Report on an inspection of police custody suites in Gloucestershire

21 – 22 July 2008

by

HM Inspectorate of Prisons and

HM Inspectorate of Constabulary

Printed and published by:

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

Contents

1. Introduction

This is the fourth in a series of reports of inspections of police custody carried out jointly by our two inspectorates, and the first to look at a force outside London. These inspections form a key part of the joint work programme of the criminal justice inspectorates, agreed by Ministers. They also contribute to the United Kingdom's response to its international obligation to ensure regular and independent inspection of all places of detention[1]. The inspections look at force-wide strategies, treatment and conditions, individual rights and healthcare.

Gloucestershire Constabulary covers a largely rural area made up of three basic command units (BCUs) - Gloucester, Cheltenham and Stroud. Each BCU contains a custody suite designated for the reception of detainees under the Police and Criminal Evidence Act, 1984. There are a total of 47 cells (not counting three court holding cells at Stroud).

We were impressed that the Chief Constable had taken a personal interest in custodial matters and that the Police Authority was also fully engaged. As a result, there had been significant attention to the area. Gloucestershire Constabulary operated a devolved BCU command custody management structure, using a CJD department inspector as Force Custody Manager (FCM), who had responsibility for both policy and procedural matters. Specialist custody sergeants in the suites managed privately contracted custody detention officers. Working relations with the UK Border Agency were good, although relatively few immigration detainees were held.

The physical condition of the suites was far from ideal, with poor natural light and design, and some cramped conditions. Not all cells had integral sanitation. However, these deficits were partly mitigated by attention to cleanliness and generally good relationships between the staff and detainees. The need for significant action was already recognised by the force and two new custody suites are to be built. An original business case had been submitted to the Home Office in 2005 but had not been progressed because of the force merger debate at the time.

As at other suites we have visited, the design and layout of the custody sergeants' desks were poor. This meant that confidential discussion was difficult and this could prevent detainees disclosing important issues about their risks and needs. We will continue to raise these flaws with the Home Office officials responsible for design guides.

Improvements were also required in the management of risk. In some situations, the approach of custody staff appeared risk averse and insensitive. For example, we observed one troubling case where a teenage girl was forcibly restrained while the ties were cut from her blouse because they were deemed to pose a suicide risk. However, she was left with other items which arguably posed a greater risk. We considered that the actual risks were inadequately assessed and did not justify the degree of force used.

In other situations, the approach to safety was inconsistent. For example, not all staff carried cell keys or ligature knives to enable them to intervene in an emergency, cell bells were not routinely tested and some cell bells were muted by staff when they felt detainees were misbehaving, which was a patently unsafe practice.

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

No detainees were required to share cells, food was satisfactory and some basic reading material and hygiene products were provided. However, detainees were not usually made sufficiently aware of the amenities or arrangements such as when they could use showers or that they had to ask staff to flush some toilets from outside the cells.

We were satisfied that the PACE codes were consistently and rigorously applied, with custody sergeants seeking to ensure that the rights of individual detainees were respected. However, there was little awareness of, and too little attention paid to, the particular needs of women and children in detention. Delays in finding appropriate adults to accompany juveniles even had the perverse consequence of increasing their length of detention. Services for immigration detainees were limited.

Healthcare provision was generally satisfactory. We noted good practice in the management of clinical records and clinical governance, although accommodation for the forensic medical examiners tended to be cramped. Mental health and drug services were adequate, but there were gaps in coverage.

This independent inspection of police custody suites in Gloucester provides an important degree of assurance to the public that, in most respects, detention in police custody is well managed and satisfactory. Nevertheless, there are some criticisms and the report sets out a number of areas for improvement. In this way it is hoped that the Chief Constable will be assisted to improve provision further.

Jane Stichbury
HM Inspector of Constabulary

Anne Owers
HM Chief Inspector of Prisons

November 2008

2. Background and key findings

2.1 HM Inspectorates of Prisons and Constabulary have begun a programme of joint inspections of police custody suites as part of the UK's international obligation to ensure regular independent inspection of places of detention. These inspections do not look only at the implementation of the Police and Criminal Evidence Act (PACE) codes. They are also informed by *Expectations* about the appropriate treatment of detainees and conditions of detention, which have been developed by the two inspectorates to assist best custodial practice.

2.2 Gloucestershire Constabulary serves the county of Gloucestershire, which comprises six local authorities. The county covers an area of over 1000 square miles, including the rural areas of the Cotswolds and the Royal Forest of Dean. The population of just over half a million is largely white British. Although unemployment is low, there are pockets of deprivation, with 13 wards in the top quartile nationally for deprivation. The force is made up of three basic command units. Gloucestershire Constabulary has three custody suites designated under the PACE Act 1984 for the reception of detainees. All three operate 24 hours a day and deal with detainees arrested as a result of mainstream policing. The total cell capacity for the force is 47 cells. There is insufficient cell capacity to provide any cells for Operation Safeguard (prison overcrowding).

2.3 This inspection was conducted in the three custody suites in the county of Gloucestershire. Inspectors examined force-wide custody strategies, as well as treatment and conditions, individual rights and healthcare in each suite. A survey of prisoners at HMP Gloucester who had formerly been detained in the custody suites was conducted by HM Inspectorate of Prisons' researchers to obtain additional evidence (see appendix 2).

2.4 Although the physical condition of the suites was far from ideal, with poor natural light and, with the exception of Cheltenham, a cramped environment, this was mitigated by attention to cleanliness and the relationships between staff and detainees. Cheltenham was the busiest suite, with 7,118 detainees received in 2007/08, followed by Gloucester (7,037) and Stroud (4,173). All three suites held adults, juveniles and immigration detainees. Fifty-six immigration detainees had been held in custody in Gloucestershire over the previous four months, with the highest number (22) held at Stroud. The average time held was just over 24 hours, although four immigration detainees during this period had been transferred from one station to another and held for between 61 and 84 hours.

2.5 Staffing in all three custody suites consisted of a custody sergeant, all of whom were specialists in this role, supported by custody detention officers (CDOs) supplied by GSL. On occasions trained but non-specialist uniformed sergeants were used to cover abstractions. Twenty-nine CDOs, including 16 women, were employed across the county.

Strategic overview

2.6 The Chief Constable for Gloucestershire Constabulary had taken a personal interest in custodial matters and led a thematic inspection of custody in December 2007. Significant investment in custody had taken place and a force custody manager (FCM) had responsibility for policy and procedural matters. The Police Authority was fully engaged through an Estates Development Board, with work underpinned by a clear strategy.

2.7 There was a designated custody suite in each of the three basic command units (BCUs) at Gloucester, Cheltenham and Stroud. Cheltenham was the biggest, with 21 cells including six detention rooms. Gloucester custody suite had 16 cells including three detention rooms and Stroud had 10 cells with two detention rooms.

2.8 Gloucestershire Constabulary had submitted a business case to the Home Office applying for funds under a private finance initiative to build two new custody suites. This followed the submission of a business case in 2005 which was delayed because of potential force mergers at that time. If successful, the intention was to build a new custody suite in the north and one in the south of the county to replace the current custody estate. The new buildings were planned to have 70 cells with an estimated completion date of 2012.

2.9 Gloucestershire Constabulary had an assistant chief constable (ACC) who had portfolio responsibility for custody matters and an independent advisory group provided feedback to the force. Management of custody policies and procedures rested with the FCM, a chief inspector who sat within the criminal justice department. The force held bi-monthly custody user group meetings chaired by the FCM. This meeting was attended by all managers with custodial responsibilities and third party contractors contracted to provide services in the custodial environment. Day-to-day management of custody was exercised by inspectors in the respective BCUs.

2.10 There was evidence of UK Border Agency (UKBA) interaction with detainees held in custody for immigration offences and UKBA officers were present processing detainees during the inspection. Due to limited custody space there was an aim to agree acceptance of most immigration detainees in advance but sometimes little or no notice was given following arrests linked to immigration operations. Working relations between Gloucestershire Constabulary and UKBA were good.

Gloucester

Treatment and conditions

2.11 No detainees had to share cells and all cell bells tested worked. At exceptionally busy times, some detainees waited in vans for up to three hours but we were assured this happened rarely. Cells were generally clean and there was little graffiti. There was very little natural light in cells, interview rooms or communal areas. There was a good stock of clothes. Not all cells had in-cell sanitation and some detainees did not know that staff had to flush toilets. Showers were in a decent condition, but were not routinely offered. Basic washing products were provided and reading material was available. Visits were facilitated. The layout of the desk area deterred detainees from making confidential disclosures, although staff dealt with detainees sensitively and with respect. Staff did not carry cell keys and ligature knives as personal issue, which could delay responses in an emergency.

Individual rights

2.12 Staff followed the requirements of PACE consistently. Interpreters were easily accessible and used regularly. But there was no other provision for dealing with different groups, such as women or juveniles. There were some pre-release plans for vulnerable individuals. Two staff were able to use sign language. Staff were alert to the health needs of detainees and the need to provide proper breaks during the interview process. Solicitors normally arrived promptly, although there were sometimes problems with the availability of appropriate adults at night.

Stroud

Treatment and conditions

2.13 No detainees had to share cells. Cell bells worked, but were not routinely tested. Cells were clean and free from graffiti. Paper clothing was regularly issued and spare clothing was available for those whose clothing had been soiled, although this did not include underwear. There were good stocks of washing materials and sanitary products. Some detainees had to wait on the van for up to an hour during busy periods. Not all staff carried ligature knives. The high desk was a barrier to communication. Cells for juveniles did not have cameras and were the furthest away from staff. Staff sometimes muted cell bells when they felt detainees were using them inappropriately, which was unsafe.

Individual rights

2.14 Custody sergeants ensured that detainees were properly informed of their rights and published information about these was available in 30 languages. Some immigration detainees were held for long periods in the custody suite. Custody staff had received no specific training in the management and supervision of juveniles or women detainees. Interpreters were easily accessible and used regularly. There were some delays in getting appropriate adults. Notices about the right to legal advice were displayed in a range of languages. No information was displayed in cells, but all detainees received printed information about their rights and entitlements. As in the other custody suites, solicitors and police reported delay and inflexibility caused by the Crown Prosecution Service (CPS) charging arrangements.

Cheltenham

Treatment and conditions

2.15 Cheltenham was the largest of the three suites, with capacity to hold 21. Cells were split between men, women and juveniles, although in practice all were multi-functional. All cells apart from juvenile cells had integral sanitation. No detainees had to share cells and all cell bells tested worked, although not all detainees had been told how to use them. Cells were clean and free from graffiti and checked by staff after each use. A contract service provided a prompt cleaning service for bodily fluids. All staff carried ligature knives. Three sets of cell keys were shared between staff. Stores and cupboards were organised and there was access to spare clothes and shoes, but no underwear. There was a good selection of food, but little available reading material. A problem common to each of the suites was some poor equipment, particularly printers, and difficulties when the main force computer was closed for maintenance during busy times for custody suites.

Individual rights

2.16 Detention was appropriate and in most of the records we examined detainees were kept for the minimum amount of time. Reviews were completed appropriately. Solicitors normally attended promptly when requested, although there were some problems in getting hold of appropriate adults out of hours and a limited service available for immigration detainees. Vulnerable adults were treated in the same way as juveniles. Staff reported frustration with the

CPS charging system. Other than the appropriate adult, there were no special arrangements for groups such as juveniles and no staff had received child protection training. There was some confusion about protocols, such as DNA samples, when immigration authorities took over detainee authority from the police.

Healthcare

2.17 Health services were provided by an independent contractor, Essex Medical and Forensic Services (EMFS). Overall, police reported a good service from EMFS. We observed good interactions between EMFS, staff and detainees, although not all detainees were asked if they wanted to see a doctor.

2.18 The physical conditions were not always suitable and some forensic medical examiner (FME) rooms were cramped. Staff at Gloucester did not always log how long it took for a detainee to be seen, but in the other suites the typical wait was an hour.

2.19 We noted excellent practice in the management of clinical records.

2.20 Mental health services were provided by the local mental health trust, although persons detained under section 136 of the Mental Health Act (1983) were taken to a police station as a place of safety. The NHS Foundation Trust Gloucestershire was developing a new facility for section 136 detainees.

2.21 A local drug and alcohol agency, the Gloucestershire Drug and Alcohol Scheme (GDAS), provided a service to the custody suites. A worker visited each custody suite at least twice a day, except Sundays, and took on drug using clients. There was no similar provision for alcohol users, although detainees were given contact details of local advisory services. Under an alcohol arrest referral scheme, detainees arrested in circumstances where alcohol was a factor were given 24 hours to contact GDAS as part of their bail conditions.

