Report on an inspection visit to police custody suites in Greater Manchester

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by

HM Inspectorate of Prisons and

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Contents

1. Introduction

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

The inspections of police custody look beyond the implementation of the Police and Criminal Evidence Act 1984 (PACE) codes of practice and *Safer Detention and Handling of Persons in Police Custody* 2011 (SDHP) at force-wide strategies, treatment and conditions, individual rights and health care. They are also informed by a set of *Expectations for Police Custody*[1] about the appropriate treatment of detainees and conditions of detention, developed by the two inspectorates to assist best custodial practice.

There was a clear strategic approach to custody provision, and a move to central management of the custody function was beginning to bear fruit in greater consistency and raised standards. The modernisation of custody programme provided the Greater Manchester Police (GMP) with a firm foundation to improve the quality of provision and broader outcomes for detainees. A number of systems and processes were not fully embedded and a re-focus on change management principles would enhance the effectiveness of the developments. The force needed to engage more positively with independent custody visitors.

The rationalisation of the custody estate was well advanced, with the number of 24/7 custody suites significantly reduced. Some suites were in good condition while others contained a large amount of graffiti and were in need of a deep clean. Most staff interactions with detainees were professional, but management of civilian detention officers needed to be improved. There was inadequate awareness of, and provision for, the needs of vulnerable groups including juveniles, women and those with disabilities; in several suites, initial interviews could not be conducted in reasonable privacy. The assessment and management of risk needed greater attention to ensure the safety of detainees, and handover arrangements were a cause for concern at some suites. As we have found in many other forces, there was no effective process for monitoring use of force and staff needed to be more proactive in providing elements of detainee care and welfare. There was good practice with the Samaritans' attendance at the Longsight custody suite.

An appropriate balance was maintained between progressing cases and the rights of individuals. The police authority had an effective volunteer scheme to supply appropriate adults, which provided a service for juveniles, supplementing the youth offending teams and also for vulnerable adults. The process around complaints was confused leading to them sometimes not being taken.

Health care was provided by Medacs and monitoring arrangements were good. Primary health and substance misuse services were reasonable, but there were serious gaps around mental health diversion, which the force was seeking to address. Greater cohesion was needed between police and health partners.

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

Overall, police custody provision in GMP was heading in the right direction but there were some significant concerns. There was clear strategic direction and management support, but the force was at a critical point where there was a need to embed some key changes and engage staff in the process. This report provides a small number of recommendations to assist the force and the police authority in addressing these issues and improving provision further. We expect our findings to be considered and an action plan to be provided in due course.

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HM Chief Inspector of Constabulary

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June 2012

2. Background and key findings

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

2.2 At the time of this unannounced inspection, Greater Manchester Police had 10 custody suites designated under PACE for the reception of detainees, operating 24 hours a day. These dealt with detainees arrested as a result of mainstream policing. The force also had two standby suites, which provided overspill capacity for the main suites. All custody suites were visited during the inspection. There was a total cell capacity of 309, with 100,885 detainees held in 2011. In the same period, 1011 detainees had been held for reasons related to immigration.

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

Custody suite	Number of cells
North Manchester	30
Longsight	40
Pendleton	27
Swinton	28
Tameside (Ashton)	31
Cheadle Heath	36
Bolton	19
Wigan	29
Bury	24
Chadderton	16
Stretford (stand-by)	11
Oldham (stand-by)	18
Total	309

We also visited custody facilities within Manchester airport and Old Trafford football ground.

2.4 HM Inspectorate of Prisons researchers and inspectors carried out a survey of prisoners at HMP Manchester who had formerly been detained at custody centres in the force area, to obtain additional evidence (see Appendix II).[3]

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

[3] Inspection methodology: There are five key sources of evidence for inspection: observation; detainee surveys; discussions with detainees; discussions with staff and relevant third parties; and documentation. During inspections, we use a mixed-method approach to data gathering, applying both qualitative and quantitative methodologies. All findings and judgements are triangulated, which increases the validity of the data gathered. Survey results show the collective response (in percentages) from detainees in the establishment being inspected compared with the collective response (in percentages) from respondents in all establishments of that type (the comparator figure). Where references to comparisons between these two sets of figures are made in the report, these relate to

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

Strategy

2.6 The custody modernisation programme had resulted in the estate being rationalised and its management centralised. This was a positive initiative that aimed to provide a more corporate approach to custody. However, many challenges remained, not least concerning staff awareness and the embedding of a number of new processes. The working relationship between the Greater Manchester Police Authority and the force was generally constructive, having improved recently; nevertheless the force failed to engage properly with the independent custody visitors scheme.

2.7 Each suite had a full time manager. Staff working in custody were permanent, but there were issues with shift patterns, which needed to be better organised. All staff had custody-specific and refresher training, although there was room for improving the relevance of the latter. There was no formal meeting structure where practitioners could air their views and partnership arrangements with health services posed real challenges.

2.8 There was a good system for recording and learning from critical incidents. 'Learning the lessons' information from the Independent Police Complaints Commission was disseminated to staff, although there was no specific focus on custody or central point where this could be retrieved at a later date. Quality assurance systems had very recently been introduced and needed attention.

Treatment and conditions

2.9 Interactions with detainees were generally professional, although some custody detention officers were less engaged and needed better management. Awareness of diversity issues was limited. Many aspects of privacy were poor, which had implications for the respectful treatment and safety of detainees.

2.10 Initial risk assessments varied in quality; some were poor. A number of risk assessment and risk management systems were being revised, or had been newly introduced, which had led to some confusion amongst staff. Risk management was generally proportionate, but handover arrangements were not sufficiently robust. Detainees were not routinely asked if they had any dependency obligations. Pre-release risk assessments were not usually completed.

2.11 The management of cell keys needed to be improved. The use of handcuffing was proportionate, although there was no system to monitor trends in the use of force.

2.12 The physical environment of custody suites varied greatly and there was graffiti in some cells. We found some ligature points in cells, and the use of cell call bells was not routinely explained. Staff were aware of fire evacuation arrangements but these had not been practised. Health and safety checks were underdeveloped. Some aspects of detainee care and welfare

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statistically significant differences only. Statistical significance is a way of estimating the likelihood that a difference between two samples indicates a real difference between the populations from which the samples are taken, rather than being due to chance. If a result is very unlikely to have arisen by chance, we say it is 'statistically significant'. The significance level is set at 0.05, which means that there is only a 5% chance that the difference in results is due to chance. (Adapted from Towel et al (eds), *Dictionary of Forensic Psychology*.)

were by request only. There was little evidence that showers, outside exercise or reading materials were offered. The food provided was adequate.

Individual rights

2.13 Custody sergeants authorised custody and there was a reasonable focus on the necessity test, although staff reported some examples of pressure to detain individuals from divisional managers. PACE was generally adhered to.

2.14 Some detainees held for reasons related to immigration were being detained for over 24 hours. Arrangements for providing appropriate adults were good.

2.15 Some court cut-off times were too early, and there was little flexibility for juveniles or vulnerable adults. Detainees were not told how to make a complaint and when they did, the arrangements for dealing with them were poor.

Health care

2.16 Primary care services were provided by Medacs and clinical governance arrangements were reasonable. Clinical rooms were generally good, but all had infection control issues and out of date equipment and stock. Medication management was good. All the custody suites had full resuscitation kits and staff had been trained in their use. Detainee health care provision was generally good. Waiting times were reasonable, but delays sometimes occurred.

2.17 Arrangements for providing symptomatic relief for substance misusers were good and detainees could continue to receive their prescribed medications. Substance use services were well developed.

2.18 The lack of mental health diversion services was a major omission. Relatively few detainees were held in police custody under section 136 of the Mental Health Act 1983.[4] Some staff had received mental health awareness training.

Main recommendations

2.19 Risk assessment procedures, including initial and pre-release assessments, should be consistent and provide an effective system for carrying out detailed risk assessment and care planning.

2.20 Handovers should be comprehensive and should involve both CDOs and police custody staff.

2.21 There should be a programme of regular deep cleans in place at all suites and graffiti should be removed promptly.

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

2.22 The NHS should provide appropriate support to police custody to ensure that detainees with mental health problems are promptly diverted to appropriate mental health services.

National issues

2.23 Appropriate adults should be available for juveniles aged 17. [5]

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

3. Strategy

Expected outcomes:
There is a strategic focus on custody that drives the development and application of custody specific policies and procedures to protect the wellbeing of detainees.

Strategic management

3.1 An assistant chief constable (ACC) provided strategic leadership on custody issues. The custody function was centrally managed by the criminal justice and custody branch with a superintendent as head of custody, responsible for provision and policy.

3.2 The force had been engaged in a custody modernisation programme, which had resulted in the estate being rationalised and its management centralised. This was a positive initiative that aimed to provide a more corporate approach to custody. The force had a clear estates strategy with a completed programme to rationalise the custody estate down from 17 suites to the current 10 full-time suites.

