Report on an unannounced inspection visit to police custody suites in Gwent

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by

HM Inspectorate of Prisons and

HM Inspectorate of Constabulary

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Contents

1. Introduction

This report is part of a programme of inspections of police custody which are carried out jointly by our two inspectorates and form a key part of the joint work programme of the criminal justice inspectorates. These inspections also contribute to the United Kingdom's response to its international obligation to ensure regular and independent inspection of all places of detention. The inspections look at strategy, treatment and conditions, individual rights and health care.

Strategic oversight of the custody function was coherent and effective. The suites had sufficient capacity and were well run, but Newport Central had some need for better coordination between staff. Operational management, communications and initial training were generally carried out well, but lacked systematic engagement of staff in a users' forum or refresher training. Quality assurance processes were also not robust enough. Partnership working was well developed, with an effective independent visiting group.

Detainees were treated properly, although the Newport Central suite provided less privacy and was less well controlled. Vulnerable people were treated with consideration, and faith needs were met, although there was little provision for those with disabilities. Risk assessment was thorough and sensitive to individual circumstances, but it was not clear that observations and rousing of those in cells were always carried out at the appropriate intervals, and detention officers were not adequately involved in staff handovers.

Preparation for release was not always thorough, and at Newport Central call bells were not always responded to promptly. The Ystrad Mynach suite was in good condition, while that at Newport Central was less well maintained. There were gaps in the issuing of appropriate bedding and clothing and some other facilities, but food and drink were readily available. Time in the open air and, in exceptional circumstances, domestic visits were facilitated.

Detainees' legal rights were normally facilitated, although custody records did not always demonstrate this. A high level of voluntary attendance for interview suggested that detention was not overused. Telephone interpreting was used for those with poor English, and there was good coordination with the UK Border Agency. Police and Criminal Evidence Act requirements were met, and the courts were flexible in accepting cases on the day of arrest. Complaints could be and were taken in the custody suites.

Nursing cover was adequate, but gaps in the doctors' rota created problems. The prescribing and administration of medicines were not efficient and in some respects irregular, although clinical governance arrangements had improved. The substance misuse service was effective, and in mental health provision there was good liaison with court-based services. Detention of persons under section 136 of the Mental Health Act was well controlled, but the number of available NHS suites for this purpose had reduced.

Overall, the force was providing a custody operation at a reasonably good standard in most respects, with the Ystrad Mynach suite equipped and managed better than Newport Central in some ways. The area in which attention was especially needed was the provision of primary health care. This report provides a small number of recommendations to assist the force and the Police and Crime Commissioner to improve provision further. We expect our findings to be

considered in the wider context of priorities and resourcing, and for an action plan to be provided in due course.

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November 2012

2. Background and key findings

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

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

2.3 Gwent police had two full-time designated custody suites: one at Newport Central police station with 28 cells, and the other at Ystrad Mynach with 31 cells. There were no reserve or non-designated suites. The inspection team visited both custody suites.

2.4 An HM Inspectorate of Prisons researcher and inspector carried out a survey of prisoners at HMP Cardiff who had formerly been detained in the Gwent custody suites (see Appendix II).[2]

Strategy

2.5 There was effective strategic leadership, with a central custody function. The two designated suites met all normal operational needs, and there were contingency plans for exceptional situations. The police authority was fully engaged with the strategy and planning for custody. Staffing was adequate and appropriate, although it was unclear at Newport Central how the different operational roles in custody suites were integrated.

2.6 There were clear lines of responsibility and accountability in the custody management structure, and the custody inspectors were well informed about the operation of the suites. Management meetings were held weekly and monthly, but there was no custody users' forum. There was effective recording of and learning from incidents. Some aspects of quality

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

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

assurance needed development. A wide range of information was readily available to staff on a well-designed custody intranet site.

2.7 Partnership arrangements were effective within Gwent and more widely. The force worked closely with an active team of independent custody visitors. The training programme was well developed, although some staff said they had not received recent refresher training. A current change programme would enable police officers to act as custody staff, working flexibly between custody and other roles according to need, and an appropriate training package was in place.

Treatment and conditions

2.8 The sergeants worked very well with the wide range of detainees, giving careful individual attention to each, especially first-time detainees. They took an appropriately informal but professional approach with those detainees whom they knew well. Team working between sergeants and detention officers to ensure safety and welfare appeared to be more successful at Ystrad Mynach than at Newport Central. There was insufficient control over movement around the suite in Newport Central, where the booking-in area was cramped and afforded little privacy. There was more space at Ystrad Mynach, but there was still not always sufficient privacy in interviews.

2.9 We saw some good, considerate care of young people and women, although there were some omissions in addressing the needs of vulnerable detainees or dependants. There was very limited provision for those with mobility difficulties, but reasonable resources to meet religious needs.

2.10 Risk assessments were thorough, particularly in relation to medical and self-harm issues; sergeants were alert to body language and verbal answers, using supplementary questions as appropriate. They were careful to check detainees' understanding of what was said to them. At the time of our inspection, the lowest level of observations appeared to be underused. Staff were familiar with rousing procedures but custody records often did not show evidence of rousing at the required times. Ligature knives were not carried by all custody staff. Shift handovers between sergeants were good, but detention officers were not sufficiently involved in the exchange of information about individual risk.

2.11 Insufficient attention was given to preparation for release. There was good attention to practical need in some cases, including lifts home, but pre-release risk assessments lacked consistency and detail. The records for some young people did not say what was to happen to them after release. At both suites some detainees were kept in handcuffs until they came to the desk for booking-in. Strip-searching was not overused and was properly recorded.

2.12 The cells at Ystrad Mynach were well maintained and very clean and tidy. At Newport Central the cells were fairly clean but paintwork and floors were worn and in need of a deep clean, with a considerable amount of graffiti. Regular health and safety checks took place. Cell call bells were not reliably answered at Newport Central.

2.13 Pillows were stored at both suites but were not issued; extra blankets were issued instead. Mattresses were not wiped between uses. Showers were available by request only at both suites. Ystrad Mynach had integral sanitation and reasonable natural light. Replacement clothing was given if clothes had been seized, but only paper suits were issued if the detainee was unwilling to have the waist cord cut in tracksuit trousers.

2.14 Low-calorie microwave meals were supplied. Staff were flexible in giving food when detainees were hungry as well as at normal mealtimes, with cereal and milk available throughout the day. Staff would go out and buy food from petty cash for those with special dietary needs. Food preparation facilities were adequate.

2.15 Exercise yards were satisfactory and several detainees were given the opportunity to be in the yards, often for significant periods. There was very little for detainees to read: in effect, only newspapers that staff had brought in. At Newport Central, we were pleased to see a visit arranged for a man with his partner and baby.

Individual rights

2.16 Overall, solicitors were content with the treatment of their clients. Some custody records did not reflect contact with a solicitor, even when the detainee had named a firm. Some custody staff felt that there was a presumption of detention in case of doubt and little discretion to apply the necessity test, but there was no clear evidence for this, and we saw a sergeant pressing the arresting officer on the justification for detention. There was considerable use of voluntary attendance.