2.22 There were clear clinical governance arrangements and lines of accountability and some clinical audits were carried out by senior EMFS staff.

2.23 Mental health support was provided by the 2gether Mental Health Foundation Trust. A community psychiatric nurse (CPN) was available from 9am to 5pm on weekdays. There was no holiday cover and out-of-hours services were notably worse, with some detainees waiting up to 36 hours for an assessment.

3. Strategy

3.1 The chief constable took a personal interest in custody matters and was supported by an assistant chief constable responsible for this area. A bid had been made to replace the existing three facilities with two purpose-built units. There were good working relationships between the UK Border Agency and the force and good protocols with the local primary care trust. There was good managerial oversight of policy and practice. Custody issues were regularly discussed. All staff were trained. Local defence solicitors reported positively about arrangements, although problems in getting appropriate adults out of hours resulted in some breaches of procedures. The procedure for hearing complaints was flawed and there were some missed opportunities to share lessons learned from professional standards.

Expectation

3.2 There is a policy focus on custody issues at a chief officer level that is concerned with developing and maintaining the custody estate, staffing custody suites with trained staff, managing the risks of custody, meeting the health and wellbeing needs of detainees and working effectively with colleagues in the health service, immigration service, youth offending service, criminal justice teams, Crown Prosecution Service (CPS), courts and other law enforcement agencies.

Findings

3.3 The assistant chief constable (ACC) was the portfolio holder on custody for Gloucestershire Constabulary and, while recently promoted, had taken an active interest in custodial matters. The force custody manager (FCM) and basic command unit (BCU) inspectors had an audit and inspection function in the custody suites and there was oversight by GSL management. A recent review of custody within Gloucestershire Constabulary by the National Policing Improvement Agency had been positive. The FCM carried out a bi-annual custody inspection, while the custody inspectors carried out monthly health and safety inspections. The force health and safety adviser was also engaged in the process bi-monthly, holding meetings with the FCM. In recognition of the need to improve arrangements an outline business case for PFI built custody facilities was submitted to the Home Office in May 2005. However, the force merger debate at that time meant the business case was not progressed. A further bid had been made with the expectation that construction would begin in 2012/13.

3.4 The FCM was supported by a custody support constable who provided standard operating procedures (SOPs) and protocols for custody suites in each BCU. These covered medical protocols, constant supervision and guidance to custody staff on exit plans for vulnerable detainees aimed at mitigating risk. The SOPs were designed to assist BCUs to deliver safe and consistent levels of service, although responsibility and accountability rested with the FCM and the ACC. Management oversight was progressive, pro-active and of a high standard, with the chief constable taking an active interest in custodial matters, including personally leading a thematic inspection of custody in December 2007.

3.5 Approved training for custody officers was delivered corporately by West Mercia Constabulary. The provision of custody detention officers (CDOs) was outsourced to a private company, GSL. CDOs supplied by GSL attended a six-week training programme that included a two-week course provided by West Mercia Constabulary. All were subject to enhanced vetting

checks by Gloucestershire Constabulary. All custody sergeants and CDOs had received nationally approved custody training before their deployment in custody suites and custody staff were organised, polite and professional in their approach to detainees. They received annual refresher training and all staff were trained in first aid, the use of defibrillators and the provision of oxygen.

3.6 Medical provision was outsourced to a private company, Essex Medical Forensic Services (EFMS). The contract covered year-round 24-hour provision of doctors and nurses. Clinical governance was of a very high standard and good practice. Local protocols had been developed with the primary care trust (PCT) and ambulance trust for detainees identified as at risk due to drugs or intoxication. The force and Gloucestershire Drug and Alcohol Scheme (GDAS) used a working agreement that was utilised in conjunction with bail conditions. Drug and alcohol workers from the scheme visited the custody suites and actively reached out to detainees with drug problems.

3.7 Gloucestershire Constabulary had been actively engaged with the PCT at chief officer level over the provision of places of safety under the Mental Health Act, which are not police custody suites. It was anticipated that the PCT would provide places of safety at Wootton Lawn from February 2009 onwards. We welcomed this positive step and will actively monitor developments and timelines in this important area of welfare.

3.8 The force had a positive local relationship with the Crown Prosecution Service (CPS) and the chief crown prosecutor, with ongoing partnership work being developed at local criminal justice board level. The only substantive criticism of the CPS related to its capacity to provide lawyer cover, but no criticisms about the quality of CPS cover were put forward to the inspection team.

3.9 Defence solicitors described good relationships with the police and said custody staff were professional in their approach to detainees. We witnessed positive interaction between detainees and custody staff and some custody staff demonstrated clear empathy with detainees.

3.10 In each of the custody suites, staff described difficulties with court arrangements, usually involving early cut-off points during the day, which led to detainees spending unnecessarily long periods in police cells or having to travel to distant courts.

Expectation

3.11 There is an effective management structure for custody that ensures that policies and protocols are implemented and managed and that there are mechanisms for learning from adverse incidents, rubbing points or complaints.

Findings

3.12 Not enough was done to interrogate the UNITY custody system to identify the profile of detainees entering the custody suites.

3.13 An intranet site provided good information and advice on detainee supervision and identified health and safety learning points gleaned from investigating adverse incidents. However, there was no link from the site to the 'Lessons Learned' newsletters from the Independent Police Complaints Commission. All policies and protocols could be accessed through the site.

3.14 Complaints from detainees were not usually taken while they were in custody unless they were of a serious nature. Detainees who wanted to complain about their treatment were told to do so on their release by reporting to the front desk of the police station. This process was flawed and could have been viewed as a mechanism for suppressing complaints.

3.15 Custody officers and managers did not sufficiently recognise the impact of custody on juveniles and female detainees, whose different needs were not reflected in how they were dealt with. The inspection team witnessed interactions between custody officers and juvenile detainees that should have been more focused on the outcome for the young person, rather than viewed purely from a police perspective in terms of a custodial process.

3.16 At Gloucester, there were delays in obtaining appropriate adults out of hours. The inspection team sampled a number of custody records across the force that clearly identified detainees risk assessed on the custody records as vulnerable and in need of the services of an appropriate adult before being interviewed. However, in a number of cases that were not exempted under special clauses within the PACE Act 1984, no appropriate adult had been provided and the detainee had been interviewed anyway. These interviews amounted to breaches of PACE and unnecessarily exposed the force to complaints, and custody officers and investigating officers to disciplinary action. It also meant that detainees' rights were not always safeguarded as required by PACE.

Expectation

3.17 Maintenance of facilities only occurs when the suite is closed down.

Findings

3.18 Due to the age and limited capacity of cell provision in Gloucestershire Constabulary, maintenance was completed when facilities were open.

Additional information

3.19 At Cheltenham and the other two custody suites, there were some problems with poor equipment and printers often broke down. Staff also experienced difficulties in accessing computer records at weekends as the maintenance of the main force computer often took place on Saturday nights. While this was convenient for headquarters workers, it caused problems for front line staff.

Recommendations

3.20 Discussions should be held with HM Court Service to ensure that cut-off points for accepting detainees are not too early and thus result in people spending too long in police custody.

3.21 Greater effort should be made by the Gloucestershire Constabulary to utilise management information in the UNITY custody system to achieve a better understanding of the profile of detainees so as to meet their needs. This should include how many detainees are held for more than 24 hours and how many are juveniles, women and UK Border Agency detainees.

3.22 The custody intranet site should be linked to the 'Lessons Learned' newsletters from the Independent Police Complaints Commission.

3.23 Detainees wanting to make a formal complaint about their arrest or treatment should be enabled to do so while in custody.

3.24 Operating procedures and guidance should be updated to ensure greater recognition by custody officers and staff of the impact of custody on juvenile and female detainees.

3.25 Detainees identified in the risk assessment as vulnerable should not be interviewed without an appropriate adult present unless special exemptions provided in the Police and Criminal Evidence Act 1984 apply. Supervisors should regularly sample custody records to ensure that this area of weakness is addressed and appropriate adults provided as necessary.

3.26 Custody suites should have up-to-date and reliable essential office equipment such as printers.

3.27 Maintenance of the force computer system should take into account the needs of custody suite staff.

4. Treatment and conditions

Gloucester

4.1 Custody sergeants were well trained and the standard of care was mostly good. Cells were checked regularly, although not all detainees were clear about use of the bell. Most cells had toilets. Showering facilities did not provide sufficient privacy. Holding and interview rooms were small and lacked natural light. There was an adequate range of facilities, but most had to be requested.

Expectation

4.2 Custody staff are aware of the risk of self-harm from:

- attempted suicide
- drugs ingestion
- medical conditions
- alcohol

and these risks are assessed, monitored and managed appropriately.

Findings

4.3 Custody sergeants were trained to follow the safer detention manual and near-miss reports were reviewed monthly. The reception assessment covered risk of suicide, drugs ingestion, medical conditions and alcohol, using information from the reception interview, the prisoner escort record (PER) and the inspector/officer who brought the detainee in. Assessments were conducted sensitively and a doctor was called when there were any potential medical concerns. Custody sergeants were well briefed on what signs should trigger calling out the doctor and were confident about how they would manage and monitor individuals with elevated risk levels. All staff we spoke to were clear about the different levels of observations. During the inspection, a number of detainees were managed under different levels and staff were clear about the reasons. Handovers took place as new staff came on duty and included any risk-related information. However, the approach to identifying risk was uniform, over mechanistic and took too little account of individual circumstances.

4.4 We raised concerns about one woman who was very upset, but whose custody record contained no mention of this.

4.5 Keys to cells and both sizes of ligature knives were kept behind the desk. Their retrieval would waste valuable seconds in an emergency.

4.6 Cells were checked between use.

Expectation

4.7 Custody staff are aware of any risk of harm to others and this is managed appropriately. Detainees are not placed in cells together unless a risk assessment indicates that it is safe to do so. Risk assessments include whether the detainee has previous convictions for racially aggravated offences.

Findings

4.8 Custody staff kept detainees apart where possible and closely supervised them when it was not possible, such as in waiting areas. There was no cell sharing.

Expectation

4.9 Holding cells are equipped with call bell systems and their purpose is explained to detainees. They are responded to within a reasonable time.

Findings

4.10 All cells had working call bells. These were responded to promptly during the inspection, but detainees in our survey said they were often ignored. While staff had explained use of the bells to some detainees, one detainee said he thought the bell was for emergencies only and had not used it even though he needed a number of things.

Expectation

4.11 Holding areas, cells, interview rooms and detention rooms are:

- clean
- free from graffiti
- in good decorative order
- of a suitable temperature
- well ventilated
- well lit
- equipped with somewhere to sit
- free of ligature points.

Findings

4.12 There were three interview rooms. We examined two, which were claustrophobic, austerely decorated and had no natural light, and were told the third was similar. The pre-reception holding area, where detainees could be held for up to two hours, was austere with poor light. Cuffs attached to the benches were not used, but were unnecessarily intimidating.

4.13 There were three cells in the juvenile area, eight in the men's area and five in the women's area. Cells were clean and, apart from the wooden plinths/seating, free from graffiti. They were cleaned between use by GSL staff and a contractor provided a prompt service when bodily fluids needed cleaning up. Cells were free of ligature points, but poorly ventilated with little natural light.

4.14 When the suite was busy, detainees sometimes had to wait in the van for up to three hours. The overflow desk area was rarely used, but offered little privacy from the waiting area behind it, which was bare and unwelcoming.

4.15 The exercise yard was small and austere.

Expectation

4.16 A smoking policy for staff and detainees is enforced that respects the right of individuals to breathe clean air in the custody suite.

Findings

4.17 The suite was a no smoking area. There was no routine assistance for those experiencing nicotine withdrawal, but detainees could see a doctor on request.

Expectation

4.18 Detainees are provided with suitable meals that cater for special dietary requirements, and drinks at appropriate intervals.

Findings

4.19 The food and drinks preparation area was clean. Microwave meals catering for all dietary requirements were available, but during the inspection two detainees were not offered an evening meal and no comment about this was made in the custody records. In our survey, one detainee said he had waited over 24 hours for a meal. Visitors could bring food in for detainees as long as it was appropriately packed. A range of drinks was available on request.