3.3 The police authority was engaged with the estates strategy and a representative was involved in the custody modernisation programme. A police authority member described the relationship between the authority and the force as 'challenging but improving'.

3.4 A police authority representative coordinated the active independent custody visitor (ICV) scheme and administered the scheme's panels. There were quarterly meetings for panel coordinators, but there had been a lack of police attendance during the period of the custody modernisation programme, although this was improving. ICVs said that they were generally admitted to custody centres promptly and that the implementation of the custody modernisation programme had professionalised the service. However, they reported that some issues had been highlighted consistently, but not addressed, for example graffiti in some cells.

3.5 The force had a comprehensive custody operating policy, which all staff could access via the custody intranet site. This policy was still in draft form and there was some confusion among staff because there had been a number of versions of the policy and changes to procedures, which at the time of the inspection, had not been fully embedded, most concerning risk assessment (see safety section).

3.6 The new custody newsletter, which was available on the custody intranet site, was also emailed to custody staff. The professional standards branch disseminated the Independent Police Complaints Commission 'Learning the lessons' (LtL) document on a force-wide basis. However, there was no custody specific dissemination of LtL, or a central point where all such information could be accessed. There were varying levels of awareness among custody staff regarding what information was available and where to find it.

3.7 The force had introduced a centralised management 'silver custody' role to triage the allocation of custody spaces, minimise delays, maximise operational effectiveness and make best use of custody capacity.

3.8 There had been a bimonthly user group aimed at custody staff during the period of rationalisation of the estate, but this had stopped operating. This made it difficult for staff to inform policy and practice at a time of significant change in the organisation.

3.9 There was a dedicated custody inspector, who undertook the role of custody manager for each of the 10 custody suites in GMP. The chief inspector from the criminal justice and custody branch took on the line management responsibility for custody inspectors and they in turn, were responsible for the line management of the permanent custody sergeants at their suite. Custody sergeants were responsible for the line management of custody detention officers (CDOs). However, custody sergeants and CDOs worked different shift patterns, which made line management and some other aspects of work such as handovers difficult. Negotiations were taking place with a view to aligning shift patterns.

3.10 There was a good centrally managed process for recording adverse incidents and other risk based custody issues, through the risk tracker template. Once completed by the custody sergeant, adverse incident forms were reviewed within the criminal justice and custody branch. The branch senior management team met with custody inspectors and staff association representatives biweekly to review progress and actions.

3.11 Quality assurance processes had very recently been introduced and there was evidence that dip sampling of custody records was taking place. Custody managers who were carrying out dip sampling had access to a corporate template. However, the application and understanding of the process and its requirements, varied among custody managers. There was no assertive oversight from the criminal justice and custody branch, although we were advised that this was being addressed.

3.12 CCTV was only being sampled against complaints and not in conjunction with custody record dip sampling.

Recommendations

3.13 The force should introduce a forum where custody practitioners and managers can discuss custody issues so that they are able to inform and be part of the change process.

3.14 The force should ensure that all managers with responsibility for custody understand and carry out the required quality assurance of custody records, including person escort records.

Housekeeping point

3.15 The dissemination of 'LtL' bulletins and other information should be improved and made more readily accessible.

Good practice

3.16 *The risk tracker template enabled all risks related to custody to be monitored and managed centrally. These included adverse incidents, serious case reviews, health and safety reports, ICV reports, rule 43 recommendations, IPCC issues and new policies.*

Partnerships

3.17 Partnership arrangements were described as good, and there was active engagement with relevant criminal justice partners at a strategic level. The force was registered as an early

adopter of NHS commissioning of health provision in police custody, but was faced with some difficult issues around mental health provision. The ACC lead for custody chaired the local criminal justice board and the regional criminal justice group. The force was part of the Transforming justice: payment by results pilot programme for restorative justice (RJ) and was dealing with between 500 and 600 RJ cases every month. However, custody managers did not seem to be engaged with partners and generally did not attend any partnership meetings.

Learning and development

3.18 Training for custody staff was good and the custody training programme was aligned to the National Police Improvement Agency programme for custody training. All custody staff had received training specific to their role before they had started working in custody, including personal safety training. A refresher training day had been built into the shift patterns of custody sergeants every five weeks and of CDOs every eight weeks. This was a relatively new process and although still bedding in, staff felt that some aspects of the training were not particularly pertinent to their role, and the opportunity to communicate on more relevant procedures and issues at a time of change was not being fully realised. It was positive that the training department was using custody specific material contained in the LtL document in the refresher training.

Housekeeping point

3.19 The force should review custody refresher training to prioritise the most relevant training needs.

4. Treatment and conditions

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

Respect

4.1 Custody sergeants interacted with detainees in a professional manner – they were respectful and friendly. At Swinton for example a custody sergeant was particularly responsive to a female detainee who was visibly upset. He took time to explain what would happen next and gave her the opportunity to ask questions during the booking process. Most detainees we spoke to said that they had been well treated, and while most staff demonstrated concern for detainees' wellbeing while in custody this was not always the case. Some of the custody detention officers (CDOs) at Longsight spoke abruptly with detainees and appeared to be irritated by their requests. At most custody suites there appeared to be a lack of direct supervision of the CDOs. CDOs were generally not involved in the booking-in process nor were they proactive with detainees unless prompted by the custody sergeants.

4.2 The booking-in areas in all custody suites were spacious, but in many suites levels of privacy were poor particularly as detainees were asked to disclose sensitive or personal information.

4.3 The acoustics at Wigan were particularly poor. This meant that conversations at the booking-in desk could be clearly overheard by other detainees. This problem was exacerbated at Wigan and North Manchester by a number of police officers and other personnel who were observed holding conversations while detainees were being booked in. We were concerned to see detainees at Bolton, Ashton and Longsight standing in the booking-in area unsupervised by a police officer, although custody sergeants were present, behind the booking-in desk.

4.4 Staff demonstrated a limited awareness of diversity, with a 'one size fits all' approach to dealing with detainees. Custody staff demonstrated little understanding of the particular impact of detention on potentially vulnerable individuals such as women and juveniles, although there were notable exceptions (see paragraph 4.1). Female detainees were not given the option of speaking with a female member of staff. Nobody told them about the availability of sanitary products – the women were usually expected to ask for them themselves. In general, detainees were not asked about their commitments to the caring of dependants as part of the booking-in process.

4.5 There was little difference in the way that juveniles were treated, although some examples of good treatment of young people point the way for other suites. For example, at Longsight custody suite staff showed a great deal of patience with a challenging young person, and at Chadderton, we were told that juveniles were sometimes allowed to sit in the holding room, which was a more comfortable environment than a cell. Similarly at Cheadle Heath staff would allow juveniles to wait in a holding room with an appropriate adult. Custody staff told us that they had received no child protection awareness training, although some custody sergeants knew about local safeguarding structures. Some, but not all, staff told us that they had been aware of the particular needs of transgender detainees when they were being searched.

4.6 Detainees were not asked during the booking-in process if they wanted to observe any religious practices while in custody. All suites had a Qur'an, Bible and prayer mats, but these were not respectfully stored. The direction of Mecca was not indicated in all the cells.

4.7 The custody policy contained basic instructions relating to dealing with detainees with disabilities, but there were limited adjustments to the environment. Although many of the suites had toilets and showers that had been adapted for detainees with disabilities, most did not have cells that offered similar adaptations. Bury had good facilities for disabled detainees, including a disabled cell as well as a separate low level booking-in area. However, we observed that a detainee, who was on crutches, had to stand in pain, at the main desk throughout the lengthy process. There was an induction loop for the hard of hearing in the booking-in area at Bury, North Manchester, Tameside and Bolton, but staff did not know how to use it. Interview and consultation rooms also had induction loops.

Recommendations

4.8 Booking-in areas should be sufficiently private so that staff and detainees are able to communicate effectively, and custody sergeants should exercise greater control over personnel present in the booking-in areas to this end.

4.9 There should be clear policies and procedures in place to meet the specific needs of detainees particularly those of women, juveniles and detainees with disabilities.

4.10 Staff should inform detainees that arrangements may be made to enable them to observe any reasonable religious practice while in custody, and items should be stored respectfully.

4.11 Custody sergeants should ask detainees during the booking-in process if they have any concerns about dependants.

4.12 Staff should receive up to date awareness training on child protection and safeguarding in respect of juveniles and vulnerable adults.

Housekeeping point

4.13 All custody staff should be made aware of how to operate the hearing induction loop.

Safety

4.14 There was no set format for initial risk assessments and custody sergeants had adopted a range of approaches, the quality of which varied greatly. At some suites, custody sergeants had prepared their own questions in addition to the prompts on the ICIS custody record system. These focused mainly on medical history, self-harm and drug or alcohol addiction. In our custody record analysis, many of the risk assessments contained the standard comment 'detainee appears fit and well'. Others, however, went into extensive detail about the detainee and any issues they may have had. These were generally cases where there were obvious mental health or self-harm issues. A standardised risk assessment process was being developed, but staff were not confident about how effectively this would operate.