2.17 Rights and entitlements were given. Copies of rights and entitlements in other languages were not readily to hand, but telephone interpretation was used. The offer to notify someone of the detainee's arrest was not always recorded in custody records. For young people under 17, appropriate adults were provided by the relevant agencies during working hours, but less consistently at night. There were good working relationships with the Cardiff UK Border Agency enforcement team.

2.18 Police and Criminal Evidence Act requirements were met and detention reviews were generally timely. Courts were flexible in accepting cases on the day, without cut-off times, although some staff found court staff less cooperative. DNA samples were well managed. Managers were prepared to take complaints, but there was limited awareness among detainees of how to make a complaint.

Health care

2.19 The force employed its own nurses, with considerable recent use of agency staff. Forensic medical examiners (FMEs) were retained, but they did not provide complete cover. We were told that during a recent night, nine detainees had been taken to hospital.

2.20 Treatment rooms were reasonable and properly equipped. A clinical governance committee had been set up in the last year. Detainees had good access to health care professionals, and clinical reviews were good. The standard of clinical records was reasonable, although FMEs took their notes home. There was no Caldicott guardian. The lack of any patient group directions meant that all medications were authorised by an FME, generally by telephone. There was evidence of medications being collected from home by police, but methadone was not given in custody.

2.21 An adequate substance misuse service was provided by Crime Reduction Initiative, which maintained good liaison with the force, with an effective 'DIP intensive' (drug intervention) programme at Newport Central. There were no needle exchange schemes in custody, but information was given about local services.

2.22 Two police nurses were mental health trained and there was very good liaison and exchange of information with court liaison services. Excellent records were kept of those detained under section 136 of the Mental Health Act[3], and the information was fed back to the force and the NHS. Regular liaison meetings took place on section 136 cases but there was likely to be an increase in the use of police custody because the number of section 136 suites in the force area had been reduced. Mental health issues were included in initial training for custody staff, but there was no regular programme of mental health awareness training.

Main recommendations

2.23 There should be a forensic medical examiner on call at all times, who should ensure that correct prescribing practice is followed.

2.24 Pre-release risk assessment of detainees should consider all known risk factors and staff should take appropriate action to manage and mitigate the risks.

National issues

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

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

3. Strategy

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

Strategic management

3.1 An assistant chief constable (ACC) provided strategic leadership on custody issues, with a central custody function delivered through the Criminal Justice Department (CJD). A police staff manager was head of the CJD, and a chief inspector was head of custody in the CJD.

3.2 There were two full-time designated custody suites. Contingency plans were in place to use custody facilities in neighbouring forces.

3.3 The force estates strategy had determined a reduction in the number of custody suites to the current two suites. The Police Authority (PA) was fully engaged with the estates strategy and there was a lead member for custody.

3.4 Staffing levels in custody suites were adequate, with minimal requirement for backfill from operational resources. Staff consisted of permanent custody sergeants and custody detention officers (CDOs) employed by Gwent Police. There was no use of acting sergeants to undertake custody duties. CDOs looked after the care and welfare of detainees, but the work was not managed and supervised with sufficient clarity. The PA was engaged with the 'Staying Ahead' programme to meet the Government's comprehensive spending review and the proposals for custody, which included a reduction in CDOs and the training of police constables to undertake the gaoler role.

3.5 There were clear arrangements for custody management and a dedicated custody inspector for each of the two custody suites, reporting to the head of custody. The custody inspectors line managed the custody sergeants, who in turn line managed the CDOs.

3.6 The ACC lead for custody held a monthly meeting with the head of the CJD and head of custody, at which custody matters could exceptionally be escalated for resolution. A weekly custody management meeting chaired by the head of custody focussed on custody performance, staffing and the custody review. While there had been formal engagement with custody staff during the custody review, there was no formal custody users' forum for staff to raise issues with management. Custody inspectors had good oversight of staffing and custody issues.

Housekeeping points

3.7 At Newport Central, the work of CDOs should be clarified and supervised to ensure consistently safe and decent treatment of detainees.

3.8 The force should introduce a forum for custody practitioners and managers to discuss custody issues.

Partnerships

3.9 Partnership arrangements were good, with active strategic engagement with criminal justice partners. The head of the CJD attended the All Wales Criminal Justice Board. The ACC custody lead chaired a monthly Criminal Justice Strategy Board meeting with the Crown Prosecution Service, Courts, Probation and the Community Safety Partnership. The chief constable chaired a regular meeting with the five local authorities for Gwent and the Gwent Healthcare NHS Trust.

3.10 The senior business manager for the PA coordinated the independent custody visitors (ICV) scheme, comprising nine members who made weekly visits to each of the custody suites. ICVs said that they were generally admitted to custody suites quickly, and there had been noticeable improvements in the scheme over recent years. There were bi-annual meetings of ICVs with the PA, with consistent police attendance.

Learning and development

3.11 All custody sergeants and CDOs had undertaken custody-specific training on a course provided by South Wales Police (based on 'Safer Detention and Handling of Persons in Police Custody') before undertaking custody duties. There was also regular training courses in first aid and in the use of personal protection equipment.

3.12 There was custody-specific refresher training for custody staff, although some staff said they had not received this recently. Custody sergeants were able to suggest content for the refresher training.

3.13 Proposals for the introduction of police constable gaolers in the custody suites were supported by a newly developed gaolers' training package, which was to be delivered to all existing staff.

3.14 The force had a comprehensive custody manual based on the National Policing Improvement Agency's 'Safer Detention and Handling of Persons in Police Custody' document. It was reviewed bi-annually and accessible to all staff on the force intranet. The custody intranet site contained a number of useful information sources, including 'learning the lessons' documents from the Independent Police Complaints Commission and the Gwent police, compiled in conjunction with the force standards department. Staff showed good awareness of the custody intranet site.

3.15 There was a thorough procedure for recording near-miss incidents in custody through the completion of a form, submitted to the custody manager. Submissions were encouraged from custody sergeants and civilian detention officers. All near misses were entered on a database for analysis and held on specific intranet pages for the information of staff. There was effective analysis of the near-miss information which produced useful management information to identify trends. Near misses were discussed at the weekly custody management meeting and escalated exceptionally to the monthly ACC meeting.

3.16 There was an effective quality assurance process for custody records, with each custody inspector required to review 50 records a month using a corporate template, which was accessible on the custody intranet site. The process was overseen by the head of custody and was auditable. The head of custody also determined themes for the dip sampling of records, focussing, for example, on higher-risk detainees. Person escort record forms formed part of the quality assurance process and 20 forms were dip sampled by each custody inspector each

month. However, the dip sampling was not cross-referenced to the corresponding CCTV footage because of technical deficiencies in the CCTV systems. There was no quality assurance of shift handovers.

Recommendation

3.17 The force should cross reference custody record dip sampling to CCTV checking and monitor handovers as part of its quality assurance regime.

