly treated no differently from adults. For example, we saw a very frightened 12-year-old detained in a cell overnight for a relatively minor allegation with nothing but an adult newspaper to occupy him.

4.6 Staff told us that child safeguarding was covered in their custody training but were uncertain about their responsibilities. We observed several children and young people aged 13 to 17 (both male and female) being booked in at 9pm when arrested in the company of a 32-year-old non-related male on suspicion of criminal damage, with a suggestion that drinking alcohol had been involved. The custody staff did not initially identify this as a safeguarding issue.

4.7 All women being booked in were asked if they were pregnant and whether they wished to speak with a female member of staff. They were not routinely told about the availability of female sanitary products – they were usually expected to ask for these themselves. In our custody record analysis (CRA), all the women in the sample were asked if they were pregnant and if they would like to see a female member of staff. There was nothing further recorded about their treatment as females, such as the possible need for sanitary products, although one woman who was pregnant was given a lift home. We were told that on some shifts it was often difficult to locate a female member of staff when required. Similarly, there were some all-

female DO shifts where it was difficult to provide showers for male detainees because there was no male member of staff (although at one suite a female DO said that female DOs supervised males taking showers).

4.8 All detainees were asked, with appropriate explanations, whether any dependants were affected by their detention. We saw one woman at Basildon allowed to make a telephone call to arrange for a friend to collect her child from school.

4.9 Not all staff were aware of the correct way to search transgender detainees (as per annex L, PACE code C guidance), with staff detailing varying ways in which they would deal with such a situation.

4.10 Some suites had accessibility ramps. Chelmsford, Basildon and Grays had toilet facilities for disabled users. None of the suites had hearing loops fitted at the booking-in desks but some had notices indicating that signers were available. There was no Braille documentation. The wheelchair available at Grays had flat tyres, and the one at Colchester was dirty. None of the cells had specific adaptations for individuals with disabilities, although a few could take a wheelchair.

4.11 Bibles, prayer mats, and Qur`ans were available, easily located and mostly respectfully stored. However, at Grays they were stored in a plastic box on the top of a cupboard with a portable toilet placed on top of the box. The direction of Mecca was not always indicated but the prayer mats usually included a compass. Grays and Rayleigh also had a copy of a Hindu text available. The box at Grays indicated it should have had a copy of a Sikh text and the Jewish daily prayer, but neither was present.

4.12 At Basildon we saw a good example of care and consideration afforded to a physically disabled 18-year-old with learning difficulties, who was allowed to remain with his mother in a consultation room for over five hours, rather than being placed in a cell. He was subsequently bailed pending further enquiries.

Recommendations

4.13 **Booking-in areas should provide sufficient privacy to facilitate effective communication between staff and detainees, and there should be clear policies and procedures to meet the specific needs of females, children and young people and those with disabilities.**

4.14 **The role of detention officers should be clarified to ensure that detainees receive a level of care which ensures they are looked after and kept safe.**

4.15 **Adult and child safeguarding training should be given to and understood by all custody staff.**

Housekeeping points

4.16 Staff should be made aware of the procedures for searching transgender detainees outlined in annex L, PACE code C.

4.17 Hearing loops should be available.

4.18 Items for religious observance should be respectfully stored.

4.19 Risk assessment questions were prompted through set questions on the NSPIS IT system, but before they carried out the initial risk assessments, custody sergeants checked information held on the police national computer (PNC) as well as on previous custody records, which allowed them to take PNC warning markers into account. In our CRA, 18 detainees (30%) reported current or previous self-harm or suicide issues. In nine of those cases, the PNC showed self-harm markers, which on being identified, informed the subsequent care plan.

4.20 Custody officers conducting the risk assessments had a reassuring approach and encouraged detainees to elaborate their answers where there might have been additional risk, such as when self-harm or medication needs were disclosed. This was confirmed in our CRA, where we found that the risk assessments were sufficiently detailed and recorded thorough accounts of detainees' medication and previous self-harm issues. Many other assessments we saw were generally balanced and proportionate. Detainees' shoes, jewellery and clothes with cords attached were routinely removed, but not necessarily their spectacles.

4.21 Custody sergeants told us that strip searching was only used if detainees were arrested for specific offences or if warning makers required a thorough search before the detainee was located in a cell. We were told that strip searches took place in appropriately private rooms or in cells not covered by CCTV.

4.22 At busy times, some booking-in areas were crowded with non-custody staff, which made for a chaotic atmosphere. We routinely witnessed officers picking up cell keys and going to cells to remove detainees for interview or to speak with them. Custody staff did not always have firm control over the suite and often were unaware of who was present there.

4.23 Staff told us, and we witnessed, that they were not always advised in advance of detainees being brought to the custody suites, which made it difficult to manage working arrangements at peak times. In the case of violent detainees, they were usually pre-warned of their arrival, which allowed them to clear the booking-in area if required.

4.24 There were some long waits before detainees were booked in because of the low staffing levels, with a single custody sergeant in many cases. At Basildon we observed one detainee who waited two hours 20 minutes from arrival to being booked in, while another took one hour 53 minutes to be booked in. These delays had resulted from the number of detainees already in the custody suite and a backlog that then built up in the holding room. At Harlow and Clacton there was no seating in the holding rooms and detainees had to remain standing for long periods, sometimes handcuffed (see paragraph 4.41).

4.25 Most of the detainees we observed being booked in were placed on 30-minute observations. Our CRA indicated that detainees placed on 60-minute observations tended to be checked more frequently in any case. We saw DOs carry out checks diligently, in accordance with care plans, and they knew how to use proper rousing techniques to elicit responses from detainees (for example, if they had been brought in intoxicated). Some suites displayed prominent aide-memoires reminding staff of this.

4.26 In our CRA, of 18 detainees who came into custody intoxicated, 11 were placed on rousing observations. Observations were on time for 57 (95%) of the detainees. In two cases, some observations lapsed from 30 to up to 45 minutes. In a third case, a 20-year-old detainee with a history of self-harm was placed on 60-minute observations. There were two gaps in his detention log – one of over four hours and the other of 90 minutes. There was evidence that observation levels were monitored and changed when appropriate. It was not always clear that

observation levels were appropriate for the perceived risk. For example, three of the detainees placed on 30-minute observations had stated during their initial risk assessment that they might attempt to self-harm while in custody. One young female aged 15 with a history of depression, anxiety and recent self-harm who was in custody for the first time was also placed on 30-minute observations.

4.27 We observed some constant watches by uniformed patrol officers. The custody sergeants generally briefed and supervised them, although this was not always the case. They were responsible for completing a separate 'constant watch detention log', and these were detailed and well maintained. This information was not always recorded on NSPIS, but we were assured that the logs were filed along with a copy of the custody record and any other relevant documentation.

4.28 Every suite had some cells that were monitored by CCTV, and in the recently modernised suites, such as Chelmsford, all cells had CCTV cameras. There was no evidence that CCTV was used in place of personal checks.

4.29 Very few custody staff carried anti-ligature knives, even though some suites, such as Chelmsford, had long corridors and a long distance between the furthest cell and the booking-in desk. At Stansted, an anti-ligature knife was attached to the cell keys, and they were kept at the booking-in desk at all other suites, except Harlow. Several staff were unaware if the anti-ligature knives available were for single or multi-use, and some of these knives were used inappropriately to cut cords on detainees' clothing, which with regular use could result in the blade becoming blunt.

4.30 Staff checked cells after each occupation to identify any unauthorised items or any damage. Staff assured us that all cells were single occupancy and detainees would never be doubled up.