4.15 At Longsight, representatives from the Samaritans attended the custody suite every weekend to meet with any detainees who wished to access the confidential service. This was a positive initiative and custody staff told us that detainees, particularly those that had been detained over the weekend, welcomed the opportunity to speak with someone.

4.16 In most cases we observed that the police national computer (PNC) check had not been undertaken until after the risk assessment had been completed. This increased the risk of PNC warning markers not being taken into account.

4.17 Custody staff had recently been given instructions to place all detainees on a minimum of 30-minute observations. Some staff were unclear about what purpose this served and did not regard it as proportionate in all circumstances. Some staff were confused about the difference between observation levels. At some suites custody sergeants continued to use their discretion and place detainees on hourly observation, for example, if they considered them to be low risk or to avoid disturbing them unnecessarily at night.

4.18 Our custody record analysis showed that in a small number of cases, risk assessments were reviewed to reflect a change in the detainees' condition or new information that had become available, although it was not always clear why this information had not been evident during the booking-in process. Observation levels were amended accordingly. Staff were aware of the need to obtain, during rousing checks, responses that demonstrated a satisfactory level of consciousness. Our custody record analysis found instances in which rousing checks were not happening or at least being recorded.

4.19 Staff at all suites carried anti-ligature knives but we were concerned that at Wigan and Bury these were used routinely to cut cords in detainees' clothing when they were being booked in which could leave them ineffective for their intended use. Laces were routinely removed from shoes and were not returned until the detainee left custody.

4.20 North Manchester was the only custody suite where all cells had CCTV coverage; the other suites had at least four cells with CCTV. Toilets were appropriately obscured; however, those at North Manchester were visible if they were viewed on certain monitors.

4.21 Pre-release risk assessments were not routinely conducted, and there was no prompt on the ICIS system to remind staff to complete them before releasing detainees although this deficiency was due to be rectified in a planned upgrade. There was a leaflet about local health services for detainees at Wigan, but no similar leaflet at the other suites. The centralised management of custody space allocations had meant that more detainees were being held in custody suites some distance from their home. An account had been set up with local taxi firms to help vulnerable detainees who had been arrested outside their home area to return home at night and we observed that some custody sergeants were considering this. However, our custody record analysis found that in several instances women had been released late at night with no evidence that their safe return home had been considered.

4.22 At the time of the inspection, there was no evidence of dip sampling of person escort record (PER) forms. The inspection found that in some instances, information about the risk of self-harm was recorded on the PER, but not mentioned in the risk assessment. In two cases, notes outlining a risk of self-harm that appeared in the custody record had not been mentioned in the PER (see recommendation 3.14).

4.23 Arrangements for handover between shifts varied greatly. There was a handover procedures template but practice differed between the suites. There were no formal handovers between custody detention officers (CDOs) at Longsight, Swinton and Cheadle Heath. At Pendleton, CDOs discussed detainee cases with colleagues; however this took place in a busy environment where there were interruptions. Handovers at Wigan and Bury were reasonably thorough. CDOs and sergeants at Bury had separate handovers, which risked losing some key information, since at this suite the CDOs were very active in progressing investigative and legal issues.

Recommendation

4.24 Staff should be briefed on the requirements of the four levels of observation in use so that observations are applied consistently.

Housekeeping point

4.25 Anti-ligature knives should not be used for routine tasks such as cutting cords from detainees' clothing.

Good practice

4.26 *The Samaritans' attendance at the custody suite was a positive initiative at Longsight custody suite.*

Use of force

4.27 In our prisoner survey, 79% of respondents said that their handcuffs had been removed when they arrived at the custody suite, compared with 72% in comparator police custody suites. We observed a proportionate approach to the application and removal of handcuffs.

4.28 Custody staff recorded the use of force on custody records, but the data was not collated on a local or force-wide level. We were told that if a detainee had been injured following the use of force in the custody area, they would normally be seen by a health care professional. Staff were able to describe good use of 'de-escalation' techniques. They said that when, on rare occasions, they had to apply force, they used only approved safety techniques.

4.29 Data supplied by the force showed that in 2011, 2222 detainees, or 2.2% of all of those held, had been strip-searched. This was lower than at other forces we have inspected, and for which data has been obtained. Of these, 22% led to the discovery of a hidden article.

Recommendation

4.30 Greater Manchester Police Service should collate use of force data in accordance with the Association of Chief Police Officers' policy and National Policing Improvement Agency guidance.

Physical conditions

4.31 The custody suites were cleaned every day and most were well maintained. North Manchester, the newest of the suites, was a bright and clean environment compared with Bury, Chadderton and Swinton, which were superficially clean but where no deep cleaning had been carried out, despite there being ingrained dirt. The cells at Chadderton were cold. There were small amounts of graffiti in most suites but at Wigan, Tameside and Bolton there were large amounts of graffiti on cell doors, some of which was dated 2008. At Bolton in particular the graffiti was offensive and, despite requests by independent custody visitors (ICVs) to have it removed, it remained in place. There was a zero tolerance approach to graffiti at Cheadle Heath and cell doors had been repainted. Detainees were being placed in the newly painted cells so that those responsible for any further graffiti could be identified and prosecuted. Apart from Bury

and North Manchester, all suites had cells containing ligature points and at Bolton the ligature points found on the benches raised concerns. Other parts of the suites, including interview and consultation rooms, were clean and well maintained.

4.32 There was a system of cell checks but this varied across the suites – some took place daily, while others were only intermittent. CDOs carried out the checks but did not always record them. At Wigan and Chadderton we could not find any records of recent daily cell checks. At Bury checks had not been recorded since 31 January 2012. We observed a custody sergeant briefing CDOs during a shift handover on the requirement to check cells each time a detainee had been discharged and to record this, confirming that the cell was suitable for use again.

4.33 There was a general lack of management when it came to cell keys. At Swinton and Pendleton cell keys were handed over to officers and a set of keys kept on a hook in the back office, to which non-custody staff had access. Custody sergeants at Longsight had a strict approach to cell key access and we observed one CDO escorting an officer to the cells and taking responsibility for unlocking detainees. However, this was not common practice.

4.34 In our survey 18% of respondents said the correct use of the cell call bell system had been explained to them compared with 22% in comparator suites. Custody staff appeared not always to hear the bell, and there were problems with the system. Staff told us that telephone calls could be put through to cells using the call bell intercom at Bury, but that they did not know how to use the system for that purpose. We observed call bells going unanswered for several minutes at Bury and Longsight. Conversely at Pendleton one of the custody sergeants dealt with queries promptly or assigned a CDO to do so.

4.35 None of the suites held regular fire drills. Fire evacuation manuals were available to all staff, though not everyone we spoke with could describe in detail what their role would be in the event of an emergency. There was an evacuation box at most suites containing plastic handcuffs. However, there was nothing similar at Chadderton – we were told that it had probably been borrowed by response teams.

4.36 Smoking in the custody suites or exercise areas was not allowed.

Recommendations

4.37 Cell heating at Chadderton should be adequate.

4.38 The correct use of call bells should be explained to all detainees, the system at Bury should function correctly and they should be responded to promptly.

4.39 Cells should be free from ligature points, and safety checks should be regular and thorough at all custody suites.

4.40 Custody staff should carry out, or be present at any visit to a cell.

Housekeeping point

4.41 Fire evacuation drills should be carried out and recorded, and adequate emergency evacuation equipment should always be in place in every suite.

Detainee care

4.42 All suites had good stocks of clean blankets, including some safety blankets, but they were not always offered to detainees. Mattresses were in good condition but were not routinely wiped down between uses. Pillows were not provided. Most cells had toilets and hand-washing facilities, but toilet paper was only available on request. We observed a detainee becoming very frustrated at Bury because of the delay in meeting his request for toilet paper.

4.43 Showers were clean but provided little privacy, particularly for women. In our custody record analysis none of the detainees had had a shower while in custody. Thirteen detainees had attended court without having been offered a chance to shower, one of whom had been held for 54 hours. In our survey, only 2% of respondents said that they had been offered a shower, compared with 9% in comparator suites.

4.44 There was a good supply of cotton towels and hygiene items such as toothpaste, soap and razors. Women were not told about the availability of sanitary products (see section on respect).

4.45 There were stocks of replacement clothing at all suites, including paper suits, tracksuits, plimsolls and underwear for women. Staff told us that they would initially encourage family and friends to bring in replacement clothing when it was needed, but that, unless detainees were being released or transferred to court, they provided a paper suit. We observed detainees at Longsight, Pendleton and Swinton in paper suits.

4.46 There was a reasonable stock of microwave meals, including halal and vegetarian options, and the calorific content of some of the meals was reasonable. However, at Bury and Chadderton the use-by dates on some meals had expired. Meals were provided at recognised mealtimes and when requested. Cereal, milk and juice were available as a breakfast option, and these were offered to detainees throughout the day as an alternative to hot food. Drinks were offered regularly.