Good practice

3.18 *Effective analysis of the near-miss information produced useful management information to identify trends, which was available to all custody staff.*

4. Treatment and conditions

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

Respect

4.1 Staff engaged with detainees professionally and respectfully at both custody suites. All detainees were asked if they could speak Welsh, in order to give them the opportunity to book in and receive written documentation in their first language. Custody sergeants confirmed with detainees how they wished to be addressed. At both Ystrad Mynach and Newport Central, custody sergeants were patient and sensitive towards detainees who were upset and nervous, and spent some time reassuring them and explaining what would happen while they were in the suites. Custody staff took an appropriately informal but professional approach with those detainees whom they knew well.

4.2 The booking-in area at Newport Central was narrow and cramped and there was very little space if more than one detainee was being booked in while staff were moving around the area. There were four booking-in terminals, but, during the inspection, custody sergeants used adjacent terminals which afforded no privacy to detainees to discuss personal information. We observed one detainee listening to another detainee being booked in. However, a custody sergeant asked for the booking area to be cleared when a detainee was being charged with serious offences, which was appropriate.

4.3 At Ystrad Mynach there were three booking-in terminals; one was screened and was used when there was a third custody sergeant to book in detainees. Despite having the screened terminal, one officer discussed sensitive and serious details of a young person's interview in full hearing of other people in the booking-in area. This was inappropriate.

4.4 Staff showed a reasonable awareness of diversity. All female detainees were asked if they might be pregnant or wanted to speak to a female member of staff. There were designated cells for female detainees, although they were not always used if they needed closer supervision. There were no specific detention rooms for juveniles at either custody suite but sergeants told us they would be located in cells closest to the booking-in desk and we observed two juvenile detainees at Newport Central located in these cells. At Ystrad Mynach a juvenile detainee and his grandmother (appropriate adult) were allowed to wait in a holding room opposite the desk rather than being placed in a cell. Custody sergeants told us they would only permit this if it was safe to do so.

4.5 We observed two foreign national detainees being booked in at Newport Central. Telephone interpretation was used for one of the detainees so that the risk assessment could be completed, and they were provided with a copy of their rights and entitlements in their chosen language (see section on individual rights). Both detainees were given the opportunity to contact their embassy or consulate about their detention. The custody sergeant showed exceptional care with these two detainees, who both had significant health concerns, which was commendable.

4.6 Although there was a prompt on the NSPIS (national strategy for police information systems) electronic case record to ask detainees if their detention might affect others, such as dependants, we observed custody sergeants rephrasing the question and asking: 'anything

else I need to know about your care?' or 'Is there anything else that might affect you?', which did not give the detainee sufficient opportunity to raise any concerns. Custody sergeants we spoke to told us that, if any detainees had dependency obligations, they would expect the arresting officer to have made arrangements. However, they also told us that they had facilitated contact for detainees with friends and family members to arrange for their children to be cared for. Custody sergeants had a good awareness of safeguarding issues affecting young people or vulnerable adults and had a list of agencies for referral if they identified any concerns.

4.7 Custody sergeants were aware of the needs of transgender detainees when they were being searched. They recalled instances when this had occurred and they had been searched in a private room by a male or female CDO as requested.

4.8 Prayer mats, a Qur'an, several bibles and a Torah were available at both custody suites. They were respectfully stored and there were instructions regarding their handling. At Newport Central a dry cell contained the direction of Mecca marked on the ceiling and we were told that, if detainees asked to pray, they were taken to this cell.

4.9 There were no adapted cells for older detainees or those with disabilities, but the door frames at both custody suites could accommodate a wheelchair. The bed plinths at Ystrad Mynach were very low and unsuitable for a detainee with a physical disability or an older detainee. Newport Central custody suite had a combined toilet and shower room for disabled detainees. There was a portable hearing loop only at Ystrad Mynach and staff were not sure how to use it.

Recommendation

4.10 Booking-in desks should allow effective and private communication between custody staff and detainees.

Housekeeping points

4.11 A hearing loop should be available in the booking-in area and all custody staff should know how to use it.

4.12 All detainees should be asked if they have dependency obligations and given the opportunity to make arrangements accordingly.

Safety

4.13 Custody sergeants carried out the initial risk assessment and explained the purpose of the assessment to the detainees. They all asked probing questions if detainees divulged that they had harmed themselves in the past and if there were health concerns. They were careful to check detainees' understanding of what was said to them. One custody sergeant had identified from a detainee's body language that he was not answering all the questions honestly and reassured him that it was in his best interests so that staff could care for him to answer honestly, which he then did. We analysed 30 custody records, in which initial risk assessment statements were generally clear with helpful information.

4.14 The force's statistics showed most detainees on 60-minute observations. During the inspection, however, and in the custody records which were analysed, the majority were placed on 30-minute observations, even when there was no risk of self-harm or concern about

health. Custody sergeants at both suites told us that they rarely used level 1, 60-minute observations. One custody sergeant told us that level 1 observation was mainly used for detainees who were brought into the suite and taken straight into interview, and another said he felt that 60-minute checks on a detainee were too infrequent.

4.15 At Ystrad Mynach one female detainee had an exceptional risk form opened, which was used for detainees who might be at risk of self-harm, affiliated to gangs or an escape risk. However, if a detainee appeared in the custody suite again, this information was not forthcoming and it was unclear what additional safeguards were provided by the exceptional risk form, which had been developed locally.

4.16 Our analysis of custody records showed that observation and rousing checks were not being recorded thoroughly. Ten detainees had been identified as intoxicated, all of whom had been put under 30-minute observations and rousing. In five of these cases, rousing had not been effectively recorded in the custody log, and five records contained gaps of up to two hours where entries should have shown that detainees were being roused. Instead, entries read 'movement noted', 'asleep' or 'breathing observed' and nothing further.

4.17 At Ystrad Mynach the three CDOs organised their cell visits so that each officer was allocated a two-hour period to conduct the visits. At Newport Central cell visit arrangements were far too casual. The CDOs told us that one of them visited the cells, but the task was not properly allocated and it was unclear who would conduct the cell visits when all the CDOs were busy.

4.18 Four cells and communal areas at each of the custody suites were monitored by CCTV. Twelve cells at Ystrad Mynach and six at Newport Central were covered by life signs monitors which detected if a detainee was not showing signs of consciousness. At Ystrad Mynach custody staff told us that the alarm system sounded incorrectly and gave false readings. All staff carried ligature knives at Ystrad Mynach but on one shift at Newport Central, CDOs did not carry ligature knives and they were located in a drawer.

4.19 We were told at Newport Central that a handover was conducted between custody sergeants. We observed an effective handover between sergeants at Ystrad Mynach which focussed on the most vulnerable detainees and any outstanding tasks. Following the handover, the incoming custody sergeants visited all the cells to introduce themselves to detainees. Custody records showed examples of observation levels being reviewed and changed at handovers. It was unclear why detention officers did not participate in handovers.

4.20 The custody record system incorporated a pre-release risk assessment prompt, to which custody sergeants had to respond before the record could be closed. Insufficient attention was given to preparation for release. Staff did not ask those well known to them where they were going and how they would get there, occasionally entering 'no issues' on NSPIS without asking any questions. On the other hand, there was good attention to practical need in some cases: we saw a sergeant asking a detainee how he was going to get home and, when releasing older people or those with medical issues, sergeants checked that there was someone at home to receive them. There was no written information for detainees on support available to them after release (see main recommendation 2.24).