Expectation

4.20 Detainees are provided with a mattress, pillow and clean blankets if held overnight.

Findings

4.21 Detainees were given a mattress, pillow and clean blankets.

Expectation

4.22 Detainees are able to use a toilet in privacy, and toilet paper and washing facilities are provided.

Findings

4.23 The juvenile cells had no in-cell sanitation and young people had to use one of two toilets located off the adult corridor areas. Three cells on the men's side and three on the women's had in-cell sanitation, but most toilets were clearly visible from the cell door and offered little privacy, particularly for women. Most had to be flushed outside the cell by a member of staff. Not all detainees were aware of this and said the toilet remained unflushed; some said they

were embarrassed to ask staff to flush their toilet. One cell toilet did not have a seat and no cells had wash basins. Toilet paper was available only on request. There was a separate toilet for detainees with disabilities in the men's corridor.

4.24 There was a shower on each of the adult corridors, but women using the shower could be seen from the waist up by anyone walking in the corridor.

Expectation

4.25 Detainees whose clothing is taken for forensic examination are provided with suitable alternative clothing before being released or transferred to court.

Findings

4.26 Detainees whose clothing had been taken and who were being released or transferred to court were given black jogging bottoms, a black T-shirt and black plimsolls. Visitors could bring in alternative clothing for detainees.

Expectation

4.27 Detainees who are held for more than 24 hours are able to take a shower and a period of outdoor exercise.

Findings

4.28 Detainees held over 24 hours or whose clothes were soiled could exercise and have a shower, but these were not routinely offered and had to be requested. Basic items such as soap, shampoo, a toothbrush, razor and shaving foam were available on request.

Expectation

4.29 Detainees who are held in custody for several days are provided with suitable reading material. Visits are also allowed, and changes of clothing, especially underwear, are facilitated.

Findings

4.30 A box of magazines was available on request.

4.31 Requested visits were facilitated, but we were told this was unusual. One visit arranged during the inspection took place in the cell as this was the most appropriate facility available.

4.32 Apart from when clothing had been taken away or soiled (see paragraph 4.26), there was no facility for changes of clothing unless visitors brought fresh clothing in.

Expectation

4.33 Custody suite staff have received fire safety training and evacuation procedures are practised frequently.

Findings

4.34 Fire safety training was part of the initial training course, but there had been no specific training in evacuation procedures or any evacuation drills. All staff we spoke to knew what the evacuation procedure was.

Other findings

4.35 Staff interactions with detainees, their visitors and other visitors to the facility were sensitive and respectful.

4.36 Muslim prayer mats were available and practising Muslims were informed when it was prayer time.

Stroud

4.37 The custody suite was clean, but poorly designed. The treatment of one young girl was a particular concern. Not all detainees were offered a shower when there were no same-sex staff on duty. There was a good stock of bedding, towels and clothing. Not all staff carried ligature knives and keys and some staff muted cell call bells.

Expectation

4.38 Custody staff are aware of the risk of self-harm from:

- attempted suicide
- drugs ingestion
- medical conditions
- alcohol

and these risks are assessed, monitored and managed appropriately.

Findings

4.39 Detainees were booked in at the front desk. This offered little privacy and did not encourage detainees to disclose important personal information about risk. The traditional high desk designed to protect custody staff also acted as a barrier to communication and created an inappropriate environment in which to gather quality information, particularly from children and many women.

4.40 Translation services were well used. Staff we spoke to were aware of the potential risks of self-harm and alert to signs of any health concerns. The risk assessment included questions on any previous history of self-harm or substance misuse, health conditions or current medication. The UNITY system included a risk assessment and care plan. A paper detention log was kept for the period of detention.

4.41 There were five full-time custody sergeants, only one of whom was female, and eight detention officers. No untrained staff were allowed to work in the custody suite. Custody sergeants new to the role shadowed more experienced colleagues and annual refresher training was provided. All detention officers received a six-week training programme. The constabulary's safer detention website was available to staff for reference.

4.42 There was a good level of awareness of potential risks, but procedures did not consider individual risk assessment. The approach was too uniform and mechanistic, without taking into account individual circumstances. One 14 year-old girl in the care of the local authority had been asked to remove a top with collar trimming that staff considered a potential ligature. She had been offered an alternative top, but had refused to change. The custody record did not indicate any previous self-harm or detail any efforts made to encourage her cooperation or that any alternative strategies had been considered. Even though other items of her clothing could have been used to self-harm, the record described two officers (one male and one female) restraining her and cutting off the trimming before the teenager was placed in a detention room without a camera. Had she been considered at risk of self-harm, we would have expected the force's stated policy to have been followed, with an officer allocated to 'manage the detainee's welfare needs until an appropriate adult is present in the custody suite'. The teenager was clearly upset by her treatment. The video recording of the incident confirmed our view that the force used in the circumstances was insensitive and unnecessary, with the teenager taken to the floor surrounded by a number of male officers. The matter was referred to senior managers for investigation.

4.43 All detainees had to remove their shoes, even those without laces. Staff said this was to stop them kicking staff or cell doors.

4.44 Detainees considered at risk were monitored on one of four levels ranging from general observations (level one) to close proximity (level four). These were recorded in the custody record. Four cells, including one used for women, but none of the detention rooms used for juveniles, had closed-circuit television. CDOs had no specific training in managing self-harming behaviour, but simple guidance on a constant watch procedure was displayed. Staff were aware of the importance of getting a response from detainees when rousing them and custody records indicated good awareness of risks when handing over responsibility at shift changes. There was a force-wide system for reporting serious near miss incidents.

4.45 The force policy was that exit plans should be completed on detainees on constant observation (level three) or close proximity observation at the point of release. No detainees were on these watches during the inspection. Guidance was also provided on exit plans for detainees who may be at risk for other reasons. Records showed that some vulnerable detainees had been taken home on release.

4.46 All staff had been issued with personal ligature knives, but not all wore these on their belts. One knife was attached to the keys giving access to cells.

Expectation

4.47 Custody staff are aware of any risk of harm to others and this is managed appropriately. Detainees are not placed in cells together unless a risk assessment indicates that it is safe to do so. Risk assessments include whether the detainee has previous convictions for racially aggravated offences.

Findings

4.48 Detention rooms for juveniles did not have closed-circuit television coverage and were not near to staff. They were located opposite two interview rooms, which allowed poor sightlines and could be disrupting when the interview rooms were in use. This meant the cell doors could not easily be left open when children were held in these rooms.

4.49 Detainees were not placed in shared cells and staff said this would not happen, but the risk assessment form used did not consider questions that could highlight potential risks should the need to share arise. The force had contingency plans with neighbouring forces if additional cell spaces were needed in an emergency.

Expectation

4.50 Holding cells are equipped with call bell systems and their purpose is explained to detainees. They are responded to within a reasonable time.

Findings

4.51 All cells had call bells and these were answered promptly during the inspection. Detainees said they had not been told how to use them and some officers said they had muted cell call bells when they thought detainees were using them inappropriately. This practice risked detainees' urgent needs being ignored. Cell call bells were not routinely tested every day.

Expectation

4.52 Holding areas, cells, interview rooms and detention rooms are:

- clean
- free from graffiti
- in good decorative order
- of a suitable temperature
- well ventilated
- well lit
- equipped with somewhere to sit
- free of ligature points.

Findings

4.53 There were two detention rooms, two cells for women and six for men. Communal areas and individual cells were clean and reasonably well decorated. Custody officers carried out routine cleaning and contract cleaners responded promptly when more specialised cleaning was needed. Graffiti was painted over and there was little in evidence. Any damage to a cell was noted on a board before a detainee was placed in it. Most cells were poorly lit with little natural light. The detention rooms had no natural light at all. The bed bases were high enough for detainees to sit down, but cells were stark. Low plinths in some cells were a safety feature used particularly for intoxicated detainees. Ventilation appeared satisfactory. There were few obvious ligature points. Inspectors responsible for the suite made regular daily and monthly management checks.

Expectation

4.54 A smoking policy for staff and detainees is enforced that respects the right of individuals to breathe clean air in the custody suite.

Findings

4.55 The suite was a no smoking area. One custody record showed that a detainee suspected of smoking had been challenged.

Expectation

4.56 Detainees are provided with suitable meals that cater for special dietary requirements, and drinks at appropriate intervals.

Findings

4.57 Custody records showed that detainees were offered regular meals and drinks. There was a good supply of microwave meals, including halal, gluten-free and vegetarian options, and a selection of hot and cold drinks. These were adequate for most prisoners in custody for a relatively short time. The kitchen area where meals were prepared was clean.

Expectation

4.58 Detainees are provided with a mattress, pillow and clean blankets if held overnight.

Findings

4.59 Every cell contained a mattress and pillow, and spares were available in a store room. They were in good condition. Clean blankets were given to detainees on request and sent to be cleaned after use.

Expectation

4.60 Detainees are able to use a toilet in privacy, and toilet paper and washing facilities are provided.

Findings

4.61 Not all cells, including the two detention rooms, had toilets. Cells with toilets allowed detainees reasonable privacy and had adequate hand washing facilities. Toilet paper was given only on request as there were concerns that rolls would be used to flood cells. Soap was provided and there were good stocks of soap and towels. Detainees in cells without a toilet used the cell call system to ask to be let out and there was no evidence of any delays. None of the toilet facilities had been adapted for use by a wheelchair user.

Expectation

4.62 Detainees whose clothing is taken for forensic examination are provided with suitable alternative clothing before being released or transferred to court.

Findings

4.63 There were supplies of new jogging bottoms, T-shirts and plimsolls in a range of sizes. These were given to detainees whose clothing was required for forensic examination and when they were released or taken to court. Paper suits were used as a temporary measure when replacement clothing was being brought in by relatives or friends, but there was no clear guidance on when these rather than normal clothing should be offered.

Expectation

4.64 Detainees who are held for more than 24 hours are able to take a shower and a period of outdoor exercise.

Findings

4.65 The small exercise yard was stark with little light. Custody officers said few detainees asked to use it since the ban on smoking. There was little evidence that detainees were routinely offered the opportunity to exercise.

4.66 There was one men's and one women's shower. Detainees could shower on request when there were sufficient staff of the same sex as the detainee to supervise. Otherwise, detainees could have a wash. Custody records showed that few detainees were held more than 24 hours.

Expectation

4.67 Detainees who are held in custody for several days are provided with suitable reading material. Visits are also allowed, and changes of clothing, especially underwear, are facilitated.

Findings

4.68 A small selection of magazines donated by staff or left behind by other detainees was available, but these were not routinely replaced when damaged or destroyed. There were no books. Only legal advisers or appropriate adults were allowed to visit.

4.69 There was no stock of underwear and detainees were encouraged to ask family or friends to bring clothing in. This was inadequate for those with no local or immediate family support.

Expectation

4.70 Custody suite staff have received fire safety training and evacuation procedures are practised frequently.

Findings

4.71 Detention officers were familiar with contingency plans and were aware of evacuation procedures. Table top exercises had taken place, but in practice they would rely on direction from the custody sergeant. The evacuation procedures had not been practised.

Cheltenham

4.72 Custody staff were trained and aware of their responsibilities. Staff were vigilant about self-harm and other risks. Cells were clean and free from graffiti, but contained little information. There was a good stock of replacement clothing. Showers were not routinely offered and lacked privacy. Handover arrangements were good. Detainees were not told about all the facilities and procedures.

Expectation

4.73 Custody staff are aware of the risk of self-harm from:

- attempted suicide
- drugs ingestion
- medical conditions
- alcohol

and these risks are assessed, monitored and managed appropriately.

Findings

4.74 Custody staff were aware of the risks of self-harm. All bookings into the custody suite took place at a high front desk and there was little privacy. Custody sergeants carried out individual risk assessments that included questions on vulnerability, drugs and alcohol misuse and mental health. Staff also accessed the force-wide UNITY computer system and the Police National Computer, which highlighted areas such as mental health concerns based on previous custody or contact with the police. However, mental health issues flagged on the computer about one detainee were not taken into consideration during the risk assessment process.

4.75 Initial training for custody staff covered these areas, but refresher training was not routinely provided. Risk assessments were sometimes delayed when detainees were under the influence of alcohol or drugs. These detainees were put on frequent observations, which involved staff entering a cell to rouse them. Instructions about this were specific and adhered to. Other levels of observation were applied depending on the risk assessment. These ranged from general observations to constant supervision, although use of the latter was rare. However, the approach to identifying risk was uniform and mechanistic and took too little account of individual circumstances.

4.76 Information about detainees was communicated at shift handover and any issues such as risk of self-harm written on a whiteboard. Detainees at risk were often located to one of the two camera cells or a cell near the charge desk. All custody staff carried anti-ligature knives as

personal issue. There were three sets of cell keys, one of which was always available in an emergency. The others were carried in loose bunches and shared between the staff on duty.