4.47 All the custody suites had an exercise yard. The yards were monitored by CCTV, but staff said that they were required to provide constant supervision of the detainees who used the facility. We were informed that staff rarely had time to do this. Our custody record analysis and survey revealed that few detainees had been offered outside exercise.

4.48 Most custody suites had a limited range of books and newspapers which were rarely offered. Nothing was available in foreign languages or in an easy-read format. There was a reasonable supply of reading material at Cheadle Heath and inspectors observed this being provided. Visits from family members were not encouraged and rarely happened.

Recommendations

4.49 Showers should be offered to all detainees held overnight and to those who require one.

4.50 Replacement clothes rather than paper suits should be given to detainees to wear when their clothes are removed.

4.51 Detainees held for long periods should be offered outside exercise.

Housekeeping points

4.52 Blankets should be provided routinely and mattresses should always be wiped down between uses.

4.53 Toilet paper should be routinely provided in each cell.

4.54 Hygiene packs should be routinely offered to female detainees.

4.55 Reading material suitable for a range of detainees, including young people, those whose first language is not English and those with limited literacy skills, should be made available.

4.56 Visits should be allowed where appropriate, particularly for juveniles and those held for longer periods.

5. Individual rights

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

Rights relating to detention

5.1 Detainees were observed being booked in promptly after arrival at the custody suite, and most custody sergeants explored the reasons for detention with the arresting officer to ensure that appropriate grounds existed. Custody sergeants told us that they often felt under pressure from divisional policing staff to detain individuals, even when they did not consider that the necessity test had been met, although we did not observe this during the inspection.

5.2 Alternatives to custody were available, such as restorative justice and voluntary attendance. At Swinton, we saw records that documented 116 suspects being interviewed voluntarily at the station over the previous 86 days. Some custody sergeants told us that there was scope to make much greater use of alternatives to detention, such as using street bail or fixed penalties.

5.3 Many custody staff said that they believed that too many detainees had been detained for an unnecessarily long period of time, often for minor misdemeanours. Custody staff told us that on occasion delays were caused by the lack of available prisoner processing unit (PPU) staff, whose task it was to carry out investigative interviews with detainees. PPU staff were either busy or, if it was late in the evening or at night time, less readily available. We were informed that arresting officers were seldom given the task of interviewing suspects. Staff told us about a case at Wigan, which involved a female who had been arrested for drink driving. She had been kept in custody overnight and was to be interviewed by the PPU in the morning. However, as she was still in custody at 12 noon and no PPU staff were available to interview her, the custody sergeant decided to release her on bail.

5.4 However, we also observed an excellent example of attempts to minimise time spent in detention at Chadderton. The custody sergeant and the arresting officer made great efforts to negotiate with the local court clerk to arrange for a woman with a young baby, who had been arrested, to be bailed to attend court at a later date. This meant that she did not have to be kept in custody overnight.

5.5 Custody staff reported good relations with the UK Border Agency (UKBA), but we were told that some immigration detainees waited up to two days for the agency to collect them. Data supplied by the force showed that in 2011, 1012 immigration detainees had been held in the custody suites.

5.6 Detainees were routinely given leaflets outlining their rights and entitlements and this information was available in all the principal foreign languages. There was no information in an ‘easy read’ format for detainees with limited literacy.

5.7 A professional telephone interpreting service was used during the booking-in process. Access was through a telephone loudspeaker, which lacked privacy, or by passing a handset between custody staff and the detainee, which was cumbersome. Staff advised us that a good face to face interpreter service was available for interviews, but that there could be delays. Our custody record analysis found that two foreign national detainees had required interpretation services. In the first case, the detention log indicated that an interpreter had been called,

although their attendance had not been recorded. However, the risk assessment was detailed and suggested that an interpreter had been used. In the second case, it appeared that an interpreter had not been used during a police inspector's review. The log indicated that the detainee had been reminded of his rights, which he did not appear to understand. He was later charged using the telephone interpreting service.

5.8 Staff assured us that the custody suites were never used as a place of safety for children under section 46 of the Children Act 1989. Custody sergeants told us that they attempted to find PACE beds for young people via social services but were rarely successful. One sergeant could recall two occasions when accommodation had been provided in the previous 10 years. The police did not request unsecured accommodation.

5.9 The force adhered to the definition of a child outlined in PACE rather than in the Children Act (1989). This meant that those aged 17 were not provided with an appropriate adult (AA) unless they were otherwise deemed vulnerable. Family members or family friends were usually contacted in the first instance. Staff advised us that the triage system of distributing detainees across the custody estate had led to some difficulties for family members acting as AAs if long travel distances were involved. The police authority had an effective volunteer scheme in place, which supplemented the youth offending teams and adult services, providing a service for both juveniles and vulnerable adults. This scheme operated across all the custody suites with the exception of Wigan and Bolton, where Child Action North West provided a similar service. Custody staff were positive about how AAs conducted themselves and this was reinforced by comments from solicitors we spoke to. There were concerns about the continuation of this scheme once police and crime commissioners were in place.

Recommendation

5.10 Greater Manchester Police should engage with the local authority to ensure the provision of safe beds for juveniles who have been charged but who cannot be bailed.

Housekeeping points

5.11 Information about detainees' rights and entitlements should always be available in a range of formats to meet specific needs.

5.12 Two-handset telephones should be provided in all suites to facilitate telephone interpretation.

5.13 The attendance and use of an interpreter in any dealings with a detainee should be clearly recorded on their custody record.

Rights relating to PACE

5.14 We observed detainees being told that they could read the PACE codes of practice during the booking-in process. Posters were on display in all the custody suites in a range of languages advising detainees of their right to free legal advice. Solicitors we spoke to said that they thought custody staff adhered to PACE and outlined how they and their clients were dealt with. Not all suites had private facilities for telephone conversations and consequently detainees were seen and heard speaking to their legal representatives on the telephone in the presence of other people.

5.15 Custody records indicated that all detainees were offered legal representation, however 34 detainees (57%) declined the offer of legal advice. The reason why legal advice had been declined was generally not recorded.

5.16 We saw interviews with legal advisors being facilitated appropriately and there appeared to be sufficient consultation and interview rooms except at Ashton where we were told that there were sometimes queues for rooms. Not all consultation rooms were equipped with safety alarms.

5.17 Detainees whom we observed being booked in were all given the opportunity to contact someone to let them know that they were being held in custody. In each case, this involved an officer making the telephone call on behalf of the detainee. However detainees were permitted to make telephone calls during their detention where appropriate and if there were sufficient staff to facilitate this.

5.18 Reviews of detainees in custody were generally undertaken by the duty inspector, who, in addition to having specific PACE responsibilities, also carried out operational duties. We observed several reviews by duty inspectors, all of which took place face to face with detainees and on time.

5.19 There was a process for monitoring and the regular collection of PACE DNA samples from custody. However, inspectors found extraneous items in the freezers at some custody suites, while one freezer also contained multiple volunteer DNA samples, which had been there for a significant period of time.

5.20 Arrangements for getting detainees to court on time were efficient, but some courts lacked flexibility and would not accept detainees past the cut-off time. For example, at Longsight, a juvenile charged and refused bail at 2.15pm, was not accepted by Manchester and Salford Magistrates Court, which had a cut-off time of 12.30pm; he had to remain in custody overnight. Similar issues were observed elsewhere, for example, the cut-off times at Bury and Wigan courts were too early – 12.30pm on weekdays – even though there was some limited flexibility.

Recommendation

5.21 Senior police officers should engage with HM Court Service to ensure that the early court cut-off times do not result in unnecessarily long stays in custody.

Rights relating to treatment

5.22 When detainees arrived in custody, they were not advised of the complaints process and there were no notices about the complaints procedure on display in any of the custody suites.

5.23 Although there was a general expectation from the force that the duty inspector would deal with complaints from detainees while they were still in custody, practices varied. Some staff said that the duty inspector would record a complaint when they were notified; however other staff reported that it would be recorded once the detainee had been released. One duty inspector we spoke to confirmed that the practice was discretionary, and that it was most likely that any complaint made would be noted at the front desk once an individual had been released from custody.

Recommendation

5.24 Detainees should be told routinely how to make a complaint in line with the Independent Police Complaints Commission statutory guidance and, unless there is a clear reason not to do so, complaints should be taken while they are still in police custody.

6. Health care

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

Governance

6.1 Medacs provided health care to detainees in Greater Manchester Police (GMP) custody suites. Custody staff and detainees we spoke with were generally happy with the service they received.

6.2 The GMP had been working with the NHS regional offender health team (NHS team) to prepare a health needs analysis (HNA) as part of the early adopter scheme, through which health care in police custody is to be commissioned. The HNA was in draft form at the time of our visit. The HNA should lead to a more systematic approach to Lord Bradley's recommendations[6] across the GMP area.