4.31 We observed several staff handovers. These were not done as a team, but conducted separately for custody sergeants and for DOs, although the current shift patterns allowed joint briefings. Staff said that the separate handovers were necessary as sergeants needed to know about PACE and investigation issues, while the DOs focused more on care and welfare. We did not support this view. Although the quality of information passed between officers was good, this approach and lack of team ethos did not ensure that essential information about risk was passed on. For example, we observed one handover between two sergeants where a DO passing by interrupted a discussion about a particular detainee to give them the benefit of her experience of dealing with the detainee on several occasions. Handovers between custody sergeants generally took place in front of a computer terminal in the booking-in areas, allowing the content to be recorded, but this was not always the case with the DO handover.

4.32 The custody record system incorporated a pre-release risk assessment (PRRA) form, which prompted the sergeant releasing a detainee to consider potential issues. In our CRA, PRRAs were recorded as complete for 58 (97%) detainees, with the remaining two not recorded as having been released. The PRRAs that we saw were not always very detailed, with often no risks identified. Two detainees in the sample (3%) had some vulnerability on release that appeared not to have been addressed, either because the PRRA showed no risk or identified risks had not been acted upon. One case involved a female detainee with a history of depression and self-harm who was bleeding heavily following an abortion two weeks previously. Her PRRA identified no risks and she was released at midnight with no record of how she would travel home. In the second case, a detainee who arrived in custody intoxicated failed a field impairment test for drugs, and the attending health care professional deemed him

not fit for interview. His PRRA identified these risks yet failed to address them, and he was released at 5.26am with no record of travel arrangements.

4.33 The PRRAs for the few detainees we saw released during the inspection also tended to be scant. However, custody officers told us that they would take great care to find out how detainees were to get home, especially at night. We observed one custody officer at Harlow going to great lengths to ensure that a vulnerable person reached home and had the opportunity to collect medication at a nearby pharmacy. We also saw some vulnerable detainees given a comprehensive leaflet detailing local support agencies when they left the custody suite, although the leaflet was available only in English and not at all suites. Some suites had travel warrants to facilitate transport home for vulnerable detainees but we were told that these were rarely issued. In most cases, vulnerable detainees were taken home in police vehicles and we observed this taking place. In our CRA, there were some positive examples of detainees' receiving lifts home from police officers, and most detainees had been given advice leaflets on release.

4.34 We observed person escort records (PERs) being completed for detainees due to be transported to court. We were told that in some suites, such as Rayleigh, the custody sergeants completed the PERs, but at some others they were completed by DOs with the custody sergeant checking and signing them. At Grays we saw one detainee returning from hospital with a fully documented and completed PER.

Recommendations

4.35 **All custody staff should carry anti-ligature knives in the custody suite.**

4.36 **Risk assessments and subsequent observation levels should be monitored to ensure they are appropriate.**

4.37 **Staff handovers should be comprehensive, recorded and attended by all custody staff, and take place in an area cleared of other staff and detainees.**

4.38 **Pre-release risk assessment of detainees should take into account all known risk factors, and staff should take action appropriately to mitigate the risks.**

Housekeeping point

4.39 The force should ensure that strip searching data is accurately recorded and collected to monitor use, identify trends and take action for proportionate and appropriate application of strip searching.

Use of force

4.40 All custody staff had been trained in approved personal safety techniques and received annual refresher training, but DOs did not receive the same level of training as custody sergeants.

4.41 A minority of detainees were handcuffed on arrival. The local policy was that detainees remained in handcuffs until the custody sergeant authorised their removal. Due to the understaffing in some suites, some detainees were kept waiting handcuffed in the holding area for significant periods (see paragraph 4.24). In Basildon, Grays and Harlow, we observed several cases where detainees were held in handcuffs for an excessive time. In one case, a

60-year-old male, who was fully compliant, was handcuffed to the rear for almost an hour before the handcuffs were moved to the front. He was then held in that position for another hour before the handcuffs were removed when he was booked in. His co-accused, who was also compliant, was similarly held, but it took a further 20 minutes before he was booked in. However, many detainees were brought into the suite not handcuffed, and it was clear that arresting officers judged whether it was necessary and justified, which was commendable. During the inspection, we considered that handcuffs were justified for most of those arriving at the suite in them.

4.42 We were told that force was used in the custody suites infrequently, and staff placed a strong emphasis on the need to de-escalate situations and only used force as a last resort. When force was used, this was recorded on the custody record and a use of force report usually completed, although not all custody sergeants were aware of this form. There was little use of this data for analysis or to identify trends. We were told that detainees were not routinely seen by a health care professional after force had been used, unless an injury had been sustained, or the detainee requested it.

Recommendations

4.43 **Handcuffs should be removed from detainees as soon after arrival in the custody suite as the evidenced level of risk permits.**

4.44 **Essex police should monitor the use of force at each custody suite by ethnicity, age, location and officers involved, identifying trends and taking appropriate action in line with the Association of Chief Police Officers (ACPO) guidance.**

Physical conditions

4.45 There was a lack of formal, systematic maintenance and health and safety checks in many custody suites, rather than the daily checks, records and management overview that we usually see elsewhere.

4.46 The condition of the custody estate was mixed and the force was in the process of a refurbishment programme (see paragraph 3.2). Chelmsford, which had opened in November 2012, was very clean and well equipped, as were Grays and Basildon, although the latter was already showing signs of wear. The rest of the estate appeared tired, run-down and in need of refurbishment. However, cells were generally in a reasonable condition and appropriately heated and ventilated, although some at Harlow were cold. We were told that responses to maintenance needs varied considerably, and that two cells at Southend had been out of use for almost a fortnight.

4.47 At Rayleigh and Clacton, the cells had no or very restricted natural light and were very dark. Some cells there, as well as in Southend, also had considerable graffiti. At Harlow, the outside of the cell doors of juvenile rooms bore a great deal of graffiti, as did the doors in the holding areas, even though we were informed that detainees were always supervised in these areas. Staff told us that this damage had been there many years. Elsewhere, graffiti was minimal, except on the wooden benches. Some graffiti was offensive. Although we were told that detainees found causing damage to the cell were charged with criminal damage, nobody could remember this ever happening.

4.48 Some parts of the Braintree suite were dirty and there were cracks in the masonry. Several cells had toilet paper stuck to the ceilings, showers had ingrained dirt and the exercise yard

was shabby. Staff told us that deep cleaning was rare and that the cleaning staff were not permitted to clean higher than where they could reach without step ladders. As a result, there was a build up of dirt and grime on the higher parts of the walls and ceilings. We also saw this, to a lesser degree, at the relatively modern Grays suite.

4.49 Call bells functioned correctly. We saw DOs explaining their use to detainees and responding to them promptly. However, we also saw many detainees taken to the cells by arresting officers, rather than custody staff, after they were booked in, with no explanation about the call bell or any other information. This was particularly unfortunate in the newer suites, where the call bell was simply a coloured tile. The call bell panels at Southend and Basildon did not have an audible warning signal, and staff had to see the flashing light on the call bell panel or CCTV screen to realise a bell had been activated.

4.50 Cells in some suites had ligature points but most were a relatively low risk, and we brought them to the attention of the force during the inspection.

4.51 Most staff were aware of fire evacuation procedures, and about half the suites could produce evidence of a recent fire drill. There was a fire evacuation box with handcuffs in all suites.