4.77 Cameras covered communal areas, although some were only motion activated. There was no protocol governing closed-circuit television observations.

Expectation

4.78 Custody staff are aware of any risk of harm to others and this is managed appropriately. Detainees are not placed in cells together unless a risk assessment indicates that it is safe to do so. Risk assessments include whether the detainee has previous convictions for racially aggravated offences.

Findings

4.79 No cells were shared. The suite rarely reached capacity and on the one occasion staff could recall, the exercise area had been used. Information was available from the Police National Computer to identify those who posed a risk to others or had previously been convicted of racially motivated offences. A policy determined the assessment that needed to be undertaken before detainees shared cells.

Expectation

4.80 Holding cells are equipped with call bell systems and their purpose is explained to detainees. They are responded to within a reasonable time.

Findings

4.81 All holding cells had a call bell. All detainees we spoke to knew how to use the system, although one believed it was for emergencies only. Not everyone had been told explicitly what the call bell was for and there was no information in the cell explaining how to use it. There was no system to record response times. During the inspection, bells were responded to promptly, but there were sometimes delays in busy periods. Detainees used call bells to ask staff for toilet paper, drinks, the exercise yard and reading materials.

Expectation

4.82 Holding areas, cells, interview rooms and detention rooms are:

- clean
- free from graffiti
- in good decorative order
- of a suitable temperature
- well ventilated
- well lit
- equipped with somewhere to sit
- free of ligature points.

Findings

4.83 The environment was largely clean and cells were free from graffiti. Washing facilities were well maintained. There was a cleaning policy and a company on 24-hour call to deal with specialist cleaning. Notices stated that detainees found damaging cells would be charged, although custody sergeants used their discretion. Some cells had poor lighting and ventilation. They were equipped with a space to sit or lie and were free from ligature points.

4.84 All cells, apart from juvenile cells, had in-cell sanitation. Juveniles had to ring the bell to use the toilet and showers.

4.85 Cells were austere, with little information apart from a CrimeStoppers notice and advice on contacting a solicitor.

Expectation

4.86 A smoking policy for staff and detainees is enforced that respects the right of individuals to breathe clean air in the custody suite.

Findings

4.87 The suite was completely no smoking.

Expectation

4.88 Detainees are provided with suitable meals that cater for special dietary requirements, and drinks at appropriate intervals.

Findings

4.89 Detainees were offered meals catering for vegans, vegetarian and coeliacs. Halal meals were also available. There were clear instructions in the kitchen about which meals were suitable for which diet and preparation times. The meals tasted were adequate and there was no limit to how much a detainee could be given. Cereal and long-life milk was offered to detainees who remained in the cells overnight. Water and hot drinks were offered to detainees.

Expectation

4.90 Detainees are provided with a mattress, pillow and clean blankets if held overnight.

Findings

4.91 Detainees held overnight were given a mattress, pillow and clean blankets.

Expectation

4.92 Detainees are able to use a toilet in privacy, and toilet paper and washing facilities are provided.

Findings

4.93 Toilet paper and a shower were provided on request, but detainees were not told how to access them. Doors on the men's and women's showers obscured only the lower half of the body and did not offer sufficient privacy. Staff said they would use the more private facilities in the juvenile section if appropriate.

Expectation

4.94 Detainees whose clothing is taken for forensic examination are provided with suitable alternative clothing before being released or transferred to court.

Findings

4.95 Most detainees kept their own clothes. Detainees were offered a paper suit or the option of cutting any strings attached to their clothing, which was inappropriate, and little thought was given to this or the individual circumstances. We saw part of the cord in a hooded top, which could have been used as a ligature, left inside the hem.

4.96 Detainees whose clothing was taken were given jogging pants and a T-shirt. Black plimsolls were also available. We saw detainees with no socks or alternative footwear, despite the custody suite having foam slippers that could have been offered.

Expectation

4.97 Detainees who are held for more than 24 hours are able to take a shower and a period of outdoor exercise.

Findings

4.98 Custody staff were flexible about allowing detainees in the exercise yard. One distressed detainee was allowed to sit in the yard until she calmed down. However, one young adult who had been sick was offered a change of clothes, but not a shower.

Expectation

4.99 Detainees who are held in custody for several days are provided with suitable reading material. Visits are also allowed, and changes of clothing, especially underwear, are facilitated.

Findings

4.100 The room that could have been used for family visits was used for storage, indicating that visits had not been allowed for some time. A limited range of reading material was available on request and detainees could keep any they came in with. There were stocks of clothing, but no underwear.

Expectation

4.101 Custody suite staff have received fire safety training and evacuation procedures are practised frequently.

Findings

4.102 Custody staff had received training as part of their initial introduction to custody procedures. There had been one fire drill six months previously, but this had been a simulated exercise and had not involved an evacuation of the suite.

Recommendations

4.103 Booking in and discharge arrangements should be improved so that detainees are dealt with at a desk of an appropriate height and which allows sufficient privacy to disclose any vulnerabilities or for confidential information to be passed.

4.104 The risk assessment form for cell sharing should include questions to highlight potential risks.

4.105 Mental health flags from the Police National Computer should routinely be included in risk assessments.

4.106 Custody staff should receive specialist self-harm training that takes into account the needs of specific groups and individual risk.

4.107 All custody staff should carry personal cell keys and ligature knives.

4.108 Staff should explain the use of the call bell to detainees and this should be recorded.

4.109 Cell call bell systems should not be muted under any circumstances.

4.110 All cells should have decent natural light, ventilation and heating with appropriate sanitation and hand washing facilities.

4.111 There should be sufficient and appropriately equipped cells to meet the needs of those with physical disabilities.

4.112 Holding facilities, interview rooms and the exercise yard area should be made less austere.

4.113 Detainees should not have to wait in vans for prolonged periods.

4.114 Detainees should be offered meals at appropriate intervals and this should be recorded in the custody records.

4.115 Young people under 18 should be held in appropriate well supervised accommodation and dealt with taking into account their legal status and vulnerabilities as children, including an awareness of child protection issues.

4.116 Items to meet basic needs, such as toilet paper and sanitary products, should be routinely available unless their removal can be justified by an individual risk assessment.

4.117 All showers should provide appropriate privacy.

4.118 Detainees who need a shower for decency and good hygiene reasons should always be offered a shower, as should those held for more than 24 hours.

4.119 A clear policy on when paper suits should be used should be published.

4.120 Custody records should routinely record when detainees have been offered exercise.

4.121 Detainees held for more than 24 hours should be able to receive visits in a welcoming and comfortable environment.

4.122 A stock of suitable reading material, including newspapers, religious texts and material in relevant languages, should be available.

4.123 Detainees with no family or local support who need a change of clothing should be offered basic clothes, including a change of underwear.

4.124 Custody suite staff should receive fire safety training and evacuation plans should be practised.

5. Individual rights

Gloucester

5.1 The administrative arrangements for detention were carried out following the PACE Act requirements. Staff engaged well with detainees and the basic needs of most detainees were adequately met. Staff showed an interest and some concern for the detainees in their care. There was little specialist provision for minority groups, such as women and juveniles. The physical conditions were poor and the facilities limited. Staff held an appropriately broad view about their duty of care and this was reflected in the relatively thorough pre-release arrangements for vulnerable individuals.

Expectation

5.2 Detention is appropriate, authorised and lasts no longer than is necessary. In the case of immigration detainees alternative disposals are expedited.

Findings

5.3 The initial three reviews were carried out by an inspector. Records indicated that they were completed within the timescales specified under PACE and covered the necessary legal requirements. If a formal review was required after 24 hours, this was carried out by an officer of the rank of Superintendent. We were unable to determine whether detention was always properly authorised and lasted no longer than necessary.

Expectation

5.4 Detainees, including immigration detainees, are told that they are entitled to have someone concerned for their welfare informed of their whereabouts. Any delay in being able to exercise this entitlement, such as phoning a person concerned for their welfare, is authorised at the level of Inspector or above. They are asked if they wish to see a doctor.

Findings

5.5 All detainees were issued with a rights and entitlements leaflet when they arrived in the cells. This detailed leaflet, endorsed by the Criminal Defence Service and the Law Society, explained all the rights and entitlements that detainees were guaranteed. The main points, including that they were entitled to have someone told of their whereabouts, were also explained to each detainee by the custody sergeant. Staff usually allowed detainees to make any number of necessary calls and understood that authorisation by a senior officer was required when telephone calls were not permitted, such as for evidential reasons.

5.6 Detainees were not always given the option of seeing a doctor. In practice, detainees saw a doctor either on request or if the custody sergeant dealing with the admission had any concerns.

Expectation

5.7 Detainees who have difficulty communicating are adequately provided for with staff who can communicate with them or interpreters.

Findings

5.8 Staff quickly used an interpreter when there was any doubt about a detainee's ability to understand what was being said. Interpreters were selected from an official list and staff said their services were not normally difficult to obtain. There were some unavoidable delays when a detainee spoke a particularly unusual language.

5.9 Help was sought from the Deaf Advisory Service when a detainee had a hearing impairment and two staff working in the cells were trained in British sign language. There were no formal arrangements to assist detainees who were visually impaired to communicate. We saw a detainee who suffered from a degenerative disease and had lost one of his limbs being dealt with sympathetically by custody staff.

Expectation

5.10 There are special arrangements for detained young people that cover:

- the limited use of restraints
- the conduct of any strip search
- location in unlocked detention rooms close to the custody desk where possible for observation purposes
- separation from adults at all times including in showers and the exercise yard
- specially trained officers allocated until the appropriate adult arrives
- whether appropriate adults are indeed appropriate for the task
- the capacity for the relative, guardian or appropriate adult to remain with the detained young person during waiting periods, in the detention room if necessary.

Findings

5.11 Three cells had been designated for use by juveniles. Staff said these were the quietest, being located in a small wing separate from the remaining cells. None was fitted with cameras. Staff said juveniles were usually kept separate from adults, but that it was sometimes necessary to place them in cells next to adults when a large group was admitted. There was no facility to keep male and female juveniles on separate corridors.

5.12 Apart from ensuring that an appropriate adult was allocated, the formal arrangements provided for the care of juveniles were the same as those for adults. A policy on juveniles and young people had been published, but contained nothing that resulted in substantive differences in how juveniles were treated or recognised their specific needs and vulnerabilities.

5.13 The height of the front desk made it particularly difficult for the custody sergeant to communicate with young people, but staff tended to take more time and care with young people being processed to ensure that they understood what was happening. Subject to risk assessment, appropriate adults were permitted to sit with detainees in their cells.

Expectation

5.14 Female detainees are able to be dealt with by female staff, or where this is not possible, hygiene packs for women are routinely provided. Staff are aware that the impact of detention on women is different to the impact on men, and adopt their level of observation and support appropriately.

Findings

5.15 Female staff were not always on duty, but could be called in from other areas. Staff said to minimise the risk of harm, female detainees were not given hygiene packs, but that sanitary towels were supplied on request. Available stock was very limited and female detainees had to hand used towels in a bag to staff for disposal, which was embarrassing. There were no special arrangements for female detainees and staff we spoke to did not appear to appreciate that they might experience custody differently to men.

Expectation

5.16 Persons detained who have dependency obligations are catered for.

Findings

5.17 Detainees who requested help with child care were allowed to use the telephone and staff said police officers had picked up children from school as a last resort when a family member could not be contacted.

Expectation

5.18 Detainees are able to have a solicitor present when interviewed by police officers. Those under the age of 17 or vulnerable adults or those with learning disabilities are not interviewed without a relative, guardian or appropriate adult present. Solicitors and advocates arrive promptly so as not to unnecessarily prolong the period in custody. Detainees are able to consult with legal representatives in privacy.

Findings

5.19 Detainees were always given the opportunity to have a solicitor present when interviewed by police and those under the age of 17 were never interviewed alone. Records indicated that appropriate adults were contacted for vulnerable adults. Solicitors usually arrived reasonably promptly, but staff said it was sometimes difficult to get an appropriate adult out of hours. Solicitors could interview their clients in private.

Expectation

5.20 Detainees are not interviewed by police officers while under the influence of alcohol or drugs, or if medically unfit unless in circumstances provided for under PACE.

Findings

5.21 Custody staff did not hesitate to involve medical staff if they had any doubt that the detainee was fit to be interviewed.