6.3 Monitoring arrangements were good and there were monthly clinical governance and contract performance meetings, underpinned by the reporting of key information such as response times, potential areas of risk and adverse incidents. A chief inspector was responsible for ensuring contract compliance. Medacs health care professionals (HCPs) included a lead nurse for custody services, four nurses throughout the day and three at night, backed up by two forensic medical examiners (FMEs). Staff credentials were checked centrally with registration bodies and Medacs offered staff appropriate training. Clinical supervision was infrequent and not recorded, which was inadequate. A full time FME was responsible for the clinical direction of the service and other doctors undertook FME sessions as first on call or to support nurses.

6.4 On average the GMP called Medacs over 3,000 times per month. There were two contracted response times for Medacs attendance – 60 minutes for urgent matters and 90 minutes for non-urgent matters. In the year to February 2011, Medacs' monthly performance report indicated a 95% attendance response; response times were within the 90% target. Not all custody staff where clear about what the expected response times were. In our custody record analysis, 23% of detainees saw an HCP. The average waiting time to see an HCP was an hour and 41 minutes.

6.5 The quality of the medical rooms in suites was generally good. All rooms had been designed recently and at North Manchester there were two rooms that were particularly good. Most rooms lacked natural light, but all had natural light lamps. The standard and type of equipment varied from room to room, as did approaches to infection control. No room was fully compliant with infection control standards. For example, most rooms had chairs for HCPs that could not be wiped clean and no room displayed the correct hand-washing procedure. The NHS team had mapped out detailed equipment and infection control issues in audits, which were presented to the police in August 2011, but there had been no change in the custody suites since. Cleanliness was generally acceptable although floors could have been much cleaner in several suites. We did not see any signed, daily cleaning schedules for the medical rooms.

[6] Lord Bradley's report on the experience of people with mental health problems and with learning disabilities in the criminal justice system.

6.6 The amount and type of stock in the medical rooms varied and there were inconsistencies in stock management. Some materials and equipment were out of date, missing or stored in an inappropriate way. For example, there was a large number of a variety of airways, but in different quantities at different sites and although Oxygen was available, at Bury the cylinder nearest to hand was empty. We did not find any pulse oximeters with the oxygen equipment. All staff were trained in the use of automated external defibrillators, which were available and subject to regular checks. Where there were equipment checklists not all were up to date.

6.7 Refrigerators were available in all medical rooms. None were being used to store clinical supplies or medicines, and at Bury the refrigerator had not been switched on. Several fridges had temperature monitoring equipment, but daily monitoring did not appear to be recorded.

6.8 We were very concerned at Longsight where we found clear glass vials of Marquis (a drug-testing reagent that contained concentrated sulphuric acid) next to boxes of sterile water for injection. Some vials of Marquis were mixed into one of the boxes of sterile water for injection. This was potentially very dangerous. Medacs took action immediately to rectify this, while insisting that it had not supplied or used these items. Custody staff were unclear about the ownership of the stock and no one appeared to have an overview of stock storage and management.

6.9 Although it could take several hours to arrange, detainees could see an HCP of their own gender if requested. At Longsight this was explained in a notice near the reception desk in several languages. Interpreting services were available though rarely used. No rooms had privacy screens, although we observed rooms being used in such a way as to preserve the privacy and dignity of patients.

Recommendations

6.10 HCPs should be offered regular clinical supervision, receipt of which should be recorded.

6.11 There should be robust infection control procedures for all medical rooms, which should be cleaned regularly. It should be possible to take forensic samples in the rooms. A daily record of scheduled cleaning should be kept.

6.12 Equipment within medical rooms should be rationalised and standardised and the ownership of stock within the medical rooms should be clarified, and effectively managed.

Housekeeping points

6.13 Where refrigerators are used to store clinical supplies, the temperatures should be recorded daily; action should be taken where temperatures fall outside the range of manufacturers' storage guidelines.

6.14 Privacy screens should be provided in all medical rooms.

Good practice

6.15 *The sign displayed in several languages at Longsight police custody suite indicating the detainee's right to choose the gender of an attendant HCP represented good practice by reinforcing patient choice.*

Patient care

6.16 When booking in to police custody, detainees were asked if they wished to see an HCP. HCPs were available 24 hours a day via the Medacs telephone line. They were based in the busier custody suites.

6.17 Clinical records were kept on hand-written standardised forms but Medacs had begun the process of introducing computerised clinical records. Assessment findings and treatment indications were clearly recorded, and care instructions were given to custody staff. Occasionally custody staff found instructions difficult to read. The Medacs director of nursing was the Caldicott guardian (responsible for overseeing the use and confidentiality of personal health information) and records were stored in compliance with the Data Protection Act. On some occasions, when a detainee left police custody, clinical records supplied by Medacs to custody staff were shared with other agencies without the consent of the detainee or the HCP. This was in breach of medical confidentiality.

6.18 The treatment offered appeared appropriate in the cases we sampled, and followed contemporary guidance. The quality of care provided to detainees by staff and HCPs appeared good. Some concerns were raised with us about two HCPs who had been described as being overly risk averse – they had been too ready to send people to hospital. The Medacs lead nurse assured us that he had dealt with such matters on a case by case basis.

6.19 In some suites wound suturing equipment was out of date. In all suites, there was an absence of wound glue, which reduced therapeutic options. There was a general absence of health promotion material in the medical rooms or custody suites.

6.20 Medicines management was generally good across the custody suites. Detainees we spoke with were happy with their interactions with HCPs and their prescribed medications. Medicine stocks were appropriate, although methadone maintenance was not available to detainees requiring it. Symptomatic relief for withdrawal from substances was available. We found two out of date editions of the *British National Formulary* at Bury.

6.21 Custody officers kept medicine that was to be given to individual detainees in locked drawers or cabinets. Medicines were dispensed from containers or individually labelled Henley tablet bags. At Swinton there was a stock of salbutamol in the custody suite medicine cabinet that was available on loan. While well intended this represented poor practice.

6.22 The stock of medicines was kept in key code protected cupboards in medical rooms in the custody suites. In some suites the key code boxes were broken and the keys to the medicine cupboards were kept with custody staff – this introduced an unnecessary variable in the audit trail.

6.23 Medacs staff recorded all medicines used in a stock control book. We observed no discrepancies in stock levels. We saw medicines being administered at the prescribed times. Custody officers signed to say that they had assisted detainees in taking their medication and

a record was made in the person escort record. Detainees would take their pre-prescribed medication with them on release from custody.

6.24 The system used by custody staff to dispose of unused or discarded medicines was insecure as no records were kept. It was possible for a person to reach into the apertures in the disposal tubs as they were sufficiently large. The disposal of medication was being reviewed on behalf of the clinical governance meeting at the time of our visit.

Recommendations

6.25 Detainee clinical records should not be routinely shared with third parties except by express permission of the detainee and the HCP.

6.26 Clinically indicated medication should be available to patients for whom they are prescribed and should only be administered to detainees following prescription by an HCP.

6.27 Discarded medicines should be disposed of securely and should not expose custody staff to unnecessary risk.

Housekeeping points

6.28 All clinical options associated with the primary treatment of wounds should be available.

6.29 Patient information leaflets and health promotion material should be available in all medical rooms.

6.30 Out of date pharmacological reference materials should be discarded.

6.31 Keys to medical room medicine cabinets should only be available to HCPs. Medicine cabinets should be constructed and installed to the required standards.

Substance use

6.32 Ten local authorities provided drugs services in the GMP custody suites. A chief inspector was responsible for the substance misuse strategy. Local arrangements were in place to ensure that contracted services were monitored. The GMP said that some providers were better funded than others, but that it was generally happy with the services and had a say in the commissioning process.

6.33 Detainees were offered the services of a drug or alcohol arrest referral worker where appropriate and referred to community drugs and alcohol teams as necessary. The service providers and the extent of services varied from area to area. The local statutory drug services usually provided services, although the Arch Initiative, a charity, was the provider in Bolton. Some service providers covered more than one custody suite.

6.34 Budget cuts were beginning to have an impact on some services provided. In Cheadle Heath, for example, there were no longer permanent drug or alcohol workers in the custody suite; an appointment had to be made following all positive drugs tests. Custody staff believed that the service was not as supportive as it had been. The service provider noted that there had been

less detainee contact than previously, which suggested that there were teething problems with the new referral system.

6.35 The GMP was an intensive area under the drug intervention programme (DIP). All suites carried out drug testing and had drugs workers available to provide the required assessments. Substance misuse workers were generally available from 7am to 11pm every day, working shorter hours at weekends. At Longsight, however, there was 24-hour access to substance misuse workers. In most areas, drugs workers visited every day and saw all detainees, whether or not they had been referred. Most services did not provide alcohol intervention, but referred detainees to specialist local providers. However, in North Manchester and Longsight the substance misuse workers undertook some alcohol support work.