Recommendations

4.52 **There should be thorough daily and weekly maintenance checks to ensure cell and other detainee areas are in a good state of repair, clean, free of graffiti and have a source of natural light.**

4.53 **All visits to cells should be made by, or accompanied by, a member of custody staff.**

4.54 **The correct use of call bells should be explained to all detainees, and all call bells should activate an audible alert.**

Housekeeping point

4.55 Regular fire evacuation drills should be carried out in all suites.

Detainee care

4.56 All cells contained a mattress and a pillow but some were in a poor condition and needed replacement, especially at Colchester and Basildon. Mattresses and pillows were seldom wiped down between use. DOs were either reluctant or had been informed not to do this or clean up minor food and drink spillages. Clean blankets were provided on request and also at night.

4.57 The majority of cells had toilets, but none had any handwashing facilities. A small box of toilet paper was routinely available in the cells (except at Harlow), subject to risk assessment. In our prisoner survey, 61% of respondents, against the comparator of 48%, indicated that toilet paper was provided. The view of the toilet area was obscured on the CCTV images of the cells, but we did not hear this explained to detainees.

4.58 Showers were available at all the suites but their use, cleanliness and privacy varied widely. Many staff told us they were rarely able to provide showers for detainees owing to a lack of staff to supervise. Our CRA also showed no evidence that showers were routinely offered to

detainees. Three (5%) detainees had been offered a shower or wash while in custody, one of whom accepted. However, in our prisoner survey, 24% of respondents, against the comparator of 9%, indicated they had been offered a shower. Cotton towels were available at all suites as well as good stocks of toiletries but few detainees knew about this.

4.59 Detainees who had their clothing removed were usually given a red tracksuit and plimsolls. Colchester had a stock of donated spare clothing, and one homeless detainee had a warm coat and jumper placed in his property for his release. Underwear was rarely provided. We saw one detainee walking to and from the medical room in a shirt and long johns. This was in front of other detainees and a female appropriate adult.

4.60 Safety clothing was also available for vulnerable detainees deemed to be at risk of self-harm. We saw a detainee who had just been interviewed walking around the suite, in view of non-custody staff, wearing this clothing and also barefoot.

4.61 Detainees generally received microwave meals (which were of ~~a~~ low calorific content) at recognised mealtimes, although most DOs said they would supply them at any time on request. Vegetarian and halal diets were provided for. DOs told us that they were under instruction to serve only one meal at a mealtime, but they were appropriately flexible on this. Breakfast was a choice of a cereal bar or a microwave breakfast, but DOs said they did not always follow the instruction to provide just one cereal bar. Drinks were available on request and routinely offered by custody sergeants when a detainee was booked in.

4.62 Each custody suite, except Stansted, had an exercise yard or area, although some were shabby and seldom used. Some of the exercise yards, such as at Colchester, Basildon, Grays and Braintree, were indoor rooms with air flow through grilles. The yard at Chelmsford was open to the air at the top. There was no force-wide approach to the supervision of detainees in exercise yards. Some staff indicated that detainees would be personally supervised by a member of staff, while others said that supervision was through CCTV monitoring. Exercise was seldom offered. Staff told us that detainees were always given exercise on request, but that this was rare (although we did see several detainees using the yards during the inspection).

4.63 The provision of reading material was poor, although all suites had a small selection of books and old magazines and newspapers provided by staff, but with little that was appropriate for young people or in foreign languages. Some DOs offered detainees something to read but most said that they would supply if asked. Many detainees said that they were given reading materials, but it appeared that the others had not been offered anything to read, as nothing was recorded on the detention logs.

4.64 We were told that visits to detainees by relatives were allowed in exceptional circumstances, but custody staff at just one suite could recall this happening. In our CRA, one young person under 17 was allowed a visit from his girlfriend. There were no closed visit facilities

Recommendations

4.65 **All detainees held overnight, or who require one, should be offered a shower, which they should be able to take in private.**

4.66 **Food offered to detainees should be of adequate quality and calorific content to sustain them for the duration of their stay.**

4.67 **Detainees held for long periods should be offered outside exercise.**

4.68 **Detainees should not walk around the custody suite semi-clothed and barefoot.**

Housekeeping points

4.69 Replacement underwear should be available at all suites.

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

4.71 A range of reading materials, including in foreign languages and material suitable for young people, should be available in all suites and actively offered.

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 We observed detainees being booked in reasonably promptly at many custody suites with some exceptions (see paragraph 4.41). We also saw detainees at Harlow waiting for up to 80 minutes to be booked in. Custody sergeants checked the reasons for detention with arresting officers to ensure that they were appropriate.

5.2 Custody sergeants were aware of the renewed emphasis on reversing the decline in arrest numbers and advised that arrest targets had been introduced. Several sergeants told us they had never refused detention, even when there may have been options to deal with the detainee outside the custody environment. Many operational officers we spoke to appeared vague about alternatives to custody, such as voluntary attendance at police stations. However, some custody sergeants gave recent examples of when detention had been refused where there had been insufficient evidence or the necessity test was not met, and spoke of alternative ways of dealing with detainees.

5.3 We spoke to solicitors who also felt that alternatives to arresting detainees were not used enough, and that some detainees spent too long in the custody suite waiting for an area investigation team (AIT) to progress the investigation. Custody sergeants were clear about their obligations to ensure that cases proceeded quickly but confirmed that there were occasionally delays in waiting for the AIT.

5.4 The force had introduced training for custody and operational staff on the new PACE G code of practice relating to voluntary attendance. This had been introduced in November 2012 and it was too soon to assess the impact on arrest figures. We observed a small number of voluntary attendees interviewed at custody suites across the force area.

5.5 We also observed detainees brought into the suite after arrest on warrants and, although the warrants were lawfully executed, in two cases we were concerned at their timing. In one case, a young woman was arrested from her home address at 2.17pm on a non-payment of fine warrant. This warrant necessitated a court appearance, and we were told that it was a pre-planned task for operational officers. Due to the early court cut-off times (see paragraph 5.22) it was inevitable that this young woman would have to be detained overnight in police cells. Arresting her just two hours earlier would have allowed her to appear before the afternoon court and thus prevented 18 hours in police custody. In the other case, a man was arrested at his home at approximately midnight on a warrant for a breach of a court order and was detained overnight for the morning court. There did not appear to be any reason why he could not have been arrested at 6–7am and so appear promptly before the morning court, preventing unnecessary time in police custody and occupation of a cell. Custody staff at several suites said such cases were common.

5.6 Custody staff told us that they had a good relationship with UK Border Agency staff and that most immigration detainees were collected within 24 hours. According to force data, 447 immigration detainees had been held at the custody suites in the previous 12 months. We

were told that their average length of detention was 18 hours, although staff at Grays said that detainees detained at Tilbury docks could be lodged with them for up to three days.

5.7 Staff assured us that the custody suite was never used as a place of safety for children under section 46 of the Children Act 1989.

5.8 Essex Police adhered to the PACE definition of a child instead of that in the Children Act, which meant that those aged 17 were not provided with an appropriate adult (AA) unless they were otherwise deemed vulnerable[5] (see national issue 2.46). Family members were usually contacted initially to act as an AA. In the record analysis, an appropriate adult was contacted for six of the young people, but whether the AA was present while they were read their rights and for their interview was not well recorded. The need for an AA was recorded for one young person but no attempt to contact one was recorded. Another young person, aged 16, was subjected to a strip search before the AA was contacted or arrived, as he was suspected of carrying drugs. He arrived in custody at 5.50pm, authorisation for the strip search was given at 6.27pm and carried out at 6.43pm, and the AA was contacted after the strip search, at 6.54pm, with the record that: it was: 'impracticable to await AA for search'. Although the AA eventually attended, the time of arrival was not recorded.