Expectation

5.22 Suitable legal advice is available for both police detainees and immigration detainees.

Findings

5.23 Custody staff made sure that detainees were given the opportunity of receiving legal advice and this right was outlined clearly in the leaflet issued to all detainees. Access to a solicitor was through a call centre that routed the request either to an immigration lawyer or to a criminal lawyer, although immigration advice was limited.

Expectation

5.24 Detainees are not subject to inhuman or degrading treatment in the context of being interviewed, or in the denial of any services they need. They are allowed a period of eight hours continuous break from interviewing in a 24-hour period.

Findings

5.25 Reviewing officers were alert to the need for detainees to have sufficient breaks between interviews. Detainees could read through their records, if necessary with the aid of an interpreter, and were given appropriate advice about their responsibility to sign the document.

Expectation

5.26 Detainees are not handcuffed in secure areas unless there is a risk of violence to other detainees or staff.

Findings

5.27 Although detainees occasionally entered the custody suite in handcuffs, they normally had them removed as soon as the custody sergeant was satisfied that there was no unnecessary risk.

Expectation

5.28 Those charged are produced at court promptly either in person or via video link.

Findings

5.29 Detainees were usually produced at court on the day they arrived at the cells or the next working day.

Expectation

5.30 Detainees know how to complain about their care and treatment. They are not discouraged from doing so but are supported in doing so where necessary.

Findings

5.31 Detainees we spoke to did not have a clear idea about how to make a complaint. There was no evidence that they had been told how to complain and it was not covered in the rights and entitlements leaflet. Staff said very few complaints were made and that they would try to deal informally with any issue raised. If this was not possible or if the complaint was serious, an investigation would be carried out, probably by an inspector.

Expectation

5.32 There is an effective system in place for reporting and dealing with racist incidents.

Findings

5.33 There was no racist incident procedure. Staff said racist complaints would be dealt with in the same way as other complaints.

Expectation

5.34 All custody suites hold a copy of the PACE Code of Practice C, and detainees, including immigration detainees, know they are able to consult it. Detainees or their legal representatives are able to obtain a copy of their custody record on release, or at any time within 12 months following their detention.

Findings

5.35 Up-to-date copies of the PACE code of practice and relevant amendments were held at the custody sergeant's desk. Detainees were informed about their right to consult the code of practice during the booking in procedure. Staff said solicitors could obtain copies of their client's custody record on request. The same was true for detainees, although this was unusual.

Expectation

5.36 Pre-release risk management is conducted and vulnerable detainees are released safely.

Findings

5.37 Exit plans were produced for vulnerable detainees, who were usually on some form of observation before discharge. The plans were quite simple and often amounted to little more than a leaflet being issued containing contact details of local support organisations in the community. In a number of cases, detainees had been transported to their home address and

in one incident a detective officer had spoken to the detainee's wife to pass on relevant information.

5.38 The exit plans were useful, but there were not many of them. In some cases, detainees were given support on release, but this was not recorded on an exit plan. The criteria for when to produce an exit plan were unclear and allowed a considerable amount of discretion.

Stroud

5.39 Custody sergeants ensured that detainees were properly informed of their rights and published information given to detainees was available in 30 languages. Some immigration detainees were held for long periods in the custody suite. Custody staff had received no specific training in the supervision of juveniles or women detainees. Interpreters were easily accessible and used regularly. There were some delays in getting appropriate adults.

Expectation

5.40 Detention is appropriate, authorised and lasts no longer than is necessary. In the case of immigration detainees alternative disposals are expedited.

Findings

5.41 There was no evidence of inappropriate detention and custody records contained authorisation, reasons for initial detention and reviews by an inspector, which were conducted on time. However, we were concerned that a 14 year-old girl had been detained too long during the inspection. Although it had been planned to bring her to the station, no arrangements had been made in advance for an appropriate adult to be present. This thoughtlessness meant she was held for some hours until one could attend.

5.42 Solicitors and police reported delay and inflexibility caused by the CPS charging arrangements. The CPS made most decisions whether to charge, leaving custody officers with discretion only in very low level cases. This required greater input from the CPS, but a CPS officer was only occasionally present in any of the custody suites. Police usually had to communicate by telephone, faxing over bundles of documents, which caused delay, aggravated by lack of continuity of CPS personnel.

5.43 Police officers and solicitors were uncomfortable that if the charging decision was made without speaking to the arresting officer and detainee, the decision-maker would not always have a full picture of what happened or sufficiently appreciate mitigating factors such as vulnerability. Custody staff did not get much feedback, as much of the process bypassed them.

5.44 The custody records of immigration detainees that we saw were all of short duration. However, in the previous four months, 22 immigration detainees had been detained for an average of just over 24 hours. Four had been transferred from another custody suite to Stroud and had been held for between 62 and 81 hours.

Expectation

5.45 Detainees, including immigration detainees, are told that they are entitled to have someone concerned for their welfare informed of their whereabouts. Any delay in being able to exercise this entitlement, such as phoning a person concerned for their welfare, is authorised at the level of Inspector or above. They are asked if they wish to see a doctor.

Findings

5.46 Detainees, including immigration detainees, were informed that they could have someone told of their whereabouts. Any delay in this entitlement was authorised at the level of inspector or above and the reason recorded in the custody record. Detainees were not asked if they wished to see a doctor, although their right to do so was included in the rights and entitlements leaflet.

5.47 One of the two telephones was directly in front of the custody sergeant's desk, which could not be used in private, and the other was in the solicitors' interview room. The only telephone we saw offered and used was the one opposite the desk.

Expectation

5.48 Detainees who have difficulty communicating are adequately provided for with staff who can communicate with them or interpreters.

Findings

5.49 Custody staff could use a telephone interpreting service and this was evidenced in custody records. Posters on which non-English speakers could indicate their spoken language were displayed. Face-to-face interpreters, including a signer for detainees with a hearing impairment, were also available. The rights and entitlements leaflet was available in 30 languages.

Expectation

5.50 There are special arrangements for detained young people that cover:

- the limited use of restraints
- the conduct of any strip search
- location in unlocked detention rooms close to the custody desk where possible for observation purposes
- separation from adults at all times including in showers and the exercise yard
- specially trained officers allocated until the appropriate adult arrives
- whether appropriate adults are indeed appropriate for the task
- the capacity for the relative, guardian or appropriate adult to remain with the detained young person during waiting periods, in the detention room if necessary.

Findings

5.51 Apart from the directions about the treatment of juveniles included in PACE, there was no specific policy for dealing with children. Young people aged 17 were treated as adults.

5.52 Juvenile cells had recently been identified, but were not distinct from other cells and, although clean, were stark and had not been softened to lessen the impact on children. They had no toilets, no closed-circuit television surveillance and were not close to the custody sergeant's desk. Children were locked in the cells and there was no policy of increased observations or specific training for officers. Female officers were allocated to the care of detained girls, but this did not extend beyond accompanying her to the shower or toilet. No one sat with a girl until an appropriate adult arrived.

Expectation

5.53 Female detainees are able to be dealt with by female staff, or where this is not possible, hygiene packs for women are routinely provided. Staff are aware that the impact of detention on women is different to the impact on men, and adopt their level of observation and support appropriately.

Findings

5.54 Hygiene packs were not routinely provided. Women had to ask for sanitary tampons and towels, but there were no notices about this on display. There was no specific policy for dealing with women, no difference in the cells used for women and no increased observation or any additional support.

Expectation

5.55 Persons detained who have dependency obligations are catered for.

Findings

5.56 Custody staff could contact social services, but detainees were not asked about any care responsibilities for either children or older relatives, including women who were more likely to be primary carers. Custody staff said they relied on the woman or arresting officer telling them about any caring responsibilities.

Expectation

5.57 Detainees are able to have a solicitor present when interviewed by police officers. Those under the age of 17 or vulnerable adults or those with learning disabilities are not interviewed without a relative, guardian or appropriate adult present. Solicitors and advocates arrive promptly so as not to unnecessarily prolong the period in custody. Detainees are able to consult with legal representatives in privacy.

Findings

5.58 All detainees could have a solicitor present when interviewed and the custody sergeant clearly explained their right to legal advice. Custody records evidenced very quick responses from duty solicitors. Notices about the right to legal advice were displayed in a range of languages, but were unlikely to be read by detainees, whose attention was given to the custody sergeant. No information was displayed in cells, but all detainees were given a rights and entitlements leaflet.

5.59 Juveniles and vulnerable adults were not interviewed without an appropriate adult, but it was not unusual for juveniles to have to wait some time for appropriate adults, particularly in the evenings or at night.

Expectation

5.60 Detainees are not interviewed by police officers while under the influence of alcohol or drugs, or if medically unfit unless in circumstances provided for under PACE.

Findings

5.61 Detainees were not interviewed while under the influence of alcohol or drugs.

Expectation

5.62 Suitable legal advice is available for both police detainees and immigration detainees.

Findings

5.63 Detainees could use the duty solicitor scheme and signed a form to indicate that they had been told verbally and in writing about the availability of legal advice and their rights and entitlements. They also signed to confirm whether they had requested or declined legal advice. This form was included in their custody record. Solicitors could speak to detainees in private.

5.64 Detainees held under immigration act powers were advised of their legal rights and referred to CDS Direct, although CDS Direct practitioners were accredited to provide advice on criminal rather than immigration matters. Under a new pilot scheme funded by the Legal Services Commission, CDS Direct could refer an inquiry to a firm accredited to give immigration advice. However, on the custody record seen, the firm contacted was located in the north-east and, although it could give some telephone advice, it was not able to visit a detainee in Gloucestershire.

Expectation

5.65 Detainees are not subject to inhuman or degrading treatment in the context of being interviewed, or in the denial of any services they need. They are allowed a period of eight hours continuous break from interviewing in a 24-hour period.

Findings

5.66 There was no evidence of any inappropriate treatment, but no recognition of the different needs of children and women. Custody records indicated that detainees received an eight-hour break when necessary.

Expectation

5.67 Detainees are not handcuffed in secure areas unless there is a risk of violence to other detainees or staff.

Findings

5.68 Detainees were not handcuffed on arrival or while in the cells unless deemed necessary following an individual risk assessment.

Expectation

5.69 Those charged are produced at court promptly either in person or via video link.

Findings

5.70 Detainees usually arrived at court promptly as the cells were directly below the magistrates court. However, solicitors and police officers complained that those arrested for breach of bail did not always appear before the court within 24 hours. Although the court had issued a warrant and police had made the arrest, the court declined to list the detainee at the next sitting, which meant they stayed more than 24 hours in police cells because police were not supposed to bail them.

Expectation

5.71 Detainees know how to complain about their care and treatment. They are not discouraged from doing so but are supported in doing so where necessary.

Findings

5.72 Detainees we spoke to did not know how to make a complaint and there was no formal complaints system. Custody sergeants said detainees could complain directly to them, but detainees were not told this and there were no notices to this effect.

Expectation

5.73 There is an effective system in place for reporting and dealing with racist incidents.

Findings

5.74 There was no racist incident procedure.

Expectation

5.75 All custody suites hold a copy of the PACE Code of Practice C, and detainees, including immigration detainees, know they are able to consult it. Detainees or their legal representatives are able to obtain a copy of their custody record on release, or at any time within 12 months following their detention.

Findings

5.76 Detainees could read a copy of the PACE code of practice. Detainees and legal representatives could view their custody records on request or within 12 months following their detention and this information was included in the rights and entitlements leaflet.

Expectation

5.77 Pre-release risk management is conducted and vulnerable detainees are released safely.

Findings

5.78 Exit plans were completed for vulnerable detainees, such as those with mental health or medical issues and alleged sex offences. A leaflet of available services was given to detainees including information about drug and alcohol support, NHS Direct, legal services and the Samaritans. Some detainees were taken home or to a safe address by officers. Custody staff could also make referrals to appropriate agencies and give advice to family and friends with the detainee's consent.

5.79 The decision to complete an exit plan was at the discretion of the custody sergeant and there was no formal policy to ensure consistency of support. Children were not automatically considered vulnerable.

Cheltenham

5.80 Detention was appropriate and usually for the minimum period, although court timings sometimes resulted in unnecessary detention. There were some delays in dealing with immigration detainees. No staff had received child protection training, although significant numbers of juveniles were held. Detainees were not told how to complain and there was no procedure for dealing with racist complaints. Individual rights were respected.

Expectation

5.81 Detention is appropriate, authorised and lasts no longer than is necessary. In the case of immigration detainees alternative disposals are expedited.

Findings

5.82 There was no evidence of inappropriate detention and custody records contained authorisation, reasons for initial detention and reviews by an inspector, which were conducted on time. Most records we examined suggested that detainees were kept for as short a period as possible.