4.21 Many of the pre-release risk assessments in our analysis of custody records stated 'no risks identified', although there was evidence in some cases that risk was taken into account. Four detainees were taken home by police officers and in two cases, where the arrest had been related to domestic violence, the victims were given 'safety interviews' and detainees were told to stay away from the victim's address.

Recommendation

4.22 Handovers should be comprehensive and attended by detention officers and police custody staff.

Housekeeping points

4.23 Pre-release leaflets should be available in a range of languages.

4.24 Cell visits, including observations and rousals, should take place as set out in the care plan, and be recorded.

4.25 Each CDO should carry a ligature knife.

Use of force

4.26 In our prisoner survey, 74% of detainees said that their handcuffs had been removed on arrival at the custody suite. Our observations confirmed this. At Ystrad Mynach a sign in the holding area stated: 'officers do not remove handcuffs in holding area'. The custody sergeants explained that arresting officers had not searched detainees effectively in the past and weapons and other paraphernalia had been found at the custody desk. Despite this notice, not all detainees were brought into the custody suite at Ystrad Mynach in handcuffs. At Newport Central, detainees were asked at the desk why handcuffs had been used and if they had any injuries.

4.27 Staff recorded the use of force on custody records and a use of force form which was submitted to the custody inspector. Information on use of force in custody suites was not collated at a local or force-wide level. We were told that if force was used in the custody area, a detainee was seen by a health care professional shortly afterwards. All staff had been trained in approved safety techniques and received annual refresher training.

4.28 Data supplied by the force showed that strip-searching had been authorised 519 times between October 2011 and March 2012. Analysis of custody records showed that one female detainee had had her clothes removed for a strip-search after she had disclosed previous self-harm attempts and concealed items while in custody. The detainee had been provided with an anti-rip suit and placed in a CCTV cell.

Recommendation

4.29 Gwent police service should collate use of force data in accordance with the Association of Chief Police Officers' policy and National Policing Improvement Agency guidance.

Housekeeping point

4.30 Detainees should only be handcuffed in holding areas when a risk assessment indicates it is necessary for the safety of staff and other detainees.

Physical conditions

4.31 The cells at Ystrad Mynach were clean and well maintained and largely free of graffiti. The cells were thoroughly cleaned at least twice a day by cleaners who attended the custody suite every morning and afternoon. A cleaning schedule outside each cell recorded when it was last cleaned, and any repairs or specialist cleaning required. The cells were temperate during the inspection, but custody sergeants told us they could not control the cell temperatures which could be excessively hot or cold.

4.32 The cells at Newport Central would have benefited from a deep clean. Paint was chipping from the floor in some cells and communal areas, and there was considerable graffiti in the cells. The corridors leading to the cells were ingrained with dirt. Cleaners attended the suite daily. Toilets, washbasins and showers were clean and tidy at both sites. There were ligature points in cells at both custody suites, including sinks in some cells at Ystrad Mynach, the floor drains at Newport Central and ventilation grilles and benches.

4.33 Monthly risk assessment meetings at each of the suites included an inspection of the physical conditions with appropriate action taken.

4.34 The custody area was generally well managed and non-custody staff were not permitted behind the desk unless authorised by a custody sergeant. At Newport Central, one of the custody sergeants tried to keep the number of non-custody staff in the booking area to a minimum. We observed cell keys at both suites being handed over to non-custody staff so that they could have access to detainees, which was not appropriate.

4.35 The use of cell call bells was explained to all detainees who were in custody for the first time at Newport Central and we observed the custody sergeant explaining to detainees how and when to use the bell. At Ystrad Mynach custody staff told us they explained the use of the cell call bell if it was a detainee's first time in custody and we saw staff responding promptly to cell call bells. At Newport Central the cell call bell panel rang behind the custody desk but was barely audible. The panel light identified the cell bell but we observed detention officers walking past the lit panel. On several occasions, the custody sergeants had to ask a CDO, who was located in a back office, to respond to the bell.

4.36 A fire evacuation policy was displayed in both booking-in areas. There had been two fire evacuation exercises in the previous 12 months and all custody staff were well versed in the fire evacuation plans. Sets of handcuffs were available at both custody suites. Smoking was not permitted in the custody suites.

Recommendation

4.37 Custody staff should ensure that non-custodial staff do not visit detainees in cells unsupervised.

Housekeeping points

4.38 All detainees should be told how to use the cell call bell.

4.39 Custody staff should respond promptly to cell call bells.

4.40 Each cell contained a mattress, but it was not wiped between uses. Pillows were not issued; extra blankets were distributed instead for detainees to use as pillows. We found a good stock of clean blankets. All cells except the dry cells had toilets and handwashing facilities. Toilet paper was available only on request. The toilet area was obscured on the CCTV images of the cells at Ystrad Mynach. At Newport Central the only cell with a toilet in it was not pixellated on CCTV, which was inappropriate.

4.41 Showers were clean and private and cotton towels were provided. Our analysis of custody records showed that no detainees had a shower, although they had been in custody for up to 34 hours. Custody staff at both suites told us that they would offer showers to detainees who had been held overnight.

4.42 Hygiene items such as toothpaste and razors were available. A variety of sanitary products were available for women but female detainees were not routinely offered a hygiene pack.

4.43 There were stocks of replacement clothing, including paper suits, tracksuits and plimsolls, but no replacement underwear. We observed some detainees wearing paper suits which were issued if detainees did not want to have waist cords cut out of their clothes. Tracksuits and plimsolls were only provided to detainees if their clothes had been taken for evidence purposes. Family and friends could bring in clothing for immigration detainees and we observed this happening at Newport Central. Detainees in paper suits had their clothes put on the floor outside their cell door which was not appropriate, particularly at Newport Central where the floors needed deep cleaning.

4.44 There was evidence in custody records that detainees were given meals whenever they requested them. In our survey, 88% of detainees said they had been offered something to eat. Both custody suites used ambient microwave meals, with a good range of vegetarian and halal options. Cereal and milk were available throughout the day. The kitchen at Ystrad Mynach was large and clean and all microwave meals were in date. There were two food probes, but the temperature log book had not been completed since 2011. At Newport Central an old staff canteen on the first floor was used to prepare meals for detainees, with a lift to convey them down to the custody suite. The ambient microwave meals were low in calories and custody sergeants were flexible in the number of microwave meals they offered. A small quantity of petty cash was available to custody sergeants to buy food for detainees who were spending long periods in the custody suite or whose dietary needs could not be adequately met.

4.45 Hot and cold drinks were provided to detainees and meals were served outside recognised mealtimes. At Newport Central, the wife of a Ugandan immigration detainee was able to bring in a meal for him.

4.46 There was an exercise yard at each of the custody suites, covered by CCTV, and detainees were left unsupervised in the yards. During the inspection, good use was made of the exercise yard, particularly for a recalled prisoner at Newport Central. In our survey, 22% of detainees said they were offered a period of outside exercise against the comparator of 6%.