5.9 There were several schemes that operated when it was not possible to contact a family member or friend to be an AA. For example, at Southend and Grays, Essex Social Services provided an AA for vulnerable adults during office hours, while the local youth offending team (YOT) provided AAs for children and young people up to 10pm. Custody staff told us that there had been problems in getting the relevant social services/YOT department to attend when detainees were taken to suites outside their home area. Elsewhere, the Catch22 charity was the provider of AA volunteers for both children and young people and vulnerable adults between 7am and 11pm. Out-of-hours cover for all suites was provided by the social services emergency duty team (EDT), although staff said that they rarely attended when asked. The provision of AA was variable and sometimes delayed.

5.10 Some custody officers tried to avoid keeping children and young people in cells overnight; we saw some good examples at Harlow. Custody staff said that they would try to contact social services to arrange accommodation for young people who could not be bailed but were always informed that none was available. In our CRA, the longest wait for an AA was approximately three and a half hours in the case of two young people, one of whom was aged 12. However, at Basildon we saw a 16-year-old girl who had been detained 17 hours due to the unavailability of anyone to attend from an AA scheme, as well as the frightened 12-year-old detained in a cell overnight (see paragraph 4.5). However, we observed some AAs arriving very promptly. One complained that she was often kept waiting at the police station front desk.

5.11 Leaflets about legal rights were available in several languages and were easily accessible. The material was not available in Braille or in a pictorial format for detainees with sight or learning difficulties or with limited literacy. In our CRA, there were seven foreign nationals (12%), of whom six had been informed of their rights as foreign nationals, but in the seventh case it was unclear if the detainee was given their rights and entitlements in their own language over the telephone when they were booked in or when an interpreter eventually attended for interview over 10 hours later.

5.12 A professional telephone interpreting service was available to aid the booking-in process. In some suites this was operated through a speakerphone, which compromised privacy. Staff said there was a good face-to-face interpreter service available for interviews, although there

[5] In all other UK law and international treaty obligations, 17-year-olds are treated as children.

could be long delays. However, the interpreters we saw had attended promptly. Our CRA identified one case where an interpreter did not arrive for over 13 hours, and there had been two reviews without the detainee being spoken to or reminded of his legal rights in his own language. His record did not indicate if the reviews were carried out with the assistance of the telephone interpreting service.

Recommendations

5.13 **Police should engage with the local authority to ensure the provision of safe beds for children and young people who have been charged but cannot be bailed to appear in court.**

5.14 **All suites should have two-way telephone handsets to facilitate telephone interpreting.**

5.15 **The force should evaluate the impact of the PACE G code of practice training relating to voluntary attendance over the next 12 months.**

Housekeeping point

5.16 Custody records should clearly indicate any use of telephone interpreting and interpreters in dealings with a detainee.

Rights relating to PACE

5.17 Criminal Defence Service posters advising detainees of their right to free legal advice were displayed in most custody suites in a range of languages. At most suites detainees could speak to solicitors privately using a portable telephone, or through the cell intercom system, but the portable telephone in Colchester was broken so detainees had to speak to their legal representatives next to the booking-in desk with no privacy. Detainees' right to free legal representation was clearly explained to them. Those who refused the offer were asked why, and reminded that they could change their mind at any time. Solicitors were contacted promptly and stayed in close communication with staff at the custody suite. Of the 36 detainees in our CRA who declined the offer of a solicitor, 42% were later reminded of their rights to a solicitor and the rest were not. When a detainee declined legal advice, the reasons were recorded in the rights documents in eight cases.

5.18 Detainees were advised that they could have someone told of their whereabouts, and several detainees made this telephone call themselves. In our CRA, all detainees were offered the opportunity to have someone informed of their arrest.

5.19 Detainees were informed that they could read the PACE codes of practice, and at least one copy was available at all suites. However, the codes of practice were sometimes difficult to locate and some were out of date. Legal representatives could easily obtain copies of detainees' custody records. The legal representatives we spoke to said they had a professional relationship with the police, and considered that PACE issues were applied efficiently and fairly.

5.20 Inspectors undertook reviews of detainees in custody, mostly in person. The custody records suggested most were done on time, although several were done very early. The records in the CRA highlighted reviews undertaken when the detainee was asleep, but it was not clear that they were informed of their reviews once they had woken up. Three reviews in the CRA were

carried out late – one for a young person and the other two for detainees with mental health needs.

5.21 The handling and processing of DNA and forensic samples were well managed and there was an effective process for the prompt collection of samples.

5.22 We were told that the court cut-off times could be as early as 1pm on weekdays and 10am on Saturday. Colchester magistrates' court only accepted detainees bailed to court and not from police cells, and detainees in Colchester and Clacton police custody suites had to be conveyed to Chelmsford (although it had been decided to discontinue this restriction shortly after the inspection). In practice this meant that any detainee for court had to leave these police stations by noon at the latest – and as early at 8am on a Saturday – to guarantee a hearing, although court staff were flexible in some cases.

Recommendation

5.23 **Senior police managers should engage with HM Court Service to ensure that early court cut-off times and the restricted hearings for remanded detainees do not result in unnecessarily long stays in custody.**

Housekeeping points

5.24 Criminal Defence Service posters should be prominently displayed in all custody suites.

5.25 Up-to-date copies of the PACE codes of practice should be available at all custody suites, and staff should be aware of them.

Rights relating to treatment

5.26 Although there was a clear expectation from senior management that complaints from detainees would be taken by an inspector while the detainee was still in custody, staff told us of varying practices throughout the force area. Detainees were not told how to make a complaint, although at Basildon the custody sergeant asked all detainees when they left the custody suite if they had any complaints about their treatment while in custody.

5.27 Notices about the complaints procedure were displayed at most custody suites, as well as some Independent Police Complaints Commission leaflets. Custody sergeants told us that they usually tried to resolve minor matters straightaway. If a detainee wanted to make a complaint of a criminal nature, the matter would be referred to a duty inspector. However, one inspector told us that he would only take a complaint while the detainee was in custody if it was a serious assault case. In all other cases, detainees were told to report the matter at the front desk once they were released, but there was no follow up if this did not happen. There was no analysis of complaints or process to identify trends, apart from the flagging up of individual staff if more than three complaints were made against them.

Recommendation

5.28 **Detainees should be able to make a complaint about their care and treatment 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.

Governance

6.1 Health services were provided by G4S Medical Services (G4S). A chief inspector and support officer managed the contract well. Both police and G4S said that working relationships were very good. Custody staff expressed general satisfaction with the health services available to detainees, and detainees we spoke with were satisfied with their interactions with health care staff. The force was in the second wave of early adopters for NHS commissioning of police health services, and preparatory work was in hand. A health needs analysis by the Eastern Region Public Health Observatory had been commissioned and was due to start following our visit.

6.2 G4S had robust clinical governance arrangements. Clear lines of management and accountability included systems for regular checking of staff's professional credentials. Health care professionals (HCPs) included nurses, paramedics and forensic medical examiners (FMEs). There were opportunities for staff to receive clinical supervision, although the frequency was sometimes a problem and it did not appear to be recorded. There was a programme of annual appraisal. The HCPs we observed were courteous and professional, but not all were immediately recognisable as they did not wear uniforms – although they did wear identity cards. We observed that some custody staff at Harlow did not immediately recognise a HCP when she arrived. Some HCPs did not comply with the G4S dress code standards. Telephone interpreting services were available when required.