6.36 Detainees who were subject to substance misuse assessments or who were engaged in substance misuse programmes received follow up assistance in the community. Those who required clean needles, harm minimisation advice and supplies were signposted to relevant services.

6.37 Juvenile detainees were not covered by the DIPs; they were signposted to local specialist services and to young offender team workers. In some areas, appointments were made for them with juvenile services.

Mental health

6.38 Within the GMP area, the Greater Manchester Cluster (of primary care trusts) was commissioning mental health services from four NHS specialist mental health trusts – the 5 Boroughs Partnership, Central Manchester, Greater Manchester West (GMW) and Pennine Care. The police expressed frustration that they were unable to engage local providers sufficiently so that problems associated with detainees who had suspected mental health problems could be addressed and resolved.

6.39 The chief constable and the cluster chief executive initiated a strategic consultation about the provision of mental health services to the GMP. The consultation raised many of the issues that had been brought to our attention by custody staff and it was envisaged that it would prompt mental health providers to address concerns about liaison and regarding sections 135 and 136 of the Mental Health Act 1983[7]. This work was expected to result in revised section 136 and information sharing protocols between the Association of Greater Manchester partners.

6.40 There was no systematic approach to the diversion of detainees with mental health problems from police custody. In central Manchester a handful of courts had access to the liaison, assessment and diversion scheme offered by GMW, but not all custody staff knew of the scheme. Detainees who were thought to require mental health assessments were referred to Medacs first. It would in turn refer them to mental health providers, which would carry out formal Mental Health Act assessments. The process was cumbersome and left many detainees with suspected mental health problems in police custody for protracted periods of time. Custody staff expressed frustration; while they had received mental health awareness

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

training this had not prepared them to provide direct support and care for people with mental health problems in inappropriate settings.

6.41 Custody staff appeared unaware of the location of the current 136 protocols, although they were aware of the difficulties in engaging NHS providers. Problems included: mental health providers' section 136 suites being closed due to staffing problems; disagreements about levels of intoxication in detainees and ad hoc changes to custom and practice introduced by the providers, which put the police service at a disadvantage. The police believed that NHS workers did not understand their powers to detain under section 136, which meant that police officers could spend several hours in section 136 suites.

6.42 We examined one case in which the NHS provider would not accept a detainee under section 136. The mental health provider claimed the detainee was intoxicated, but the police disagreed. The detainee spent several hours in a police van while the police attempted to persuade NHS staff to see her earlier than her given appointment time because she did not appear intoxicated. The provider refused to assess her before the agreed time. The detainee had been found unclothed in the snow and had to be examined in hospital to ensure she was not suffering from hypothermia before being taken to the provider's place of safety. There were examples of unsatisfactory situations across all custody suites, although at Longsight and Wigan cases of good practice were also highlighted.

6.43 In several custody suites, for example, at Bury and Wigan, staff insisted that the use of section 136 was frequent – there were up to one or two cases every week. However, this contradicted the data supplied to us by the GMP; it indicated that in the 12 months to February 2012, 139 detainees had been held in police custody under section 136 across the GMP area. This was less than 12 per month, which was low, especially considering the throughput of detainees in 2011.

Recommendation

6.44 Police custody should be used as a place of safety for the purposes of section 136 on an exceptional basis only.

7. Summary of recommendations

Main recommendations

7.1 Risk assessment procedures, including initial and pre-release assessments, should be consistent and provide an effective system for carrying out detailed risk assessment and care planning. (2.19)

7.2 Handovers should be comprehensive and should involve both CDOs and police custody staff. (2.20)

7.3 There should be a programme of regular deep cleans in place at all suites and graffiti should be removed promptly. (2.21)

7.4 The NHS should provide appropriate support to police custody to ensure that detainees with mental health problems are promptly diverted to appropriate mental health services. (2.22)

National issues

7.5 Appropriate adults should be available for juveniles aged 17. (2.23)

Recommendations

Strategy

7.6 The force should introduce a forum where custody practitioners and managers can discuss custody issues so that they are able to inform and be part of the change process. (3.13)

7.7 The force should ensure that all managers with responsibility for custody understand and carry out the required quality assurance of custody records, including person escort records. (3.14)

Treatment and conditions

7.8 Booking-in areas should be sufficiently private so that staff and detainees are able to communicate effectively, and custody sergeants should exercise greater control over personnel present in the booking-in areas to this end. (4.8)

7.9 There should be clear policies and procedures in place to meet the specific needs of detainees particularly those of women, juveniles and detainees with disabilities. (4.9)

7.10 Staff should inform detainees that arrangements may be made to enable them to observe any reasonable religious practice while in custody, and items should be stored respectfully. (4.10)

7.11 Custody sergeants should ask detainees during the booking-in process if they have any concerns about dependants. (4.11)

7.12 Staff should receive up to date awareness training on child protection and safeguarding in respect of juveniles and vulnerable adults. (4.12)

7.13 Staff should be briefed on the requirements of the four levels of observation in use so that observations are applied consistently. (4.24)

7.14 Greater Manchester Police Service should collate use of force data in accordance with the Association of Chief Police Officers' policy and National Policing Improvement Agency guidance. (4.30)

7.15 Cell heating at Chadderton should be adequate. (4.37)

7.16 The correct use of call bells should be explained to all detainees, the system at Bury should function correctly and they should be responded to promptly.(4.38)

7.17 Cells should be free from ligature points, and safety checks should be regular and thorough at all custody suites. (4.39)

7.18 Custody staff should carry out, or be present at any visit to a cell. (4.40)

7.19 Showers should be offered to all detainees held overnight and to those who require one. (4.49)

7.20 Replacement clothes rather than paper suits should be given to detainees to wear when their clothes are removed. (4.50)

7.21 Detainees held for long periods should be offered outside exercise. (4.51)

Individual rights

7.22 Greater Manchester Police should engage with the local authority to ensure the provision of safe beds for juveniles who have been charged but who cannot be bailed. (5.10)

7.23 Senior police officers should engage with HM Court Service to ensure that the early court cut-off times do not result in unnecessarily long stays in custody. (5.21)

7.24 Detainees should be told routinely how to make a complaint in line with the Independent Police Complaints Commission statutory guidance and, unless there is a clear reason not to do so, complaints should be taken while they are still in police custody. (5.24)

Health care

7.25 HCPs should be offered regular clinical supervision, receipt of which should be recorded. (6.10)

7.26 There should be robust infection control procedures for all medical rooms, which should be cleaned regularly. It should be possible to take forensic samples in the rooms. A daily record of scheduled cleaning should be kept. (6.11)

7.27 Equipment within medical rooms should be rationalised and standardised and the ownership of stock within the medical rooms should be clarified, and effectively managed. (6.12)

7.28 Detainee clinical records should not be routinely shared with third parties except by express permission of the detainee and the HCP. (6.25)

7.29 Clinically indicated medication should be available to patients for whom they are prescribed and should only be administered to detainees following prescription by an HCP. (6.26)

7.30 Discarded medicines should be disposed of securely and should not expose custody staff to unnecessary risk. (6.27)

7.31 Police custody should be used as a place of safety for the purposes of section 136 on an exceptional basis only. (6.44)

Housekeeping points

Treatment and conditions

7.32 All custody staff should be made aware of how to operate the hearing induction loop. (4.13)

7.33 Anti-ligature knives should not be used for routine tasks such as cutting cords from detainees' clothing. (4.25)

7.34 Fire evacuation drills should be carried out and recorded, and adequate emergency evacuation equipment should always be in place in every suite. (4.41)

7.35 Blankets should be provided routinely and mattresses should always be wiped down between uses. (4.52)

7.36 Toilet paper should be routinely provided in each cell. (4.53)

7.37 Hygiene packs should be routinely offered to female detainees. (4.54)

7.38 Reading material suitable for a range of detainees, including young people, those whose first language is not English and those with limited literacy skills, should be made available. (4.55)

7.39 Visits should be allowed where appropriate, particularly for juveniles and those held for longer periods. (4.56)

Health care

7.40 Where refrigerators are used to store clinical supplies, the temperatures should be recorded daily; action should be taken where temperatures fall outside the range of manufacturers' storage guidelines. (6.13)

7.41 Privacy screens should be provided in all medical rooms. (6.14)

7.42 All clinical options associated with the primary treatment of wounds should be available. (6.28)

7.43 Patient information leaflets and health promotion material should be available in all medical rooms. (6.29)

7.44 Out of date pharmacological reference materials should be discarded. (6.30)

7.45 Keys to medical room medicine cabinets should only be available to HCPs. Medicine cabinets should be constructed and installed to the required standards. (6.31)

Good practice

7.46 The Samaritans' attendance at the custody suite was a positive initiative at Longsight custody suite. (4.26)

7.47 The sign displayed in several languages at Longsight police custody suite indicating the detainee's right to choose the gender of an attendant HCP represented good practice by reinforcing patient choice. (6.15)

Appendix I: Inspection team

Sean Sullivan	HMIP team leader
Peter Dunn	HMIP inspector
Gary Boughen	HMIP inspector
Fiona Shearlaw	HMIP inspector
Vinnett Pearcy	HMIP inspector
Angela Johnson	HMIP inspector
Ian Macfadyen	HMIP inspector
Paul Davies	HMIC inspector
Mark Ewan	HMIC inspector
Rob Bowes	HMIC inspector
Jim McLachlan	HMIC inspector
Paul Tarbuck	HMIP health care inspector
Kathleen Byrne	CQC inspector
Amy Summerfield	HMIP researcher
Hayley Cripps	HMIP researcher

Appendix II: Summary of detainee questionnaires and interviews[8]

Detainee survey methodology

A voluntary, confidential and anonymous survey of the prisoner population, who had been through a police station in Greater Manchester, was carried out for this inspection. The results of this survey formed part of the evidence base for the inspection.