4.47 The custody suites contained very little reading material for detainees and staff brought in newspapers for them. Visits from family members were not encouraged because of the lack of visiting facilities. However, at Newport Central an immigration detainee who was due to be transferred to an immigration removal centre was allowed some time with his wife and child in one of the interview rooms. This was supervised by staff who managed the situation well.

Recommendations

4.48 All detainees held overnight should be offered a shower.

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

Housekeeping points

4.50 Pillows should be provided routinely and mattresses should always be wiped down between uses.

4.51 Toilet paper should be routinely provided in each cell.

4.52 Hygiene packs should be routinely offered to female detainees.

4.53 Replacement underwear should be available at all suites.

4.54 Suitable reading material should be made available for a range of detainees, including young people, detainees whose first language is not English and detainees with limited literacy skills.

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 In the cases that we observed, the period of detention was no longer than necessary. When booking in detainees, custody detention officers (CDOs) established the reasons and necessity before granting authority to detain. Legal representatives whom we spoke to suggested that some of their clients could have been dealt with in a different way, such as voluntary attendance. They also felt the processing of their clients was slow. We were informed that the use of voluntary attendance was increasing at Ystrad Mynach, but it remained underdeveloped at Newport Central. We spoke to several operational officers and found that their knowledge of the `necessity test` for arrest was sketchy; many said that the Gwent police policy to arrest on all occasions allowed them no discretion in cases of domestic abuse allegations. All police officers whom we spoke to were in full agreement with the gravity with which the force viewed domestic abuse allegations. However, many officers suggested that some incidents should be dealt with by voluntary attendance, as the need to arrest was not always present.

5.2 We saw several immigration detainees at Ystrad Mynach, and, although we were informed that it was not uncommon for these detainees to be held at the station for two to three days, officers from the UK Border Agency were present and expediting the process throughout most of the inspection period. Across the Gwent police area, 42 immigration detainees were held between January and March 2012. We did not see any notices promoting the Immigration Legal Service Commission's Police Station Advice helpline.

5.3 Staff assured us that the custody suite was never used as a place of safety for children under section 46 of the Children Act 1989. Staff said that they contacted social services to confirm the availability of secure Police and Criminal Evidence Act (PACE) beds for young people held overnight who could not be bailed, although they were not aware of these beds ever being used.

5.4 The force adhered to the PACE definition of a child (as a person under 17) instead of the Children Act definition, which meant that those aged 17 were not given an appropriate adult unless deemed vulnerable. Appropriate adult arrangements during office hours for detainees aged under 17 were very good, usually through liaison with the local youth offending team. However, we were told that provision was poor outside these times when the local authority social services emergency duty team was contacted.

5.5 There were six juveniles in our sample of custody records, all of whom had had their rights re-read to them in the presence of an appropriate adult. In some cases, there were delays in contacting appropriate adults. For example, at Newport Central, one young woman arrived into custody at 1.11am and at 9.09am she asked for her father to act as an appropriate adult. No attempt had been made to contact her father until 10.38am, when he was found to be unavailable. An external appropriate adult arrived at the custody suite at 2.05pm.

5.6 Arrangements for vulnerable adults were described as patchy, particularly when the emergency duty team of the relevant social services department had to be relied on.

5.7 A leaflet explaining detainees' rights in relation to PACE was available in different languages from the force's intranet for detainees who could not speak English. Telephone interpretation was used, although the process was cumbersome as there was no telephone with two handsets on the booking-in desks.

Recommendations

5.8 Gwent police should further develop and promote alternative-to-custody approaches and custody officers should ensure that the 'necessity test' for arrest is properly used.

5.9 Gwent police should engage with the local authority to ensure the provision of secure beds for juveniles who have been charged but cannot be bailed to appear in court.

5.10 A two-way telephone handset should be provided to aid interpretation.

Housekeeping point

5.11 Notices promoting the Immigration Legal Service Commission's Police Station Advice helpline should be prominently displayed and immigration detainees encouraged to use it.

Rights relating to PACE

5.12 A legal rights poster was prominently displayed at Newport Central, but not at Ystrad Mynach. Detainees' rights to free legal representation were clearly explained to them. Private consultation rooms were available at both suites for detainees to speak to legal representatives but there was no provision for detainees to speak to their legal representative in private on the telephone; they had to do this at the booking-in desk. Detainees who refused the offer of legal advice were asked the reason and this was noted in the custody record, although in our analysis of custody records the reason was usually recorded as 'none given`. Detainees were reminded that they could change their mind at any time and we observed this in practice. In our survey, 67% of detainees said that they had been informed of their rights against the comparator of 81%.

5.13 There were sufficient interview rooms at both suites, although we were told that delays could occur at very busy times. The interview rooms at Newport Central were very hot and there were long- standing problems with the air conditioning.

5.14 Legal representatives described a professional relationship with the police, with mutual understanding of respective roles. They were of the opinion that PACE issues were generally applied efficiently and fairly. Copies of client custody records were seen to be routinely printed out and offered to legal representatives.

5.15 Detainees were advised that someone could be informed that they were at the police station. In our analysis of records, just eight detainees exercised this right and there was evidence that this had been successfully achieved in only five cases. In two cases, the named person had been unavailable and there was no evidence of further attempts or of the detainee being asked for an alternative person. In the third case, there was no evidence of any attempt to contact the named person.

5.16 With the exception of immigration detainees, no detainees were seen to make a telephone call, or to be offered one. However, our analysis indicated that 10% of detainees had made a

telephone call while in custody and, in our survey, 32% said they had been offered a free telephone call against the comparator of 50%. All detainees were offered the opportunity to consult the PACE codes of practice and several copies of the code were seen at each suite. Detainees were not routinely provided with a 'notice of rights and entitlements'.

5.17 Our observations and analysis indicated that most inspector reviews of detention were carried out in line with statutory requirements and timeframes and were usually conducted in person. If the detainee was asleep at the time of the review, the detainee was informed once awake.

5.18 DNA and forensic samples in custody were well managed. However, the freezers used for DNA samples were also full of older forensic samples, creating a risk that the two types could be mixed up.

5.19 Court cut-off times were said to be extremely variable. Custody staff told us that at times it could be difficult to get someone before the court as early as 11am on a weekday or 10am on Saturdays. However, during the inspection we saw a detainee taken to court by police officers at 2.20pm and he was accepted.

Recommendation

5.20 The force should liaise with the courts managers to ensure that court cut-off times are suitably flexible.

Housekeeping points

5.21 Legal advice posters should be suitably placed in custody suites.

5.22 Detainees should be able to consult their legal representative in private on the telephone.

5.23 If detainees exercise their right to have someone informed of their detention, Gwent police should, subject to lawful provision, expedite this right, and record unsuccessful attempts. Detainees should be given the opportunity to nominate an alternative person.

Rights relating to treatment

5.24 Arrangements for making complaints were reasonable, although there were no notices displayed explaining how to make a complaint, and in our survey interviews one man said he had wanted to make a complaint but had not known how. If a detainee raised a complaint, custody staff informed the duty inspector who tried to take the complaint while the detainee was in 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 The force had good partnerships with health agencies, but more work was needed to ensure sufficient medical cover at all times.