6.3 There was a medical room at every custody suite. At some sites, including Chelmsford, Harlow and Stansted, there was an intoximeter (to measure the alcohol content of a person's breath), accompanied by CCTV cameras. Not all rooms had isolating switches within the room (that at Stansted was outside) or visual warnings when cameras were operating, which risked medical confidentiality. Some rooms had natural light, others not, several did not have examination lamps (including Basildon, Chelmsford and Grays), and few had privacy screens or curtains. Most rooms lacked decent work surfaces, many chairs were not wipable and many had floors, sinks or taps that were not compliant with infection control standards. An infection control audit completed as part of second wave preparation had resulted in an action plan, and work had begun to address compliance issues. Chelmsford had recently been refurbished and set a good standard. There was a commitment to refurbish other custody suites.

6.4 We observed good attention to the privacy and confidentiality of detainees during consultations, with the doors being closed. Medical room doors were left open when the rooms were not in use, and in some suites staff used the medical room toilets.

6.5 We were informed that medical rooms were regularly cleaned, although most were grimy and dusty. The clinical waste bin at Grays was overflowing. Several required deep cleaning, including Braintree, Rayleigh and Southend. There was a process to supply sharps bins and secure them to the wall. Patient information leaflets were available, although no health screening or promotion materials were displayed.

6.6 Medicines management was good. Medicines were supplied by G4S and stored in locked safes. At Rayleigh the safe was not bolted to the wall and could be picked up, and drugs were stored in a wooden cabinet at Clacton. One safe was for G4S use only and one, the telephone advice safe, was accessible by custody officers. At Basildon there was no telephone advice safe but a locker, which was not routinely locked. There were accurate stock records and weekly audits of stock balances.

6.7 HCPs were able to supply and administer a range of medications using patient group directions (PGDs), copies of which were available in every suite, although they were out of date. Custody staff administered medicines prescribed remotely by FMEs, including prescription-only medications, from the telephone advice safes, but we saw no evidence that telephone prescribing was confirmed by written prescriptions. HCPs opened manufactured medicine packages to put smaller amounts of tablets in labelled bags for detainees, which was secondary dispensing. There were locked cabinets for the disposal of discarded medications and a record of disposal, but the disposal system did not appear to be used consistently or subject to audit. We found out-of-date pharmacy reference materials in several clinical rooms. In our survey, 53% of respondents (against the comparator of 42%) said they needed to take medication while in custody. The police retrieved detainees' medications from their homes if necessary, and their medications were stored in individual property lockers.

6.8 Emergency equipment was available in the custody suites and included first aid kits and automated external defibrillators (AEDs), which were easily accessible. There were G4S emergency bags at each site, which contained breathing support equipment designed for use with oxygen, but there was no oxygen. Suction units in the grab bags were not usually assembled and so were not immediately ready for use. Custody staff were up to date with their first aid and resuscitation training and had received instruction in the use of AEDs.

6.9 We were informed that equipment was checked regularly but records were inconsistent. In most suites there was an additional grab bag that contained incomplete resuscitation equipment, and was believed to have been left over from previous medical providers, which might have caused confusion.

Recommendations

6.10 **Medical rooms should only be used for medical examination, be locked when not in use and comply with contemporary standards of infection control.**

6.11 **Any audiovisual recording devices sited in medical rooms should have isolating switches under the control of health care professionals and visual warnings of use.**

6.12 **Scheduled drugs should be stored in compliance with contemporary regulations and all medicine storage safes should be locked when not in use.**

6.13 **Patient group directions should meet legal requirements.**

6.14 **Custody officers should not administer prescription-only medications without a signed medical prescription.**

6.15 **Secondary dispensing of medicines should cease.**

6.16 **Suction units should be assembled and ready for use in case of emergency.**

Housekeeping points

6.17 Health care professionals should be easily identifiable and they should conform to the G4S Medical Services uniform dress code.

6.18 Out-of-date pharmacy reference materials should be discarded and replaced by up-to-date materials.

6.19 The police and G4S Medical Services should review the presence of inherited grab bags with a view to their removal.

Patient care

6.20 New detainees were asked if they wanted to see a HCP, or custody officers referred them to one if they presented any health-related concerns. Custody staff rang the G4S 24-hour call centre to request assistance. Call-out and response times were entered on the custody record, but this was inconsistent. The call centre alerted clinical staff to the request and the staff determined the type of response required. Urgent responses were expected within 60 minutes, non-urgent within 90 minutes and fitness-for-transfer consultations in 120 minutes.

6.21 G4S provided a comprehensive range of monthly statistics relating to the contract and the data were verified by the support officer. The service was busy with over 1,800 calls in most months in 2012. Performance was good, with over 90% of responses within one hour. Custody staff told us there were occasional problems with the availability of G4S staff during their shift handover periods and due to the distances to be covered. Responses beyond the contracted times invoked a service credit (financial penalty). In our sample of custody records, the average wait for a HCP was 78 minutes (ranging from 14 minutes to four hours). Detainees could see a HCP or FME of the gender of their choice, although this usually entailed further waiting. Alternatively, a chaperone was provided. Custody records showed that assessments and treatments were appropriate to detainees' needs. Opiate substitution therapy was unavailable while detainees were in police custody. Symptomatic relief was available for those withdrawing from substances.

6.22 G4S staff had access to NSPIS and HCPs entered their findings and medical advice directly into individual detention records. The G4S clinical records we sampled were completed to a good standard. Records were stored in line with the Data Protection Act and Caldicott principles on the use and confidentiality of personal health information.

Recommendation

6.23 **Clinically indicated opiate substitutes should be available to detainees in line with national guidelines.**

Substance misuse

6.24 In our survey of custody records, 18 out of 60 (30%) detainees were brought into custody intoxicated, although custody officers believed the level was higher. There were two providers of substance misuse services – the Crime Reduction Initiative in Southend and the Westminster Drug Project (working through Inside Out and other projects) everywhere else. Drug workers were available in the week, visiting most suites in the morning, or for telephone advice to officers. At other times, staff made paper referrals on behalf of detainees. Actions

were under way to provide more intensive drug and alcohol programmes at some suites, including on-site presence, extended hours and testing on arrest. Children and young people were signposted to appropriate services. Needle exchange, previously available at several suites, had been withdrawn due to low take-up. Instead, detainees were made aware of local access points.

Mental health

6.25 North Essex and South Essex Partnership Foundation Trusts provided mental health services to the custody suites within their respective catchment areas. There were occasional mental health strategic and custody liaison meetings involving the police, NHS and ambulance service partners, and working relationships were said to be good. We were told that there was a multi-agency information sharing protocol.

6.26 In our survey, more respondents than the comparator said they had mental health needs (40% against 23%); custody staff believed that the majority of their detainees had mental health needs. Mental health workers visited most custody suites daily, or could visit following telephone referral, although this was uncommon. Emergency duty teams were available out of hours and responses were said to be good. Young people with suspected mental health problems were signposted to appropriate services.

6.27 Police custody suites were used frequently for detainees subject to section 136 of the Mental Health Act[6] – 286 times a year, on average, in the three years to December 2012. Work was in hand to capture NHS data on the use of section 136. The police and NHS partners were in the process of ratifying a revised section 136 protocol. Custody officers said that custody suites were used inappropriately as places of safety because of disputes about levels of intoxication and because NHS facilities were full or understaffed. There were five section 136 suites for adults in the county and it was thought that demand for access had increased since staffing levels were agreed several years ago. There was one child and adolescent section 136 suite, which had not been used.