Choosing the sample size

The survey was conducted on 28 February 2012. A list of potential respondents to have passed through Longsight, North Manchester, Wigan, Bury, Swinton, Pendleton, Ashton-under-Lyne, Bolton or Chadderton police stations was created, detailing all those who had arrived from Manchester Magistrates' Court within the past two months.

Selecting the sample

In total 89 respondents were approached. Thirty-three respondents reported being held in police stations outside Greater Manchester, and two could speak no English so it was impossible to determine which police station they had been in. On the day, the questionnaire was offered to 54 respondents; there were four refusals, one questionnaire returned blank and four non-returns. All of those sampled had been in custody within the past two months.

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

Methodology

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

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

- fill out the questionnaire immediately and hand it straight back to a member of the research team;
- have their questionnaire ready to hand back to a member of the research team at a specified time; or
- to seal the questionnaire in the envelope provided and leave it in their room for collection.

[8]Researchers routinely select a sample of prisoners who have been held in police custody suites within the previous two months. Where numbers are insufficient to ascertain an adequate sample, the time limit is extended up to six months. The survey analysis continues to provide an indication of perceptions and experiences of those who have been held in these police custody suites over a longer period of time.

Response rates

In total, 45 (83%) respondents completed and returned their questionnaires.

Comparisons

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

Some questions have been filtered according to the response to a previous question. Filtered questions are clearly indented and preceded by an explanation as to which respondents are included in the filtered questions. Otherwise, percentages provided refer to the entire sample. All missing responses are excluded from the analysis.

The current survey responses were analysed against comparator figures for all prisoners surveyed in other police areas. This comparator is based on all responses from prisoner surveys carried out in 51 police areas since April 2008.

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

Summary

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

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

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

Survey results

Section 1: About you

Q2 Which police station were you last held at?

Longsight - 16; North Manchester - 7; Wigan - 1; Swinton - 10; Pendleton - 5; Ashton-under-Lyne - 2; Chadderton - 1; Unknown - 3.

Q3 How old are you?

16 years or younger	0 (0%)	*40-49 years*	11 (25%)
17-21 years	4 (9%)	*50-59 years*	2 (5%)
22-29 years	16 (36%)	*60 years or older*	0 (0%)
30-39 years	11 (25%)		

Q4 Are you:

Male	45 (100%)
Female	0 (0%)
Transgender/transsexual	0 (0%)

Q5 What is your ethnic origin?

White - British	31 (72%)
White - Irish	4 (9%)
White - other	0 (0%)
Black or black British - Caribbean	1 (2%)
Black or black British - African	2 (5%)
Black or black British - other	0 (0%)
Asian or Asian British - Indian	1 (2%)
Asian or Asian British - Pakistani	1 (2%)
Asian or Asian British - Bangladeshi	0 (0%)
Asian or Asian British - other	1 (2%)
Mixed heritage - white and black Caribbean	0 (0%)
Mixed heritage - white and black African	0 (0%)
Mixed heritage - white and Asian	2 (5%)
Mixed heritage - other	0 (0%)
Chinese	0 (0%)
Other ethnic group	0 (0%)

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

Yes	7 (18%)
No	32 (82%)

Q7 What, if any, is your religion?

None	11 (25%)
Church of England	12 (27%)
Catholic	12 (27%)
Protestant	2 (5%)
Other Christian denomination	3 (7%)
Buddhist	0 (0%)

Hindu 0 (0%)
Jewish 0 (0%)
Muslim 4 (9%)
Sikh 0 (0%)

Q8 How would you describe your sexual orientation?
Straight/heterosexual 43 (98%)
Gay/lesbian/homosexual 1 (2%)
Bisexual 0 (0%)

Q9 Do you consider yourself to have a disability?
Yes 11 (24%)
No 34 (76%)

Q10 Have you ever been held in police custody before?
Yes 43 (98%)
No 1 (2%)

Section 2: Your experience of the police custody suite

Q11 How long were you held at the police station?
Less than 24 hours 16 (36%)
More than 24 hours, but less than 48 hours (2 days) 14 (32%)
More than 48 hours (2 days), but less than 72 hours (3 days) 10 (23%)
72 hours (3 days) or more 4 (9%)

Q12 Were you told your rights when you first arrived there?
Yes 40 (89%)
No 2 (4%)
Don't know/can't remember 3 (7%)

Q13 Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')?
Yes 24 (53%)
No 15 (33%)
I don't know what this is/I don't remember 6 (13%)

Q14 If your clothes were taken away, what were you offered instead?
My clothes were not taken 21 (50%)
I was offered a tracksuit to wear 9 (21%)
I was offered an evidence/paper suit to wear 2 (5%)
I was only offered a blanket 5 (12%)
Nothing 5 (12%)

Q15 Could you use a toilet when you needed to?
Yes 45 (100%)
No 0 (0%)
Don't know 0 (0%)

Q16 If you used the toilet there, was toilet paper provided?
Yes 17 (38%)

No 28 (62%)

Q17 How would you rate the condition of your cell:

	Good	*Neither*	*Bad*
Cleanliness	17 (38%)	12 (27%)	16 (36%)
Ventilation/air quality	6 (16%)	10 (27%)	21 (57%)
Temperature	6 (16%)	9 (24%)	23 (61%)
Lighting	14 (38%)	9 (24%)	14 (38%)

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

Yes 29 (66%)
No 15 (34%)

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

Yes 8 (18%)
No 37 (82%)

Q20 Were you held overnight?

Yes 41 (91%)
No 4 (9%)

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

Not held overnight 4 (9%)
Pillow 1 (2%)
Blanket 32 (71%)
Nothing 9 (20%)

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

Not held overnight/did not get any bedding 13 (30%)
Yes 19 (44%)
No 11 (26%)

Q23 Were you offered a shower at the police station?

Yes 1 (2%)
No 44 (98%)

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

Yes 2 (4%)
No 43 (96%)

Q25 Were you offered anything to:

	Yes	*No*
Eat?	34 (81%)	8 (19%)
Drink?	36 (92%)	3 (8%)

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

Very good	*Good*	*Neither*	*Bad*	*Very bad*	*N/A*
0 (0%)	3 (7%)	9 (20%)	18 (40%)	10 (22%)	5 (11%)

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

I did not have any food or drink	5 (12%)
Yes	16 (37%)
No	22 (51%)

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

I do not smoke	9 (20%)
I was allowed to smoke	2 (4%)
I was offered a nicotine substitute	1 (2%)
I was not offered anything to cope with not smoking	33 (73%)

Q29 Were you offered anything to read?

Yes	3 (7%)
No	42 (93%)

Q30 Was someone informed of your arrest?

Yes	19 (43%)
No	17 (39%)
I don't know	3 (7%)
I didn't want to inform anyone	5 (11%)

Q31 Were you offered a free telephone call?

Yes	21 (47%)
No	24 (53%)

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

My telephone call was not denied	25 (60%)
Yes	3 (7%)
No	14 (33%)

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

	Yes	*No*
Who was taking care of your children	6 (19%)	25 (81%)
Contacting your partner, relative or friend	21 (55%)	17 (45%)
Contacting your employer	5 (18%)	23 (82%)
Where you were going once released	8 (24%)	25 (76%)

Q34 Were you offered free legal advice?

Yes	41 (91%)
No	4 (9%)

Q35 Did you accept the offer of free legal advice?

Was not offered free legal advice	4 (9%)
Yes	29 (64%)
No	12 (27%)

Q36 Were you interviewed by police about your case?

Yes	36 (86%)
No	6 (14%)

Q37 Was a solicitor present when you were interviewed?

Did not ask for a solicitor/was not interviewed	9 (21%)
Yes	27 (63%)
No	7 (16%)

Q38 Was an appropriate adult present when you were interviewed?

Did not need an appropriate adult/was not interviewed	22 (52%)
Yes	8 (19%)
No	12 (29%)

Q39 Was an interpreter present when you were interviewed?

Did not need an interpreter/was not interviewed	21 (50%)
Yes	2 (5%)
No	19 (45%)

Section 3: Safety

Q41 Did you feel safe there?