6.2 Gwent Police directly employed custody nurses and retained forensic medical examiners (FMEs) to provide 24-hour cover. In the months prior to the inspection, the nurses' complement had been maintained by the use of agency staff to cover sickness and vacancies, but new staff had been recruited and were due to start employment. The rota provided one nurse to each shift team of police officers, with a lead nurse who tried to cover some gaps in the rota as well as manage the team. This model seemed to work well: both custody staff and nurses we spoke to talked of the good working relationships they had.

6.3 There were seven FMEs, most of whom were also GPs; one of them took the lead role and organised the rota. However, there were several gaps in the rota resulting in no doctor being available to the force for 12 hours or more.

6.4 The nurses had group clinical supervision, team meetings and appraisals, but the doctors did not.

6.5 Clinical governance meetings had been set up by the force and included partner organisations such as the local ambulance service, fire service and various police departments, but the lead FME was not a member of the group.

6.6 Both the clinical rooms were of a reasonable size and design, with relevant equipment. There were resuscitation kits including automated external defibrillators, oxygen and suction. Checks of equipment, medications and other stocks were made daily and recorded on a daily work sheet, which was an effective system. Staff were appropriately trained in first aid and defibrillation. Each cell had a pocket mask above the door, so that resuscitation could be started immediately if required; this was a simple but effective initiative.

Recommendations

6.7 If at any time a health professional is not available to attend a suite, this should be reported as a 'near-miss' incident, in accordance with force policy.

6.8 Clinical governance arrangements should include all health professionals.

Good practice

6.9 *The pocket masks stuck to the wall above each cell door was an effective initiative which meant that anybody could commence safe resuscitation immediately if required.*

Patient care

6.10 Detainees were asked on arrival and during sergeant checks whether they wanted to see a health care professional. In our survey, 40% were seen by either a doctor or a nurse. The nurses worked between the two suites, and monitored the use of the suites and the potential for them to be needed by means of the electronic white board. Nurses also contacted each other at shift handover times to ensure continuity of care. Waiting times to see a health care officer were difficult to calculate, but appeared to be short; the longest wait was almost five hours for a detainee who was heavily intoxicated on arrival in custody. The remaining waiting times all appeared to be less than one hour forty-five minutes. We did not hear of any significant delays in detainees seeing a health care professional, although we were told of instances when neither a nurse nor a doctor was available for detainees, resulting in police officers having to take detainees to local hospitals for assessment and treatment. This was clearly a drain on police resources. We witnessed some good patient assessments and nurses' clinical records were clear.

6.11 Nurses used pro forma for their clinical records. The form included a space to indicate that patient consent for the sharing of information had been sought. The forms were left in the clinical rooms in a locked drawer for a month before being collected and stored elsewhere, in line with data protection and Caldicott guidelines. This meant that if a detainee was seen more than once, their previous assessment could be referred to. By contrast, FMEs used their own notebooks to record their clinical interventions, which they then took away with them, giving the force no assurance that the notes were stored appropriately and no way for other health professionals to refer to them if required.

6.12 Both nurses and doctors used NSPIS to record summary health information for the custody staff.

6.13 A reasonable range of medications were held at each suite. There were no patient group directions in place, so nurses contacted an FME by telephone for medication to be prescribed whenever a detainee required it. Such telephone messages were not followed up in writing, leaving the nurses vulnerable and potentially in breach of Nursing & Midwifery Council standards. This was unacceptable. We found an example in our analysis of custody records where seven FMEs were contacted to no avail and the detainee was taken to hospital to have medications prescribed.

6.14 Medications were recorded on a separate medication administration chart; those that we reviewed were reasonable.

6.15 Five (17%) detainees in our sample reported being on medication on arrival in custody. Three of these detainees were seen by a health care professional and the other detainees were all held in custody for under six hours. There were several examples of police officers making trips to detainees' addresses to collect medication or contacting family members to have medication brought into custody. There was one example of a detainee who required his medication at a particular time. Staff made efforts to collect this medication from his home address but he had run out. No further attempts were made to provide him with medication and he was not released from custody until five hours later. We were also concerned to note that, even if a detainee was on a known drugs maintenance programme that could be verified, methadone was not given in custody.

Recommendations

6.16 All clinical records should be stored in line with the Data Protection Act and Caldicott guidelines.

6.17 All medications should be administered against a patient group direction or prescription that meets the standards of professional bodies.

6.18 Detainees should be able to continue any prescribed course of medication while in custody.

Substance use

6.19 Crime Reduction Initiative (CRI) provided substance misuse services. A drug and alcohol arrest referral worker was based in each suite from 8am to 6pm, Monday to Friday, and 8am to noon at weekends. At other times the police obtained the detainees' consent to refer them to services. In our survey, 43% of detainees said they had a drug or alcohol problem while in custody, and 24% of these saw a worker.

6.20 The workers saw adult detainees for drugs and alcohol issues. They undertook an initial assessment, brief intervention work and harm minimisation in the custody suite. They also referred detainees to prison drug services when needed. Workers saw young people if they had an appropriate adult with them and signposted them to relevant services.

6.21 CRI staff had access to their own database, so could easily identify if detainees were already engaged with services. In the previous quarter a total of 718 detainees had undergone a drug test in custody, of whom 174 had tested positive (24%). Of these, 91 were already engaged with substance misuse services and a further 51 were taken in to services. During the previous two months, 38 people had been referred to alcohol services, while a further 94 had accepted advice from a worker when in custody.

6.22 Needle exchange was not available in custody.

Recommendation

6.23 All detainees should be offered the services of a drugs/alcohol worker.

Housekeeping point

6.24 Needle exchange should be available to detainees leaving custody if required.

Mental health

6.25 The force had a longstanding relationship with the Aneurin Bevan Health Board, which resulted in strong links with the police in a number of areas, including multi-agency public protection arrangements, public protection and a joint homicide policy. The Board had a well established court liaison service staffed by forensic health practitioners. Custody nurses could fax

information to the team about any detainee they were concerned about, and if requested the team visited custody, although this was exceptional.

6.26 Custody staff said it was possible to get a mental health assessment conducted in custody if necessary, although there were often delays in getting an approved mental health practitioner (social worker) to attend depending on the time of day/night.

6.27 There was just one section 136 Mental Health Act suite in the force area, as one had closed a few months prior to the inspection. The force had an excellent system for collating information about detainees detained under section 136 regardless of where they were taken. The data could be analysed in a number of ways to establish patterns and trends of use. It also included systems to 'flag' individuals who had been detained more than three times. In these instances, the sergeant who monitored the data contacted the Health Board directly to ensure that the individual was receiving appropriate care and treatment. The database was populated using data completed by the arresting officers and health professionals. The forms were reviewed by a custody inspector and, if it was deemed that section 136 had been used inappropriately, the officer's line manager was informed.