6.28 We were told that 86% of custody officers had been trained in the last year, and custody officers confirmed that they received mental health awareness training. Custody staff were generally content with the support they received to work with detainees with mental health care needs.

[6]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.

7. Summary of recommendations

Main recommendations

7.1 The force should ensure that the custody staff and suites provide for a respectful and suitable environment for detainees. (2.43)

7.2 Sufficient officers should be deployed in custody to provide safe and decent management of detainees at all times. (2.44)

7.3 Police custody suites should not be used routinely as places of safety for detainees under section 136 Mental Health Act. (2.45)

National issues

7.4 Appropriate adults should be available out of hours, given informed consent where necessary, to support children and young people aged 17 and under and vulnerable adults in custody. (2.46)

Recommendations

Strategy

7.5 The force should review operating procedures for the custody suites, to include clear and consistent guidance on roles and standards relating to the treatment and conditions of detainees in particular to ensure that inspectors are undertaking the full range of duties relating to custody and fulfilling their obligations in providing care for detainees. (3.15)

7.6 The sampling of custody records should include cross-referencing checks to CCTV, and the quality assurance process should cover shift handovers. (3.16)

Treatment and conditions

7.7 Booking-in areas should provide sufficient privacy to facilitate effective communication between staff and detainees, and there should be clear policies and procedures to meet the specific needs of females, children and young people and those with disabilities. (4.13)

7.8 The role of detention officers should be clarified to ensure that detainees receive a level of care which ensures they are looked after and kept safe. (4.14)

7.9 Adult and child safeguarding training should be given to and understood by all custody staff (4.15)

7.10 All custody staff should carry anti-ligature knives in the custody suite. (4.35)

7.11 Risk assessments and subsequent observation levels should be monitored to ensure they are appropriate. (4.36)

7.12 Staff handovers should be comprehensive, recorded and attended by all custody staff, and take place in an area cleared of other staff and detainees. (4.37)

7.13 Pre-release risk assessment of detainees should take into account all known risk factors, and staff should take action appropriately to mitigate the risks. (4.38)

7.14 Handcuffs should be removed from detainees as soon after arrival in the custody suite as the evidenced level of risk permits. (4.43)

7.15 Essex police should monitor the use of force at each custody suite by ethnicity, age, location and officers involved, identifying trends and taking appropriate action in line with the Association of Chief Police Officers (ACPO) guidance. (4.44)

7.16 There should be thorough daily and weekly maintenance checks to ensure cell and other detainee areas are in a good state of repair, clean, free of graffiti and have a source of natural light. (4.52)

7.17 All visits to cells should be made by, or accompanied by, a member of custody staff. (4.53)

7.18 The correct use of call bells should be explained to all detainees, and all call bells should activate an audible alert. (4.54)

7.19 All detainees held overnight, or who require one, should be offered a shower, which they should be able to take in private. (4.65)

7.20 Food offered to detainees should be of adequate quality and calorific content to sustain them for the duration of their stay. (4.66)

7.21 Detainees held for long periods should be offered outside exercise. (4.67)

7.22 Detainees should not walk around the custody suite semi-clothed and barefoot. (4.68)

Individual rights

7.23 Police should engage with the local authority to ensure the provision of safe beds for children and young people who have been charged but cannot be bailed to appear in court. (5.13)

7.24 All suites should have two-way telephone handsets to facilitate telephone interpreting. (5.14)

7.25 The force should evaluate the impact of the PACE G code of practice training relating to voluntary attendance over the next 12 months. (5.15)

7.26 Senior police managers should engage with HM Court Service to ensure that early court cut-off times and the restricted hearings for remanded detainees do not result in unnecessarily long stays in custody. (5.23)

7.27 Detainees should be able to make a complaint about their care and treatment before they leave custody. (5.28)

Health care

7.28 Medical rooms should only be used for medical examination, be locked when not in use and comply with contemporary standards of infection control. (6.10)

7.29 Any audiovisual recording devices sited in medical rooms should have isolating switches under the control of health care professionals and visual warnings of use. (6.11)

7.30 Scheduled drugs should be stored in compliance with contemporary regulations and all medicine storage safes should be locked when not in use. (6.12)

7.31 Patient group directions should meet legal requirements. (6.13)

7.32 Custody officers should not administer prescription-only medications without a signed medical prescription. (6.14)

7.33 Secondary dispensing of medicines should cease. (6.15)

7.34 Suction units should be assembled and ready for use in case of emergency. (6.16)

7.35 Clinically indicated opiate substitutes should be available to detainees in line with national guidelines. (6.23)

Housekeeping points

Strategy

7.36 Scheduled training days should include a structured forum where custody practitioners and managers can discuss custody issues. (3.17)

7.37 Refresher training should be delivered regularly to all custody staff. (3.18)

Treatment and conditions

7.38 Staff should be made aware of the procedures for searching transgender detainees outlined in annex L, PACE code C. (4.16)

7.39 Hearing loops should be available. (4.17)

7.40 Items for religious observance should be respectfully stored. (4.18)

7.41 The force should ensure that strip searching data is accurately recorded and collected to monitor use, identify trends and take action for proportionate and appropriate application of strip searching. (4.39)

7.42 Regular fire evacuation drills should be carried out in all suites. (4.55)

7.43 Replacement underwear should be available at all suites. (4.69)

7.44 All female detainees should be offered a hygiene pack on arrival. (4.70)

7.45 A range of reading materials, including in foreign languages and material suitable for young people, should be available in all suites and actively offered. (4.71)

Individual rights

7.46 Custody records should clearly indicate any use of telephone interpreting and interpreters in dealings with a detainee. (5.16)

7.47 Criminal Defence Service posters should be prominently displayed in all custody suites. (5.24)

7.48 Up-to-date copies of the PACE codes of practice should be available at all custody suites, and staff should be aware of them. (5.25)

Health care

7.49 Health care professionals should be easily identifiable and they should conform to the G4S Medical Services uniform dress code. (6.17)

7.50 Out-of-date pharmacy reference materials should be discarded and replaced by up-to-date materials. (6.18)

7.51 The police and G4S Medical Services should review the presence of inherited grab bags with a view to their removal. (6.19)

Appendix I: Inspection team

Martin Kettle	HMIP team leader
Maneer Afsar	HMIP inspector
Gary Boughen	HMIP inspector
Peter Dunn	HMIP inspector
Vinnett Pearcy	HMIP inspector
Fiona Shearlaw	HMIP inspector
Paul Davies	HMIC inspector
Mark Ewan	HMIC inspector
Robert Bowles	HMIC inspector
Paul Tarbuck	HMIP health services inspector
Jan Fooks-Bale	Care Quality Commission inspector
Annie Crowley	HMIP researcher
Alissa Redmond	HMIP researcher

Appendix II: Summary of detainee questionnaires and interviews

Prisoner survey methodology

A voluntary, confidential and anonymous survey of the prisoner population, who had been through a police station in the Essex 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 17 December 2012. A list of potential respondents to have passed through the following police stations was created: Basildon, Braintree, Brentwood, Chelmsford, Clacton, Colchester, Grays, Harlow, Loughton, Rayleigh, Southend or Stansted Airport. This listed all those who had arrived from Basildon, Chelmsford, Colchester, Epping, Harlow, Harwich or Southend courts within the past two months.

Selecting the sample

Overall 133 respondents were approached. In total, 24 respondents reported having been held either outside of the sample time period, or in police stations outside of Essex. One respondent could speak no English and so it was impossible to determine the police station he had been in. The questionnaire was offered to 108 eligible respondents; there were eight refusals, six questionnaires returned blank and one was not returned. All of those sampled had been in custody within the last two months.