5.83 DNA samples were routinely taken for detainees covered by PACE arrangements, but there was some confusion about who was responsible for immigration detainees. In many cases, the immigration authorities took charge of the detainee and only fingerprints were taken.

5.84 There was regular contact with immigration authorities, although there were some delays in getting immigration officers to the police station and one detainee had been held for six days before moving to an immigration removal centre. Records for the last four months indicated that 19 immigration detainees had been held, with an average detention of just over 23 hours.

5.85 Juveniles were not normally held overnight, although there were some cases where this had occurred, particularly related to public order offences and when there was no suitable adult to take responsibility for them.

5.86 Solicitors and police reported delay and inflexibility caused by the CPS charging arrangements. There was limited scope for individual discretion, particularly when there were mitigating factors such as vulnerability. Police reported some delays in dealing with CPS staff and said they had very little feedback from the CPS about cases. There were also delays in court appearances, which resulted in detainees spending an additional night in custody if they missed the 3pm deadline for a court booking.

Expectation

5.87 Detainees, including immigration detainees, are told that they are entitled to have someone concerned for their welfare informed of their whereabouts. Any delay in being able to exercise this entitlement, such as phoning a person concerned for their welfare, is authorised at the level of Inspector or above. They are asked if they wish to see a doctor.

Findings

5.88 All detainees were informed they could have someone told of their whereabouts. Any delay in this entitlement was authorised at the level of inspector or above and the reason recorded in the custody record. Detainees were not asked if they wished to see a doctor, although their right to do so was included in the rights and entitlements leaflet.

5.89 There were two telephones. The one routinely offered to detainees was in the lobby area in front of the charge desk. It afforded very little privacy and staff, other detainees and visitors to the custody suite could overhear all conversations. Another telephone was available for legal calls.

5.90 Immigration detainees were frequently passed through to the community defence solicitors (CDS Direct) helpline who would, if possible, try to find an immigration solicitor.

Expectation

5.91 Detainees who have difficulty communicating are adequately provided for with staff who can communicate with them or interpreters.

Findings

5.92 Interpreting facilities were available through a professional telephone interpreting service or through the national police register of accredited interpreters. Professional interpreters were generally used between two and three times a month. The police were able to call on specialist services for deaf detainees who required a sign interpreter. The rights and entitlements leaflet was available in 30 languages.

Expectation

5.93 There are special arrangements for detained young people that cover:

- the limited use of restraints
- the conduct of any strip search
- location in unlocked detention rooms close to the custody desk where possible for observation purposes
- separation from adults at all times including in showers and the exercise yard
- specially trained officers allocated until the appropriate adult arrives
- whether appropriate adults are indeed appropriate for the task
- the capacity for the relative, guardian or appropriate adult to remain with the detained young person during waiting periods, in the detention room if necessary.

Findings

5.94 There were no special arrangements for young people. PACE was followed in relation to detention of young people under 17 and records indicated that parents or carers were contacted within an appropriate timescale. If this was not possible, an appropriate adult service attended, although there were some delays due to the lack of availability of volunteers.

5.95 Custody officers had not had any training to identify child protection or welfare issues, which was a concern given the frequency of juvenile detention.

5.96 Strip searches were conducted in the presence of an appropriate adult if one was available, but staff conducted such searches only if they believed something was concealed that could cause harm to themselves or others.

5.97 Young people were located in the juvenile cells, which were furthest away from the custody desk and possibly the most unsuitable. They had no in cell sanitation. The doors were always locked, except when an appropriate adult was permitted to sit in the cell with the young person with the door open. No alternative room was provided where a child and adult could wait. When the custody suite was not busy, juveniles were located in the other cells so that they were closer to the desk, but also to save custody officers having to let them out to use the toilets.

Expectation

5.98 Female detainees are able to be dealt with by female staff, or where this is not possible, hygiene packs for women are routinely provided. Staff are aware that the impact of detention on women is different to the impact on men, and adopt their level of observation and support appropriately.

Findings

5.99 There were enough custody officers to allow female detainees to be dealt with by female staff.

5.100 Hygiene packs had to be requested rather than being routinely provided. During the inspection, a female detainee requested sanitary products. However, the range was limited and not always what was required.

5.101 Staff were sensitive to women in custody and handled their care appropriately. We were told that it was the arresting officer's responsibility to ask about any dependency issues and staff said they did check once in their custody, but there was no evidence on the custody records (risk assessment diversity section). Staff said they would contact any family or friends of the detainee or, as a last resort, children's services.

Expectation

5.102 Persons detained who have dependency obligations are catered for.

Findings

5.103 There was no evidence on the record that detainees with dependency obligations were allowed extra calls to ensure that dependents were alright or to keep them informed.

Expectation

5.104 Detainees are able to have a solicitor present when interviewed by police officers. Those under the age of 17 or vulnerable adults or those with learning disabilities are not interviewed without a relative, guardian or appropriate adult present. Solicitors and advocates arrive promptly so as not to unnecessarily prolong the period in custody. Detainees are able to consult with legal representatives in privacy.

Findings

5.105 All detainees could have a solicitor present when interviewed and the custody sergeant clearly explained their right to legal advice. Custody records usually evidenced very quick replies from duty solicitors, although one record indicated that an interview had gone ahead without a solicitor even though the detainee had requested one, and no reason was given. Notices about the right to legal advice were displayed by the charge desk. No information was displayed in cells, but all detainees were given a rights and entitlements leaflet.

5.106 Juveniles and vulnerable adults were not interviewed without an appropriate adult, but it was not unusual for juveniles to have to wait some time for appropriate adults, particularly in the evenings or at night. Many detainees did not request a solicitor.

Expectation

5.107 Detainees are not interviewed by police officers while under the influence of alcohol or drugs, or if medically unfit unless in circumstances provided for under PACE.

Findings

5.108 The custody sergeant, and healthcare staff if appropriate, judged whether detainees were fit to be interviewed, particularly if they had been under the influence of alcohol. We saw one detainee taken to be interviewed and returned to the cell because the police officer was concerned that they were not lucid enough.

Expectation

5.109 Suitable legal advice is available for both police detainees and immigration detainees.

Findings

5.110 Detainees held under immigration act powers were advised of their legal rights and referred to CDS Direct in the same way as other detainees, but CDS was accredited for criminal advice only. Under a new pilot scheme funded by the Legal Services Commission, CDS Direct could refer cases to another agency. The firm used was in the north-east and, while it could give some telephone advice, it was not able to visit a detainee in Gloucestershire.

Expectation

5.111 Detainees are not subject to inhuman or degrading treatment in the context of being interviewed, or in the denial of any services they need. They are allowed a period of eight hours continuous break from interviewing in a 24-hour period.

Findings

5.112 There was no evidence of any inappropriate treatment and custody records indicated that detainees were usually left undisturbed overnight. An eight-hour break was not always documented.

Expectation

5.113 Detainees are not handcuffed in secure areas unless there is a risk of violence to other detainees or staff.

Findings

5.114 We saw no evidence that detainees were handcuffed in secure areas. There were restraints available, but these were not used.

Expectation

5.115 Those charged are produced at court promptly either in person or via video link.

Findings

5.116 We saw detainees taken to court promptly, but staff said this was dependent on the availability of court cells as there were only four at the local magistrates court.

5.117 The custody sergeant could also make arrangements for detainees to be taken to court after the escort contractor's, Reliance, pick up in the morning. This depended on whether the court permitted the case to be dealt with. One detainee was brought into custody at 8.30am and taken to the courts in a police car that afternoon so that he did not remain in custody overnight. The local courts had an early cut-off time of 3pm, which caused problems for police and detainees.

Expectation

5.118 Detainees know how to complain about their care and treatment. They are not discouraged from doing so but are supported in doing so where necessary.

Findings

5.119 Detainees we spoke to were not aware of how to complain and had not been given any information as part of the booking in process.

5.120 The reviews were conducted by the duty inspector, who asked detainees if they had been treated appropriately and if they wanted to make a complaint. However, detainees might have felt too vulnerable to make a complaint while in custody and they were given no information about making a complaint on release.

Expectation

5.121 There is an effective system in place for reporting and dealing with racist incidents.

Findings

5.122 There was no racist incident procedure.

Expectation

5.123 All custody suites hold a copy of the PACE Code of Practice C, and detainees, including immigration detainees, know they are able to consult it. Detainees or their legal representatives are able to obtain a copy of their custody record on release, or at any time within 12 months following their detention.

Findings

5.124 There were several copies of the PACE code of practice and subsequent amendments. Detainees were told they could consult it as part of the booking in process.

Expectation

5.125 Pre-release risk management is conducted and vulnerable detainees are released safely.

Findings

5.126 There were few exit plans to look at, but staff said they were reserved for the most vulnerable or detainees who had been charged or bailed for alleged serious offences. The plans were basic, but acted as a checklist to ensure that all aspects of the detainee's release were considered, including referrals or contact that needed to be made to specialist agencies and transport home.

5.127 One exit plan included contacting a family member to explain what had happened to the detainee. Detainees were also given an information leaflet with contact details of specialist services, including the Samaritans.

Recommendations

5.128 Immigration detainees should only be held in police custody for the minimum period possible.

5.129 Detainees should always be asked if they would like to see a doctor on admission.

5.130 Arrangements should be in place to assist visually impaired detainees to communicate.

5.131 The treatment of children and young people should go beyond procedural compliance and address more fully the distinctive needs of young people in custody.

5.132 Custody staff should receive training on the differential impact of custody on different groups of detainees, particularly juveniles, women and carers.

5.133 The availability of appropriate adults, particularly out of normal working hours, should be improved.

5.134 Charge desks should allow people to converse at approximately eye level with the charging officer.

5.135 Women should routinely be offered suitable sanitary items.

5.136 There should be consultation with the Legal Services Commission with a view to providing suitable specialist immigration advice and assistance for immigration detainees.

5.137 Detainees should be given information about how to complain about treatment by police, the UK Border Agency or contractors.

5.138 A specific procedure for handling racist incidents and complaints should be introduced.

5.139 A strategy should be introduced to ensure the consistency of exit plans, which should recognise the vulnerability of children.

6. Healthcare

6.1 Health services were provided by an independent contractor, Essex Medical and Forensic Services (EMFS). Police staff reported a good level of service. Waits to see a healthcare professional averaged just under one hour and we observed good interactions between EMFS and detainees. Clinical rooms were reasonable, but there was no cleaning contract and some were poorly designed. There was good practice in the management of clinical records. Mental health services were provided by the local mental health trust, although persons detained under section 136 of the Mental Health Act (1983) were taken to a police station as a place of safety. A local drug and alcohol agency provided a service to the custody suites.

Expectation

6.2 The decency, privacy and dignity of detainees are respected.

Findings

6.3 Nurses, paramedics (healthcare professionals – HCPs) and doctors (forensic medical examiners – FMEs) employed by EMFS provided cover to all three custody suites in Gloucestershire. There was an HCP and an FME on call at all times. Each worked a 12-hour shift, with shift changeover at 7am and 7pm. EMFS staff appeared to have a good rapport with custody staff and detainees and interactions we observed were appropriate to the individuals concerned.

Expectation

6.4 Detainees are treated by health care professionals and drug treatment workers in a professional and caring manner that is sensitive to their situation and their diverse needs, including language needs.

Findings

6.5 Interactions between EMFS staff and detainees were polite and courteous. Appropriate and relevant medical questions were asked and interviews took place in confidence.

Expectation

6.6 Clinical governance arrangements include the management, training and supervision and accountability of staff.

Findings

6.7 There were some clinical governance arrangements, lines of accountability and some clinical audits carried out by senior EMFS staff. We were told that EMFS conducted formal peer group meetings for all staff every two months, but staff did not see any records of these meetings.

There were also meetings attended by senior EMFS managers where untoward incidents were reviewed.

Expectation

6.8 Patients are treated by health care staff who receive ongoing training, supervision and support to maintain their professional registration and development. Staff have the appropriate knowledge and skills to meet the particular health care needs of detainees in police custody.

Findings

6.9 Staff said they received ongoing training through relevant monthly updates and a formalised training session at police headquarters organised by a senior EMFS doctor and outside specialists. Training records were kept at EMFS head office. Staff were encouraged to attend regular meetings for professional development.

Expectation

6.10 All equipment (including resuscitation kit) is regularly checked and maintained and all staff (healthcare and custody staff) understand how to access and use it effectively.