6.28 The section 136 suite was only able to take one person at a time: staff there told us that sometimes the police arrived without informing them and the suite was already in use. This was concerning. The Health Board had a 'red flag' system to identify warning markers about some patients. This was a source of frustration to the custody staff who saw it as a barrier to the detainee being accepted by the unit, but health staff told us that it was a way of maintaining the safety of other patients and staff. In 2011 there had been a total of 272 section 136 detentions, of which 10% were detained more than once. Of these, 54% had been taken to police custody. During the year to date, 174 people had been detained, of whom 56% had been taken in to police custody.

6.29 There were well attended section 136 steering and monitoring meetings which were used to consider the data and any incidents where learning could be shared.

6.30 Some custody staff had received mental health training, but most felt that they needed more. The court liaison team delivered a one-day training package to probation staff, but had not been asked to provide it to police staff for some time.

Recommendations

6.31 Police custody should not be used as a place of safety for section 136 Mental Health Act assessments.

6.32 All police officers should receive regular refresher training on mental health issues.

Housekeeping point

6.33 The Health Board's 'red flag' system should be understood by custody staff.

Good practice

6.34 *The section 136 database was impressive. It gave an overview across both custody and health, and could be used to monitor trends and identify individuals who were detained*

repeatedly so that their care could be assessed or reviewed. It was an exemplar to other forces.

7. Summary of recommendations

Main recommendations

7.1 There should be a forensic medical examiner on call at all times, who should ensure that correct prescribing practice is followed. (2.23)

7.2 Pre-release risk assessment of detainees should consider all known risk factors and staff should take appropriate action to manage and mitigate the risks. (2.24)

National issue

7.3 Appropriate adults should be available at all times to support without undue delay detained juveniles aged 17, provided that informed consent has been given. (2.25)

Recommendations

Strategy

7.4 The force should cross reference custody record dip sampling to CCTV checking and monitor handovers as part of its quality assurance regime. (3.17)

Treatment and conditions

7.5 Booking-in desks should allow effective and private communication between custody staff and detainees. (4.10)

7.6 Handovers should be comprehensive and attended by detention officers and police custody staff. (4.22)

7.7 Gwent police service should collate use of force data in accordance with the Association of Chief Police Officers' policy and National Policing Improvement Agency guidance. (4.29)

7.8 Custody staff should ensure that non-custodial staff do not visit detainees in cells unsupervised. (4.37)

7.9 All detainees held overnight should be offered a shower. (4.48)

7.10 Replacement clothes rather than paper suits should be given to detainees to wear when their clothes are removed. (4.49)

Individual rights

7.11 Gwent Police should further develop and promote alternative-to-custody approaches and custody officers should ensure that the 'necessity test' for arrest is properly used. (5.8)

7.12 Gwent Police should engage with the local authority to ensure the provision of secure beds for juveniles who have been charged but cannot be bailed to appear in court. (5.9)

7.13 A two-way telephone handset should be provided to aid interpretation. (5.10)

7.14 The force should liaise with the courts managers to ensure that court cut-off times are suitably flexible. (5.20)

Health care

7.15 If at any time a health professional is not available to attend a suite, this should be reported as a 'near-miss' incident, in accordance with force policy. (6.7)

7.16 Clinical governance arrangements should include all health professionals. (6.8)

7.17 All clinical records should be stored in line with the Data Protection Act and Caldicott guidelines. (6.16)

7.18 All medications should be administered against a patient group direction or prescription that meets the standards of professional bodies. (6.17)

7.19 Detainees should be able to continue any prescribed course of medication while in custody. (6.18)

7.20 All detainees should be offered the services of a drugs/alcohol worker. (6.23)

7.21 Police custody should not be used as a place of safety for section 136 Mental Health Act assessments. (6.31)

7.22 All police officers should receive regular refresher training on mental health issues. (6.32)

Housekeeping points

Strategy

7.23 At Newport Central, the work of CDOs should be clarified and supervised to ensure consistently safe and decent treatment of detainees. (3.7)

7.24 The force should introduce a forum for custody practitioners and managers to discuss custody issues. (3.8)

Treatment and conditions

7.25 A hearing loop should be available in the booking-in area and all custody staff should know how to use it. (4.11)

7.26 All detainees should be asked if they have dependency obligations and given the opportunity to make arrangements accordingly. (4.12)

7.27 Pre-release leaflets should be available in a range of languages. (4.23)

7.28 Cell visits, including observations and rousals, should take place as set out in the care plan, and be recorded. (4.24)

7.29 Each CDO should carry a ligature knife. (4.25)

7.30 Detainees should only be handcuffed in holding areas when a risk assessment indicates it is necessary for the safety of staff and other detainees. (4.30)

7.31 All detainees should be told how to use the cell call bell. (4.38)

7.32 Custody staff should respond promptly to cell call bells. (4.39)

7.33 Pillows should be provided routinely and mattresses should always be wiped down between uses. (4.50)

7.34 Toilet paper should be routinely provided in each cell. (4.51)

7.35 Hygiene packs should be routinely offered to female detainees. (4.52)

7.36 Replacement underwear should be available at all suites. (4.53)

7.37 Suitable reading material should be made available for a range of detainees, including young people, detainees whose first language is not English and detainees with limited literacy skills. (4.54)

Individual rights

7.38 Notices promoting the Immigration Legal Service Commission's Police Station Advice helpline should be prominently displayed and immigration detainees encouraged to use it. (5.11)

7.39 Legal advice posters should be suitably placed in custody suites. (5.21)

7.40 Detainees should be able to consult their legal representative in private on the telephone. (5.22)

7.41 If detainees exercise their right to have someone informed of their detention, Gwent Police should, subject to lawful provision, expedite this right, and record unsuccessful attempts. Detainees should be given the opportunity to nominate an alternative person. (5.23)

Health care

7.42 Needle exchange should be available to detainees leaving custody if required. (6.24)

7.43 The Health Board's 'red flag' system should be understood by custody staff. (6.33)

Good practice

Strategy

7.44 Effective analysis of the near-miss information produced useful management information to identify trends, which was available to all custody staff. (3.18)

Health care

7.45 The pocket masks stuck to the wall above each cell door was an effective initiative which meant that anybody could commence safe resuscitation immediately if required. (6.9)

7.46 The section 136 database was impressive. It gave an overview across both custody and health, and could be used to monitor trends and identify individuals who were detained repeatedly so that their care could be assessed or reviewed. It was an exemplar to other forces. (6.34)

Appendix I: Inspection team

Martin Kettle	HMIP team leader
Gary Boughen	HMIP inspector
Vinnett Pearcy	HMIP inspector
Paul Davies	HMIC inspector
Mark Ewan	HMIC inspector
Elizabeth Tysoe	HMIP health care inspector
Rachel Murray	HMIP researcher

Appendix II: Summary of detainee questionnaires and interviews

Prisoner survey methodology

A voluntary, confidential and anonymous survey of the prisoner population, who had been through a police station in the borough of Gwent, 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 6 September 2012. A list of potential respondents to have passed through Newport Central or Ystrad Mynach police stations was created, listing all those who had arrived from Abergavenny or Newport Central courts within the past two months. [4]

Selecting the sample

In total 57 respondents were approached. Thirteen respondents reported either being held in police stations outside Gwent and one could speak no English and so it was impossible to determine the police station they had been in. On the day, the questionnaire was offered to 43 respondents; there was one refusal, one questionnaire was not returned and one was returned blank. All of those sampled had been in custody within the last three months.