Completion of the questionnaire was voluntary. Interviews were carried out with any respondents with literacy difficulties. One respondent required an interview.

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, 93 (86%) respondents completed and returned their questionnaires.

Comparisons

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

Some questions have been filtered according to the response to a previous question. Filtered questions are clearly indented and preceded by an explanation of 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 61 police areas since April 2008.

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

Summary

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

No questions have been filtered within the summary so all percentages refer to responses from the entire sample. The percentages to certain responses within the summary, for example 'not held 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?**

Basildon – 18; Braintree – 5; Chelmsford – 7; Clacton-on-Sea – 15; Colchester – 10; Grays – 9; Harlow – 3; Rayleigh – 4; Southend – 18; Stansted Airport – 2; Unknown – 2.

Q3 **How old are you?**

16 years or younger	0 (0%)	*40-49 years*	18 (19%)
17-21 years	9 (10%)	*50-59 years*	5 (5%)
22-29 years	27 (29%)	*60 years or older*	1 (1%)
30-39 years	33 (35%)		

Q4 **Are you:**

Male	92 (99%)
Female	0 (0%)
Transgender/transsexual	1 (1%)

Q5 **What is your ethnic origin?**

White - British	73 (78%)
White - Irish	2 (2%)
White - other	5 (5%)
Black or black British - Caribbean	4 (4%)
Black or black British - African	7 (8%)
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	1 (1%)
Mixed heritage- white and Asian	0 (0%)
Mixed heritage - other	0 (0%)
Chinese	0 (0%)
Other ethnic group	1 (1%)

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

Yes	17 (19%)
No	72 (81%)

Q7 **What, if any, is your religion?**

None	32 (36%)
Church of England	29 (33%)
Catholic	14 (16%)
Protestant	1 (1%)
Other Christian denomination	9 (10%)
Buddhist	2 (2%)
Hindu	0 (0%)
Jewish	0 (0%)
Muslim	2 (2%)
Sikh	0 (0%)

Q8 **How would you describe your sexual orientation?**

Straight/heterosexual	90 (99%)
Gay/lesbian/homosexual	0 (0%)
Bisexual	1 (1%)

Q9 **Do you consider yourself to have a disability?**

Yes	25 (27%)
No	66 (73%)

Q10 **Have you ever been held in police custody before?**

Yes	88 (96%)
No	4 (4%)

Section 2: Your experience of the police custody suite

Q11 **How long were you held at the police station?**

Less than 24 hours	30 (34%)
More than 24 hours, but less than 48 hours (2 days)	33 (37%)
More than 48 hours (2 days), but less than 72 hours (3 days)	21 (24%)
72 hours (3 days) or more	5 (6%)

Q12 **Were you told your rights when you first arrived there?**

Yes	73 (79%)
No	14 (15%)
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	45 (49%)
No	38 (41%)
I don't know what this is/I don't remember	9 (10%)

Q14 **If your clothes were taken away, what were you offered instead?**

My clothes were not taken	37 (43%)
I was offered a tracksuit to wear	35 (41%)
I was offered an evidence/paper suit to wear	3 (3%)
*I was **only** offered a blanket*	6 (7%)
Nothing	5 (6%)

Q15 **Could you use a toilet when you needed to?**

Yes	85 (92%)
No	7 (8%)
Don't know	0 (0%)

Q16 **If you used the toilet there, was toilet paper provided?**

Yes	53 (61%)
No	34 (39%)

Q17 **How would you rate the condition of your cell:**

	Good	*Neither*	*Bad*
Cleanliness	30 (33%)	31 (34%)	30 (33%)
Ventilation/air quality	23 (29%)	23 (29%)	33 (42%)
Temperature	15 (18%)	14 (17%)	54 (65%)
Lighting	30 (37%)	18 (22%)	33 (41%)

Q18 **Was there any graffiti in your cell when you arrived?**

Yes	48 (53%)
No	42 (47%)

Q19 **Did staff explain to you the correct use of the cell bell?**

Yes	31 (34%)
No	60 (66%)

Q20 **Were you held overnight?**

Yes	86 (92%)
No	7 (8%)

Q21 **If you were held overnight, which items of bedding were you given? (Please tick all that apply to you.)**

Not held overnight	7 (8%)
Pillow	38 (41%)
Blanket	70 (76%)
Nothing	9 (10%)

Q22 **If you were given items of bedding, were these clean?**

Not held overnight/did not get any bedding	16 (19%)
Yes	45 (54%)
No	22 (27%)

Q23 **Were you offered a shower at the police station?**

Yes	21 (23%)
No	69 (77%)

Q24 **Were you offered any period of outside exercise while there?**

Yes	5 (5%)
No	86 (95%)

Q25 **Were you offered anything to:**

	Yes	*No*
Eat?	67 (79%)	18 (21%)
Drink?	71 (83%)	15 (17%)

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

Very good	*Good*	*Neither*	*Bad*	*Very bad*	*N/A*
0 (0%)	7 (8%)	11 (13%)	22 (25%)	38 (43%)	10 (11%)

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

I did not have any food or drink	10 (12%)
Yes	35 (42%)
No	38 (46%)

Q28 **If you smoke, were you offered anything to help you cope with not being able to smoke? (Please tick all that apply to you.)**

I do not smoke	16 (18%)
I was allowed to smoke	6 (7%)
I was offered a nicotine substitute	0 (0%)
I was not offered anything to cope with not smoking	68 (76%)

Q29 **Were you offered anything to read?**

Yes	14 (15%)
No	77 (85%)

Q30 Was someone informed of your arrest?

Yes	41 (46%)
No	31 (35%)
I don't know	3 (3%)
I didn't want to inform anyone	14 (16%)

Q31 Were you offered a free telephone call?

Yes	45 (49%)
No	46 (51%)

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

My telephone call was not denied	50 (60%)
Yes	3 (4%)
No	31 (37%)

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 (7%)	66 (93%)
Contacting your partner, relative or friend	40 (49%)	42 (51%)
Contacting your employer	12 (17%)	59 (83%)
Where you were going once released	24 (31%)	53 (69%)

Q34 Were you offered free legal advice?

Yes	83 (91%)
No	8 (9%)

Q35 Did you accept the offer of free legal advice?

Was not offered free legal advice	8 (9%)
Yes	61 (69%)
No	20 (22%)

Q36 Were you interviewed by police about your case?

Yes	82(91%)
No	8 (9%)

Q37 Was a solicitor present when you were interviewed?

Did not ask for a solicitor/was not interviewed	16 (18%)
Yes	59 (66%)
No	15 (17%)

Q38 Was an appropriate adult present when you were interviewed?

Did not need an appropriate adult/was not interviewed	43 (51%)
Yes	10 (12%)
No	32 (38%)

Q39 Was an interpreter present when you were interviewed?

Did not need an interpreter/was not interviewed	45 (51%)
Yes	4 (5%)
No	39 (44%)

Section 3: Safety

Q41 Did you feel safe there?