Findings

6.11 Emergency equipment (a defibrillator and grab bag containing the oxygen cylinder, suction machine, various airways and dressings) was kept in the custody offices at all three sites for easy access by custody staff. Staff at the three suites gave different responses when asked who was responsible for checking and maintaining the equipment. It appeared to be one of the duties of the inspector with day-to-day responsibility for checking the suites, but it was not clear that the task was actually carried out.

6.12 We were told that all custody staff underwent yearly defibrillator and cardiopulmonary resuscitation training. Records indicated that some police staff had not received defibrillator training in the previous 12 months. We were also told that this was the case for some EMFS staff.

6.13 There were first aid kits in the clinical rooms, but these did not appear to be checked regularly.

Expectation

6.14 Detainees are able to request the services of a health care professional in and out of hours, and to continue to receive any prescribed medication for current health conditions or for drug maintenance.

Findings

6.15 Detainees were not routinely told they could see a health care professional, but one was called if the custody sergeant felt it necessary. Records showed that 24% of all detainees in custody in the previous week had been seen by an HCP or FME, but some detainees with known mental health issues were not referred to an HCP. In one instance, the detainee had been

arrested on three separate occasions, the last because he had failed to attend a court hearing. At court, he had been deemed too mentally unwell to plead and had been referred to the court mental health team. As a result, he had been sectioned under the Mental Health Act (1983).

6.16 Clinical records of detainees seen at Cheltenham and Stroud for the previous week indicated that the time between the HCP being called and the detainee being seen was just under one hour. It was not possible to calculate the wait at Gloucester because in almost half of the records custody staff had not recorded when the HCP or FME had been called.

6.17 Detainees with a history of substance misuse (illicit drugs) were subject to a 'six-hour rule'. This meant they were not given any medication initially, but were re-examined after six hours of detention for signs of withdrawal. If indicated, appropriate medication was prescribed.

Expectation

6.18 Clinical examinations are conducted out of the sight and preferably out of the hearing of police officers. Treatment rooms provide conditions that maintain decency, privacy and dignity. Infection control facilities are implemented. There is at least one room that is forensically clean.

Findings

6.19 Each custody suite had a clinical room accessible by a digital lock. Each had sharps bins and clinical waste bins, small safes for the storage of medications and a separate safe for the storage of clinical records. Each had an examination couch, but none had a paper couch roll. There were no formal arrangements for the rooms to be cleaned. Some cleaning was carried out by staff and the floors were cleaned when the custody suite cleaner was asked to do so. An audit of the rooms carried out by EMFS staff accompanied by Gloucestershire Constabulary staff in October 2007 had found similar issues.

6.20 The room in Gloucester was not near to the main desk. It was too small and the examination couch was not positioned correctly. The room in Cheltenham was near the main desk and was of a reasonable size and layout. The room in Stroud was up some steps, small and had no desk. A fridge in the room contained samples, some of which were not adequately labelled, and medications.

Expectation

6.21 Detainees are offered the services of a drugs or alcohol arrest referral worker where appropriate and referred on to community drugs/alcohol teams or prisons' drugs workers as appropriate.

Findings

6.22 Gloucestershire drug and alcohol services (GDAS), a voluntary drugs agency, provided staff to the custody suites. Police did not offer the services of a drugs or alcohol arrest referral worker. A worker visited each custody suite at least twice a day, except Sundays. They spoke to all those detained to explain their role and the services they could offer, and took on clients who used class A drugs and chaotic users. They did not see those who were subject to a drug rehabilitation order or juveniles, but could give juveniles or their appropriate adult details of the young people's substance misuse service (YPSMS). If a detainee wanted to speak to them,

they arranged a suitable venue within the suite and spoke to them about harm minimisation issues. They also made arrangements to meet the detainee at a GDAS office once they had left custody so that detainees had continuity of contact. Each worker had a maximum caseload of 12. They offered referral to treatment and referrals to GDAS for psychosocial counselling, and acted as caseworker for their clients for a maximum of 12 weeks.

6.23 Through an alcohol arrest referral scheme, detainees arrested where alcohol was a factor were given 24 hours to contact GDAS as part of their bail conditions for two one-hour one-to-one sessions. These included information about alcohol, the links between alcohol and crime and referral to other organisations as required.

6.24 In 2007/08, GDAS had seen just under 4% of all detainees.

6.25 GDAS did not have formal links with EFMS, although senior managers had made plans to meet later in the year.

Expectation

6.26 A liaison and/or diversion scheme enables mentally disordered detainees to be identified and diverted into appropriate mental health services, or referred on to prison health care services.

Findings

6.27 Mental health support was provided by the 2gether Mental Health Foundation Trust. A community psychiatric nurse (CPN) was available from 9am to 5pm on weekdays. There was no cover when the post-holder was on leave. A detainee was seen by an FME, who contacted the CPN if required. The CPN undertook a full mental health assessment and checked whether the detainee was already known to services within the Trust. Out-of-hours, the emergency duty team (EDT) was contacted, but staff said response times were not as rapid, with assessments sometimes delayed as long as 36 hours at weekends.

6.28 The CPN provided some mental health awareness training for custody staff.

Expectation

6.29 Police custody is not used as a place of safety for section 136 assessments except where the detainee needs to be controlled for his or her own safety or the safety of others.

Findings

6.30 No log was kept of section 136 assessments carried out at each of the suites, although information given to us suggested that 43 detainees had been detained for 'mental health issues' in the previous three months.

6.31 All detainees brought into the station under a section 136 (MHA 1983) were referred directly to the mental health crisis team or the EDT, depending on which team was on duty. Section 136 assessments were usually carried out in the police cells[2].

Expectation

6.32 Each detainee seen by health care staff has a clinical record containing an up-to-date assessment and any care plan conforms to professional guidance from the regulatory bodies. Ethnicity of the detainee is also recorded.

Findings

6.33 All clinical records were paper based and kept appropriately in a locked metal safe accessible only to EMFS staff. Clinical records were collected weekly by EMFS, scanned and digitalised onto master discs and stored at another location.

6.34 The clinical records consisted of a four-sided booklet that provided a good assessment of the detainee's medical condition. A triplicate tri-colour D25 form, which consisted of a one-page summary, was also completed. One copy was attached to the custody record as a means of relaying important information to custody staff. Clinical details were kept to a minimum to ensure confidentiality. Consent for this sharing of information was usually obtained from the detainees, who were asked to sign the clinical record. There were some instances of D25 forms attached to the custody record when the detainee had refused to sign. This was noted, but we were unable to ascertain whether information had still been shared in the best interests of the patient.

6.35 It was not always possible to identify the qualifications of the HCP who had seen the detainee either from the clinical records or the D25 form seen by custody staff.

6.36 Ethnicity was recorded on the custody records, but not on the clinical records.[3]

Expectation

6.37 Any contact with a doctor or other health care professional is also recorded in the custody record, and a record made of any medication provided. The results of any clinical examination are made available to the detainee and, with detainee consent, his/her lawyer.

Findings

6.38 All contact with an HCP was recorded. Detainees could obtain a copy of their medical record by contacting EMFS, which was usually done by their solicitor via the police. Detainees were not routinely told that this was possible. When a request was received by EMFS for a

[2] Section 136 enables a police officer to remove someone from a public place and take them to a place of safety (e.g. 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] Only individuals who need access to patient identifiable information should have access to it. Action should be taken to ensure that those handling patient identifiable information (both clinical and non-clinical staff) are aware of their responsibilities and obligations to respect patient confidentiality.

statement, it provided a digital copy of the original records to the relevant HCP or FME and a guide on how to write a statement.

Expectation

6.39 Information sharing protocols exist with all appropriate agencies to ensure efficient sharing of relevant health and social care information.

Findings

6.40 The constabulary had a number of joint policies with the local acute hospital trust and the local ambulance trust, but there were no formal information-sharing policies between EMFS, GDAS and the 2gether Trust.

Expectation

6.41 All medications on site are stored safely and securely, and disposed of safely if not consumed. There is safe pharmaceutical stock management and use.

Findings

6.42 Medication in all three suites was kept in locked cabinets. There was an adequate range of medicines and stock levels were good. A record was kept of all stock issued. There were out-of-date medications at Stroud, both in the cupboard and the fridge, and some named-patient medications in the fridge. The fridge did not have a thermometer, so it was unclear whether thermolabile medications were stored safely. There were no formal arrangements to monitor stock levels or to return out-of-date medication to the local pharmacy.

6.43 A limited range of medication (paracetamol, ibuprofen, gaviscon and a ventolin inhaler) was available for custody staff to issue to detainees after telephone consultation with an FME if an HCP was not on site. No records were kept of the stock levels of these medications.

Recommendations

6.44 There should be clear lines of accountability for checking resuscitation equipment and first aid kits and such checks should be documented.

6.45 All staff should have annual training in resuscitation, including the use of an external automated defibrillator.

6.46 Formal arrangements should be put in place to ensure that clinical rooms are kept clean.

6.47 Police custody suites should not be used as a place of safety for section 136 assessments except where necessary for the safety of the detainee or others.

6.48 There should be information-sharing protocols with all appropriate agencies to ensure efficient sharing of relevant health and social care information.

6.49 Detainees should be able to continue to receive any prescribed clinical management for drug dependency while in custody.

6.50 Medications should be date checked and out-of-date or other unwanted medications disposed of safely.

Housekeeping points

6.51 Examination couches should be correctly positioned and equipped with paper couch rolls.

6.52 The time a healthcare professional is called should be recorded by custody staff on the custody record.

6.53 Any fridge used to store medications should have a thermometer to record minimum and maximum temperatures to ensure such medications are stored between 2 and 8 degrees Celsius.

Good practice

6.54 *The management of clinical records ensured records were kept securely in line with Caldicott principles and was a system that could be emulated by other custody suites.*

7. Summary of recommendations

Strategy

7.1 Discussions should be held with HM Court Service to ensure that cut-off points for accepting detainees are not too early and thus result in people spending too long in police custody. (3.20)

7.2 Greater effort should be made by the Gloucestershire Constabulary to utilise management information in the UNITY custody system to achieve a better understanding of the profile of detainees so as to meet their needs. This should include how many detainees are held for more than 24 hours and how many are juveniles, women and UK Border Agency detainees. (3.21)

7.3 The custody intranet site should be linked to the 'Lessons Learned' newsletters from the Independent Police Complaints Commission. (3.22)

7.4 Detainees wanting to make a formal complaint about their arrest or treatment should be enabled to do so while in custody. (3.23)

7.5 Operating procedures and guidance should be updated to ensure greater recognition by custody officers and staff of the impact of custody on juvenile and female detainees. (3.24)

7.6 Detainees identified in the risk assessment as vulnerable should not be interviewed without an appropriate adult present unless special exemptions provided in the Police and Criminal Evidence Act 1984 apply. Supervisors should regularly sample custody records to ensure that this area of weakness is addressed and appropriate adults provided as necessary. (3.25)

7.7 Custody suites should have up-to-date and reliable essential office equipment such as printers. (3.26)

7.8 Maintenance of the force computer system should take into account the needs of custody suite staff. (3.27)

Treatment and conditions

7.9 Booking in and discharge arrangements should be improved so that detainees are dealt with at a desk of an appropriate height and which allows sufficient privacy to disclose any vulnerabilities or for confidential information to be passed. (4.103)

7.10 The risk assessment form for cell sharing should include questions to highlight potential risks. (4.104)

7.11 Mental health flags from the Police National Computer should routinely be included in risk assessments. (4.105)

7.12 Custody staff should receive specialist self-harm training that takes into account the needs of specific groups and individual risk. (4.106)

7.13 All custody staff should carry personal cell keys and ligature knives. (4.107)

7.14 Staff should explain the use of the call bell to detainees and this should be recorded. (4.108)

7.15 Cell call bell systems should not be muted under any circumstances. (4.109)

7.16 All cells should have decent natural light, ventilation and heating with appropriate sanitation and hand washing facilities. (4.110)

7.17 There should be sufficient and appropriately equipped cells to meet the needs of those with physical disabilities. (4.111)

7.18 Holding facilities, interview rooms and the exercise yard area should be made less austere. (4.112)

7.19 Detainees should not have to wait in vans for prolonged periods. (4.113)

7.20 Detainees should be offered meals at appropriate intervals and this should be recorded in the custody records. (4.114)

7.21 Young people under 18 should be held in appropriate well supervised accommodation and dealt with taking into account their legal status and vulnerabilities as children, including an awareness of child protection issues. (4.115)