Yes	32 (74%)
No	11 (26%)

Q42 Did a member of staff victimise (insult or assault) you there?

Yes	20 (44%)
No	25 (56%)

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

I have not been victimised	25 (61%)	*Because of your crime*	7 (17%)
Insulting remarks (about you, your family or friends)	6 (15%)	*Because of your sexuality*	1 (2%)
Physical abuse (being hit, kicked or assaulted)	7 (17%)	*Because you have a disability*	1 (2%)
Sexual abuse	0 (0%)	*Because of your religion/religious beliefs*	1 (2%)
Your race or ethnic origin	0 (0%)	*Because you are from a different part of the country than others*	0 (0%)
Drugs	3 (7%)		

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

Yes	31 (72%)
No	8 (19%)
I wasn't handcuffed	4 (9%)

Q45 Were you restrained while in the police custody suite?

Yes	9 (21%)
No	34 (79%)

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

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

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

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

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

Very well	*Well*	*Neither*	*Badly*	*Very badly*	*Don't remember*
1 (2%)	15 (35%)	12 (28%)	8 (19%)	6 (14%)	1 (2%)

Section 4: Health care

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

Yes	11 (29%)
No	24 (63%)
Don't know	3 (8%)

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

	Yes	*No*
Doctor	13 (37%)	22 (63%)
Nurse	6 (21%)	23 (79%)
Paramedic	1 (4%)	25 (96%)

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

Yes	4 (11%)
No	17 (46%)
Don't know	16 (43%)

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

Yes	16 (41%)
No	23 (59%)

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

Not taking medication	23 (59%)
Yes	3 (8%)
No	13 (33%)

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

Yes	15 (38%)
No	24 (62%)

Q56 **Did you see, or were you offered the chance to see a drug or alcohol support worker?**

I didn't have any drug/alcohol problems	24 (62%)
Yes	4 (10%)
No	11 (28%)

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

I didn't have any drug/alcohol problems	24 (62%)
Yes	3 (8%)
No	12 (31%)

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

I was not seen by health care	*Very good*	*Good*	*Neither*	*Bad*	*Very bad*
21 (57%)	1 (3%)	2 (5%)	5 (14%)	6 (16%)	2 (5%)

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

Yes	8 (21%)
No	30 (79%)

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

Yes	8 (22%)
No	29 (78%)

Q61 **If you had any mental health care needs, were you seen by a mental health nurse/ psychiatrist?**

I didn't have any mental health care needs	29 (76%)
Yes	1 (3%)
No	8 (21%)

Prisoner survey responses for Greater Manchester Police 2012

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

Key to tables

		Greater Manchester 2012	Police custody comparator
	Any percentage highlighted in green is significantly better		
	Any percentage highlighted in blue is significantly worse		
	Any percentage highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
Number of completed questionnaires returned		45	1822
SECTION 1: General information			
3	Are you under 21 years of age?	**8%**	**9%**
4	Are you transgender/transsexual?	**0%**	**0%**
5	Are you from a minority ethnic group (including all those who did not tick white British, white Irish or white other categories)?	**19%**	**30%**
6	Are you a foreign national?	**18%**	**15%**
7	Are you Muslim?	**8%**	**11%**
8	Are you homosexual/gay or bisexual?	**2%**	**2%**
9	Do you consider yourself to have a disability?	**24%**	**19%**
10	Have you been in police custody before?	**98%**	**91%**
SECTION 2: Your experience of this custody suite			
11	Were you held at the police station for over 24 hours?	**63%**	**67%**
12	Were you told your rights when you first arrived?	**88%**	**78%**
13	Were you told about PACE?	**54%**	**51%**
For those who had their clothing taken away:			
14	Were you given a tracksuit to wear?	**44%**	**28%**
15	Could you use a toilet when you needed to?	**100%**	**91%**
16	If you used the toilet, was toilet paper provided?	**38%**	**48%**
17	Would you rate the condition of your cell, as 'good' for:		
17a	Cleanliness?	**38%**	**32%**
17b	Ventilation/air quality?	**17%**	**22%**
17c	Temperature?	**16%**	**15%**
17d	Lighting?	**38%**	**45%**
18	Was there any graffiti in your cell when you arrived?	**65%**	**56%**
19	Did staff explain the correct use of the cell bell?	**18%**	**22%**
20	Were you held overnight?	**92%**	**92%**
For those who were held overnight:			
21	Were you given any items of bedding?	**78%**	**82%**
For those who were held overnight and were given items of bedding:			
22	Were these clean?	**64%**	**58%**
23	Were you offered a shower?	**2%**	**9%**
24	Were you offered a period of outside exercise?	**4%**	**6%**
25a	Were you offered anything to eat?	**81%**	**81%**
25b	Were you offered anything to drink?	**93%**	**83%**
For those who had food/drink:			
26	Was the quality of the food and drink you received good/very good?	**7%**	**10%**
27	Was the food/drink you received suitable for your dietary requirements?	**43%**	**43%**

Key to tables

		Greater Manchester 2012	Police custody comparator
	Any percentage highlighted in green is significantly better		
	Any percentage highlighted in blue is significantly worse		
	Any percentage highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
For those who smoke:			
28	Were you offered anything to help you cope with not being able to smoke?	**6%**	**7%**
29	Were you offered anything to read?	**6%**	**13%**
30	Was someone informed of your arrest?	**43%**	**42%**
31	Were you offered a free telephone call?	**46%**	**49%**
If you were denied a free telephone call:			
32	Was a reason given?	**16%**	**14%**
33	Did you have any concerns about:		
33a	Who was taking care of your children?	**20%**	**14%**
33b	Contacting your partner, relative or friend?	**55%**	**53%**
33c	Contacting your employer?	**19%**	**20%**
33d	Where you were going once released?	**24%**	**31%**
34	Were you offered free legal advice?	**92%**	**88%**
For those who were offered free legal advice:			
35	Did you accept the offer of free legal advice?	**71%**	**69%**
For those who were were interviewed and needed them:			
37	Was a solicitor present when you were interviewed?	**79%**	**76%**
38	Was an appropriate adult present when you were interviewed?	**41%**	**28%**
39	Was an interpreter present when you were interviewed?	**9%**	**16%**
SECTION 3: Safety			
41	Did you feel unsafe?	**25%**	**39%**
42	Has another detainee or a member of staff victimised you?	**44%**	**30%**
43	If you have felt victimised, what did the incident involve?		
43a	Insulting remarks (about you, your family or friends)	**14%**	**15%**
43b	Physical abuse (being hit, kicked or assaulted)	**16%**	**10%**
43c	Sexual abuse	**0%**	**3%**
43d	Your race or ethnic origin	**0%**	**3%**
43e	Drugs	**6%**	**9%**
43f	Because of your crime	**16%**	**9%**
43g	Because of your sexuality	**2%**	**0%**
43h	Because you have a disability	**2%**	**4%**
43i	Because of your religion/religious beliefs	**2%**	**2%**
43j	Because you are from a different part of the country than others	**0%**	**3%**
44	Were your handcuffs removed on arrival at the police station?	**79%**	**72%**
45	Were you restrained whilst in the police custody suite?	**21%**	**19%**
46	Were you injured whilst in police custody, in a way that was not your fault?	**29%**	**23%**
47	Were you told how to make a complaint about your treatment?	**15%**	**13%**
48	Were you treated well/very well by staff in the police custody suite?	**38%**	**30%**

Key to tables

	Any percentage highlighted in green is significantly better	Greater Manchester 2012	Police custody comparator
	Any percentage highlighted in blue is significantly worse		
	Any percentage highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
SECTION 4: Health care			
50	Did someone explain your entitlements to see a health care professional if you needed to?	**29%**	**34%**
51	Were you seen by the following health care professionals during your time in police custody?		
51a	Doctor	**37%**	**45%**
51b	Nurse	**21%**	**20%**
	Percentage seen by either a doctor or a nurse	**45%**	**51%**
51c	Paramedic	**3%**	**4%**
52	Were you able to see a health care professional of your own gender?	**10%**	**26%**
53	Did you need to take any prescribed medication when you were in police custody?	**41%**	**42%**
For those who were on medication:			
54	Were you able to continue taking your medication while in police custody?	**18%**	**36%**
55	Did you have any drug or alcohol problems?	**39%**	**53%**
For those who had drug or alcohol problems:			
56	Did you see, or were offered the chance to see a drug or alcohol support worker?	**25%**	**43%**
57	Were you offered relief or medication for your immediate withdrawal symptoms?	**19%**	**16%**
For those who were seen by health care:			
58	Would you rate the quality as good/very good?	**18%**	**30%**
59	Did you have any specific physical health care needs?	**21%**	**32%**
60	Did you have any specific mental health care needs?	**22%**	**24%**
For those who had any mental health care needs:			
61	Were you seen by a mental health nurse/psychiatrist?	**10%**	**19%**