Yes	58 (67%)
No	29 (33%)

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

Yes	32 (36%)
No	56 (64%)

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

I have not been victimised	56 (64%)	*Because of your crime*	14 (16%)
Insulting remarks (about you, your family or friends)	16 (18%)	*Because of your sexuality*	2 (2%)
Physical abuse (being hit, kicked or assaulted)	8 (9%)	*Because you have a disability*	5 (6%)
Sexual abuse	1 (1%)	*Because of your religion/religious beliefs*	4 (5%)
Your race or ethnic origin	2 (2%)	*Because you are from a different part of the country than others*	1 (1%)
Drugs	15 (17%)		

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

Yes	58 (65%)
No	17 (19%)
I wasn't handcuffed	14 (16%)

Q45 **Were you restrained whilst in the police custody suite?**

Yes	20 (23%)
No	67 (77%)

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

Yes	20 (23%)
No	67 (77%)

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

Yes	9 (10%)
No	78 (90%)

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

Very well	*Well*	*Neither*	*Badly*	*Very badly*	*Don't remember*
5 (6%)	30 (34%)	23 (26%)	19 (22%)	10 (11%)	0 (0%)

Section 4: Health care

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

Yes	28 (32%)
No	55 (63%)
Don't know	4 (5%)

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

	Yes	*No*
Doctor	28 (36%)	49 (64%)
Nurse	16 (25%)	47 (75%)
Paramedic	4 (7%)	55 (93%)

Q52 **Were you able to see a health care professional of your own gender?**

Yes	16 (20%)
No	47 (58%)
Don't know	18 (22%)

Q53 **Did you need to take any prescribed medication when you were in police custody?**

Yes	46 (53%)
No	41 (47%)

Q54 **Were you able to continue taking your prescribed medication while there?**

Not taking medication	41 (48%)
Yes	10 (12%)
No	35 (41%)

Q55 **Did you have any drug or alcohol problems?**

Yes	52 (60%)
No	35 (40%)

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	35 (41%)
Yes	17 (20%)
No	33 (39%)

Q57 **Were you offered relief or medication for your immediate withdrawal symptoms?**

I didn't have any drug/alcohol problems	35 (41%)
Yes	12 (14%)
No	39 (45%)

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

I was not seen by health care	*Very good*	*Good*	*Neither*	*Bad*	*Very bad*
42 (48%)	4 (5%)	9 (10%)	8 (9%)	12 (14%)	12 (14%)

Q59 **Did you have any specific <u>physical</u> health care needs?**

Yes	33 (38%)
No	55 (63%)

Q60 **Did you have any specific <u>mental</u> health care needs?**

Yes	36 (40%)
No	54 (60%)

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	54 (61%)
Yes	5 (6%)
No	29 (33%)

Prisoner survey responses for Essex Police 2012

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

Key to tables

		Essex Police Custody	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		93	2262
SECTION 1: General information			
3	Are you under 21 years of age?	**10%**	**10%**
4	Are you transgender/transsexual?	**1%**	**0%**
5	Are you from a minority ethnic group (including all those who did not tick white British, white Irish or white other categories)?	**14%**	**29%**
6	Are you a foreign national?	**19%**	**15%**
7	Are you Muslim?	**2%**	**10%**
8	Are you homosexual/gay or bisexual?	**1%**	**2%**
9	Do you consider yourself to have a disability?	**28%**	**19%**
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?	**67%**	**68%**
12	Were you told your rights when you first arrived?	**79%**	**81%**
13	Were you told about PACE?	**49%**	**52%**
For those who had their clothing taken away:			
14	Were you given a tracksuit to wear?	**72%**	**38%**
15	Could you use a toilet when you needed to?	**92%**	**91%**
16	If you used the toilet, was toilet paper provided?	**61%**	**48%**
17	Would you rate the condition of your cell, as 'good' for:		
17a	Cleanliness?	**33%**	**34%**
17b	Ventilation/air quality?	**29%**	**23%**
17c	Temperature?	**18%**	**17%**
17d	Lighting?	**37%**	**45%**
18	Was there any graffiti in your cell when you arrived?	**54%**	**54%**
19	Did staff explain the correct use of the cell bell?	**34%**	**23%**
20	Were you held overnight?	**92%**	**92%**
For those who were held overnight:			
21	Were you given any items of bedding?	**89%**	**85%**
For those who were held overnight and were given items of bedding:			
22	Were these clean?	**67%**	**62%**
23	Were you offered a shower?	**24%**	**9%**
24	Were you offered a period of outside exercise?	**5%**	**6%**
25a	Were you offered anything to eat?	**79%**	**81%**
25b	Were you offered anything to drink?	**83%**	**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?	**48%**	**44%**

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For those who smoke:			
28	Were you offered anything to help you cope with not being able to smoke?	**6%**	**7%**
29	Were you offered anything to read?	**15%**	**14%**
30	Was someone informed of your arrest?	**46%**	**44%**
31	Were you offered a free telephone call?	**50%**	**50%**
If you were denied a free telephone call:			
32	Was a reason given?	**8%**	**15%**
33	Did you have any concerns about:		
33a	Who was taking care of your children?	**7%**	**14%**
33b	Contacting your partner, relative or friend?	**49%**	**53%**
33c	Contacting your employer?	**17%**	**18%**
33d	Where you were going once released?	**31%**	**30%**
34	Were you offered free legal advice?	**91%**	**89%**
For those who were offered free legal advice:			
35	Did you accept the offer of free legal advice?	**75%**	**70%**
For those who were were interviewed and needed them:			
37	Was a solicitor present when you were interviewed?	**80%**	**81%**
38	Was an appropriate adult present when you were interviewed?	**24%**	**31%**
39	Was an interpreter present when you were interviewed?	**9%**	**13%**
SECTION 3: Safety			
41	Did you feel unsafe?	**67%**	**62%**
42	Has another detainee or a member of staff victimised you?	**37%**	**32%**
43	If you have felt victimised, what did the incident involve?		
43a	Insulting remarks (about you, your family or friends)	**18%**	**15%**
43b	Physical abuse (being hit, kicked or assaulted)	**10%**	**10%**
43c	Sexual abuse	**1%**	**2%**
43d	Your race or ethnic origin	**2%**	**3%**
43e	Drugs	**17%**	**9%**
43f	Because of your crime	**16%**	**12%**
43g	Because of your sexuality	**2%**	**0%**
43h	Because you have a disability	**5%**	**2%**
43i	Because of your religion/religious beliefs	**4%**	**1%**
43j	Because you are from a different part of the country than others	**1%**	**3%**
44	Were your handcuffs removed on arrival at the police station?	**78%**	**74%**
45	Were you restrained while in the police custody suite?	**23%**	**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?	**40%**	**37%**

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SECTION 4: Health care			
50	Did someone explain your entitlements to see a health care professional if you needed to?	**32%**	**35%**
51	Were you seen by the following health care professionals during your time in police custody?		
51a	Doctor	**36%**	**42%**
51b	Nurse	**25%**	**21%**
	Percentage seen by either a doctor or a nurse	**47%**	**50%**
51c	Paramedic	**6%**	**4%**
52	Were you able to see a health care professional of your own gender?	**20%**	**26%**
53	Did you need to take any prescribed medication when you were in police custody?	**53%**	**42%**
For those who were on medication:			
54	Were you able to continue taking your medication while in police custody?	**22%**	**34%**
55	Did you have any drug or alcohol problems?	**60%**	**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?	**33%**	**42%**
57	Were you offered relief or medication for your immediate withdrawal symptoms?	**24%**	**26%**
For those who were seen by health care:			
58	Would you rate the quality as good/very good?	**29%**	**31%**
59	Did you have any specific physical health care needs?	**38%**	**31%**
60	Did you have any specific mental health care needs?	**40%**	**23%**
For those who had any mental health care needs:			
61	Were you seen by a mental health nurse/psychiatrist?	**14%**	**12%**