7.22 Items to meet basic needs, such as toilet paper and sanitary products, should be routinely available unless their removal can be justified by an individual risk assessment. (4.116)

7.23 All showers should provide appropriate privacy. (4.117)

7.24 Detainees who need a shower for decency and good hygiene reasons should always be offered a shower, as should those held for more than 24 hours. (4.118)

7.25 A clear policy on when paper suits should be used should be published. (4.119)

7.26 Custody records should routinely record when detainees have been offered exercise. (4.120)

7.27 Detainees held for more than 24 hours should be able to receive visits in a welcoming and comfortable environment. (4.121)

7.28 A stock of suitable reading material, including newspapers, religious texts and material in relevant languages, should be available. (4.122)

7.29 Detainees with no family or local support who need a change of clothing should be offered basic clothes, including a change of underwear. (4.123)

7.30 Custody suite staff should receive fire safety training and evacuation plans should be practised. (4.124)

Individual rights

7.31 Immigration detainees should only be held in police custody for the minimum period possible. (5.128)

7.32 Detainees should always be asked if they would like to see a doctor on admission. (5.129)

7.33 Arrangements should be in place to assist visually impaired detainees to communicate. (5.130)

7.34 The treatment of children and young people should go beyond procedural compliance and address more fully the distinctive needs of young people in custody. (5.131)

7.35 Custody staff should receive training on the differential impact of custody on different groups of detainees, particularly juveniles, women and carers. (5.132)

7.36 The availability of appropriate adults, particularly out of normal working hours, should be improved. (5.133)

7.37 Charge desks should allow people to converse at approximately eye level with the charging officer. (5.134)

7.38 Women should routinely be offered suitable sanitary items. (5.135)

7.39 There should be consultation with the Legal Services Commission with a view to providing suitable specialist immigration advice and assistance for immigration detainees. (5.136)

7.40 Detainees should be given information about how to complain about treatment by police, the UK Border Agency or contractors. (5.137)

7.41 A specific procedure for handling racist incidents and complaints should be introduced. (5.138)

7.42 A strategy should be introduced to ensure the consistency of exit plans, which should recognise the vulnerability of children. (5.139)

Healthcare

7.43 There should be clear lines of accountability for checking resuscitation equipment and first aid kits and such checks should be documented. (6.44)

7.44 All staff should have annual training in resuscitation, including the use of an external automated defibrillator. (6.45)

7.45 Formal arrangements should be put in place to ensure that clinical rooms are kept clean. (6.46)

7.46 Police custody suites should not be used as a place of safety for section 136 assessments except where necessary for the safety of the detainee or others. (6.47)

7.47 There should be information-sharing protocols with all appropriate agencies to ensure efficient sharing of relevant health and social care information. (6.48)

7.48 Detainees should be able to continue to receive any prescribed clinical management for drug dependency while in custody. (6.49)

7.49 Medications should be date checked and out-of-date or other unwanted medications disposed of safely. (6.50)

Housekeeping points

7.50 Examination couches should be correctly positioned and equipped with paper couch rolls. (6.51)

7.51 The time a healthcare professional is called should be recorded by custody staff on the custody record. (6.52)

7.52 Any fridge used to store medications should have a thermometer to record minimum and maximum temperatures to ensure such medications are stored between 2 and 8 degrees Celsius. (6.53)

Good practice

7.53 The management of clinical records ensured records were kept securely in line with Caldicott principles and was a system that could be emulated by other custody suites. (6.54)

Appendix 1 - Inspection team

Michael Loughlin	-	HMIP team leader
Paddy Craig	-	HMIC inspector
Eileen Bye	-	HMIP inspector
Ian Macfadyen	-	HMIP inspector
Hayley Folland	-	HMIP inspector
Susan Fenwick	-	HMIP inspector
Paul Fenning	-	HMIP inspector
Joss Crosbie	-	HMIP inspector
Elizabeth Tysoe	-	HMIP healthcare inspector
Margot Nelson Owen	-	HMIP healthcare inspector
Catherine Nichols	-	HMIP researcher

Appendix 2 – Police Custody Survey

Section 1: About You

Q1 **What police station were you last held at?**

100%

Q2 **What type of detainee were you?**

Police detainee	92%
Prison lock-out (i.e. you were in custody in a prison before coming here)	4%
Immigration detainee	0%
I don't know	4%

Q3 **How old are you?**

16 years or younger	0%	*40-49 years*	8%
17-21 years	12%	*50-59 years*	0%
22-29 years	35%	*60 years or older*	0%
30-39 years	46%		

Q4 **Are you:**

Male	100%
Female	0%
Transgender/Transexual	0%

Q5 **What is your ethnic origin?**

White - British	88%
White - Irish	0%
White - Other	0%
Black or Black British - Caribbean	4%
Black or Black British - African	0%
Black or Black British - Other	0%
Asian or Asian British - Indian	4%
Asian or Asian British - Pakistani	0%
Asian or Asian British - Bangladeshi	0%
Asian or Asian British - Other	0%
Mixed Race - White and Black Caribbean	0%
Mixed Race - White and Black African	0%
Mixed Race - White and Asian	0%
Mixed Race - Other	0%
Chinese	0%
Other ethnic group	4%
Please specify:	0%

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

Yes	4%
No	96%

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

None	35%
Church of England	46%
Catholic	8%
Protestant	0%
Other Christian denomination	0%
Buddhist	0%
Hindu	0%
Jewish	0%

Muslim 4%
Sikh 0%
Any other religion, please specify 8%

Q8 How would you describe your sexual orientation?
Straight / Heterosexual 92%
Gay / Lesbian / Homosexual 0%
Bisexual 0%
Other (please specify): 0%

Q9 Do you consider yourself to have a disability?
Yes 27%
No 73%
Don't know 0%

Q10 Have you ever been held in police custody before?
Yes 96%
No 4%

Section 2: Your experience of this custody suite

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

Q11 How long were you held at the police station?
1 hour or less 0%
More than 1 hour, but less than 6 hours 4%
More than 6 hours, but less than 12 hours 12%
More than 12 hours, but less than 24 hours 12%
More than 24 hours, but less than 48 hours (2 days) 19%
More than 48 hours (2 days), but less than 72 hours (3 days) 31%
72 hours (3 days) or more 12%

Q12 Were you given information about your arrest and your entitlements when you arrived there?
Yes 62%
No 15%
Don't know/Can't remember 19%

Q13 Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')**?**
Yes 54%
No 27%
I don't know what this is/I don't remember 19%

Q14 If your clothes were taken away, were you offered different clothing to wear?
My clothes were not taken 38%
I was offered a tracksuit to wear 19%
I was offered an evidence suit to wear 15%
I was offered a blanket 15%

Q15 Could you use a toilet when you needed to?
Yes 77%
No 23%
Don't Know 0%

Q16 **If you have used the toilet there, were these things provided?**

	Yes	*No*
Toilet paper	54%	35%
Sanitary protection	*0%*	*27%*

Q17 **Did you share a cell at the police station?**

Yes 4%
No 96%

Q18 **How would you rate the condition of your cell:**

	Good	*Neither*	*Bad*
Cleanliness	38%	8%	50%
Ventilation / Air Quality	15%	19%	58%
Temperature	12%	23%	62%
Lighting	19%	31%	46%

Q19 **Was there any graffiti in your cell when you arrived?**

Yes 38%
No 54%

Q20 **Did staff explain to you the correct use of the cell bell?**

Yes 23%
No 69%

Q21 **Were you held overnight?**

Yes 73%
No 15%

Q22 **If you were held overnight, which items of clean bedding were you given?**

Not held overnight 9%
Pillow 22%
Blanket 38%
Nothing 19%

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

Yes 12%
No 85%

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

Yes 19%
No 77%

Q25 **Were you offered anything to:**

	Yes	*No*
Eat?	77%	15%
Drink?	85%	8%

Q26 **Was the food/drink you received suitable for your dietary requirements?**

I did not have any food or drink 19%
Yes 27%
No 35%

Q27 **If you smoke, were you offered anything to help you cope with the smoking ban there?**

I do not smoke 4%
I was allowed to smoke 7%
I was not offered anything to cope with not smoking 79%
I was offered nicotine gum 4%
I was offered nicotine patches 0%

I was offered nicotine lozenges 0%

Q28 Were you offered anything to read?

Yes 31%
No 65%

Q29 Was someone informed of your arrest?

Yes 31%
No 54%
I don't know 0%
I didn't want to inform anyone 12%

Q30 Were you offered a free telephone call?

Yes 35%
No 54%

Q31 If you were denied a free phone call, was a reason for this offered?

My phone call was not denied 42%
Yes 19%
No 15%

Q32 Did you have any concerns about the following, whilst you were in police custody:

	Yes	*No*
Who was taking care of your children	4%	69%
Contacting your partner, relative or friend	31%	54%
Contacting your employer	15%	62%
Where you were going once released	12%	54%

Q33 Were you interviewed by police officials about your case?

Yes 81%
No ..... 15% If No, go to Q35

Q34 Were any of the following people present when you were interviewed?

	Yes	*No*	*Not needed*
Solicitor	69%	8%	4%
Appropriate Adult	0%	12%	23%
Interpreter	0%	12%	23%

Q35 How long did you have to wait for your solicitor?

I did not requested a solicitor 15%
2 hours or less 27%
Over 2 hours but less than 4 hours 4%
4 hours or more 46%

Q36 Were you officially charged?

Yes 54%
No 31%
Don't Know 8%

Q37 How long were you in police custody *after* being charged?

I have not been charged yet 27%
1 hour or less 0%
More than 1 hour, but less than 6 hours 4%
More than 6 hours, but less than 12 hours 4%
12 hours or more 50%

Section 3: Safety

Q39 Did you feel safe there?

Yes 62%
No 35%

Q40 Had another detainee or a member of staff victimised (insulted or assaulted) you there?

Yes 50%
No 46%

Q41 If you have felt victimised, what did the incident involve? (Please tick all that apply)

I have not been victimised	29%	*Because of your crime*	12%
Insulting remarks (about you, your family or friends)	20%	*Because of your sexuality*	0%
Physical abuse (being hit, kicked or assaulted)	15%	*Because you have a disability*	2%
Sexual abuse	5%	*Because of your religion/religious beliefs*	0%
Your race or ethnic origin	5%	*Because you are from a different part of the country than others*	0%
Drugs	7%		

Q42 Were you handcuffed or restrained whilst in the police custody suite?

Yes 42%
No 54%

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

Yes 38%
No 58%

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

Yes 23%
No 69%

Section 4: Healthcare

Q46 When you were in police custody were you on any medication?

Yes 58%
No 35%

Q47 Were you able to continue taking your medication whilst there?

Not taking medication 35%
Yes 19%
No 42%

Q48 Did someone explain your entitlements to see a healthcare professional, if you needed to?

Yes 31%
No 50%
Don't know 12%

Q49 Were you seen by the following healthcare professionals during your time there?

	Yes	*No*
Doctor	38%	46%
Nurse	42%	38%
Paramedic	8%	54%
Psychiatrist	0%	62%

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

Yes 23%
No 35%
Don't know 19%

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

Yes 73%
No 23%

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

I didn't have any drug/alcohol problems 19%
Yes 38%
No 38%

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

I didn't have any drug/alcohol problems 23%
Yes 12%
No 58%

Q54 **Please rate the quality of your healthcare whilst in police custody:**

	I was not seen by health -care	*Very Good*	*Good*	*Neither*	*Bad*	*Very Bad*
Quality of Healthcare	38%	4%	8%	12%	15%	19%

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

No 46%
Yes 46%

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

No 65%
Yes 27%

<u>Section 5: Prison Lock-Out Information</u>

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

Q58 **Were you told that you would be held in a police station, rather than a prison, before you arrived there?**

Yes 23%
No 38%

Q59 **How long did you spend in the escort van before arriving there?**

Less than 1 hour 27%
More than 1 hour, but less than 2 hours 19%
More than 2 hours, but less than 3 hours 4%
More than 3 hours, but less than 4 hours 0%
More than 4 hours 0%

Q60 **Were you offered the chance to let family/friends know where you were?**

Yes 31%
No 27%

Q61 **Did your property come with you to the police station?**

Yes 31%
No 12%
I don't know 12%

Q62 On average, how much time were you able to spend out of your police cell each day?

I was not able to spend any time out of my police cell	31%
Less than 1 hour	8%
More than 1 hour, but less than 2 hours	4%
More than 2 hours, but less than 3 hours	0%
More than 3 hours, but less than 4 hours	0%
More than 4 hours	4%

Thank you for your time.