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

Methodology

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

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

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

Response rates

In total, 40 (93%) of respondents completed and returned their questionnaires.

[4] Researchers routinely select a sample of prisoners held in police custody suites within the last 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.

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 57 police areas since April 2008.

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

Summary

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

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

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

Survey results

Section 1: About you

Q2 **Which police station were you last held at?**
Newport Central (29), Ystrad Mynach (11)

Q3 **How old are you?**

16 years or younger	0 (0%)	*40-49 years*	4 (10%)
17-21 years	11 (28%)	*50-59 years*	1 (3%)
22-29 years	12 (30%)	*60 years or older*	0 (0%)
30-39 years	12 (30%)		

Q4 **Are you:**

Male	40 (100%)
Female	0 (0%)
Transgender/Transsexual	0 (0%)

Q5 **What is your ethnic origin?**

White - British	36 (92%)
White - Irish	0 (0%)
White - other	0 (0%)
Black or black British - Caribbean	0 (0%)
Black or black British - African	0 (0%)
Black or black British - other	0 (0%)
Asian or Asian British - Indian	0 (0%)
Asian or Asian British - Pakistani	2 (5%)
Asian or Asian British - Bangladeshi	0 (0%)
Asian or Asian British - other	1 (3%)
Mixed heritage - white and black Caribbean	0 (0%)
Mixed heritage - white and black African	0 (0%)
Mixed heritage- white and Asian	0 (0%)
Mixed heritage - Other	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	3 (8%)
No	33 (92%)

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

None	21 (54%)
Church of England	9 (23%)
Catholic	4 (10%)
Protestant	0 (0%)
Other Christian denomination	2 (5%)
Buddhist	0 (0%)
Hindu	0 (0%)
Jewish	0 (0%)
Muslim	3 (8%)
Sikh	0 (0%)

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

Straight/heterosexual	38 (97%)
Gay/lesbian/homosexual	0 (0%)
Bisexual	1 (3%)

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

Yes	10 (26%)
No	28 (74%)

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

Yes	34 (89%)
No	4 (11%)

Section 2: Your experience of the police custody suite

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

Less than 24 hours	9 (23%)
More than 24 hours, but less than 48 hours (2 days)	11 (28%)
More than 48 hours (2 days), but less than 72 hours (3 days)	12 (31%)
72 hours (3 days) or more	7 (18%)

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

Yes	26 (67%)
No	10 (26%)
Don't know/can't remember	3 (8%)

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

Yes	15 (38%)
No	19 (49%)
I don't know what this is/I don't remember	5 (13%)

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

My clothes were not taken	19 (50%)
I was offered a tracksuit to wear	5 (13%)
I was offered an evidence/paper suit to wear	7 (18%)
*I was **only** offered a blanket*	5 (13%)
Nothing	2 (5%)

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

Yes	32 (82%)
No	6 (15%)
Don't know	1 (3%)

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

Yes	9 (24%)
No	28 (76%)

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

	Good	*Neither*	*Bad*
Cleanliness	7 (18%)	14 (36%)	18 (46%)
Ventilation/air quality	7 (19%)	5 (14%)	24 (67%)
Temperature	6 (16%)	5 (14%)	26 (70%)
Lighting	8 (22%)	11 (30%)	18 (49%)

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

Yes	27 (68%)
No	13 (33%)

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

Yes	5 (13%)
No	34 (87%)

Q20 **Were you held overnight?**

Yes	37 (95%)

No 2 (5%)

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

Not held overnight 2 (5%)
Pillow 4 (11%)
Blanket 24 (65%)
Nothing 10 (27%)

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

Not held overnight/did not get any bedding 12 (34%)
Yes 9 (26%)
No 14 (40%)

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

Yes 3 (8%)
No 36 (92%)

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

Yes 9 (23%)
No 30 (77%)

Q25 **Were you offered anything to:**

	Yes	*No*
Eat?	34 (87%)	5 (13%)
Drink?	26 (70%)	11 (30%)

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

Very good	*Good*	*Neither*	*Bad*	*Very bad*	*N/A*
0 (0%)	2 (5%)	0 (0%)	10 (27%)	21 (57%)	4 (11%)

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

I did not have any food or drink 4 (11%)
Yes 8 (23%)
No 23 (66%)

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 2 (5%)
I was allowed to smoke 0 (0%)
I was offered a nicotine substitute 1 (3%)
I was not offered anything to cope with not smoking 36 (92%)

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

Yes 2 (5%)
No 37 (95%)

Q30 **Was someone informed of your arrest?**

Yes 20 (50%)
No 10 (25%)
I don't know 5 (13%)
I didn't want to inform anyone 5 (13%)

Q31 **Were you offered a free telephone call?**

Yes 13 (33%)
No 27 (68%)

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

My telephone call was not denied 15 (38%)
Yes 2 (5%)

No 22 (56%)

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%)	26 (81%)
Contacting your partner, relative or friend	22 (65%)	12 (35%)
Contacting your employer	5 (18%)	23 (82%)
Where you were going once released	10 (34%)	19 (66%)

Q34 **Were you offered free legal advice?**

Yes 34 (87%)
No 5 (13%)

Q35 **Did you accept the offer of free legal advice?**

Was not offered free legal advice 5 (14%)
Yes 20 (57%)
No 10 (29%)

Q36 **Were you interviewed by police about your case?**

Yes 34 (87%)
No 5 (13%)

Q37 **Was a solicitor present when you were interviewed?**

Did not ask for a solicitor/was not interviewed 6 (16%)
Yes 29 (76%)
No 3 (8%)

Q38 **Was an appropriate adult present when you were interviewed?**

Did not need an appropriate adult/was not interviewed 23 (62%)
Yes 5 (14%)
No 9 (24%)

Q39 **Was an interpreter present when you were interviewed?**

Did not need an interpreter/was not interviewed 23 (64%)
Yes 1 (3%)
No 12 (33%)

Section 3: Safety

Q41 **Did you feel safe there?**

Yes 20 (50%)
No 20 (50%)

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

Yes 20 (51%)
No 19 (49%)

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

I have not been victimised	19 (49%)	*Because of your crime*	9 (23%)
Insulting remarks (about you, your family or friends) .	13 (33%)	*Because of your sexuality*.	0 (0%)
Physical abuse (being hit, kicked or assaulted)	9 (23%)	*Because you have a disability*.....	0 (0%)
Sexual abuse.....	0 (0%)	*Because of your religion/religious beliefs*.....	0 (0%)

Your race or ethnic origin ...	2 (5%)	*Because you are from a different part of the country than others*.....	2 (5%)
Drugs	6 (15%)		

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

Yes	23 (59%)
No	8 (21%)
I wasn't handcuffed	8 (21%)

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

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

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

Yes	8 (21%)
No	31 (79%)

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

Yes	2 (5%)
No	36 (95%)

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

Very well	*Well*	*Neither*	*Badly*	*Very badly*	*Don't remember*
1 (3%)	7 (19%)	8 (22%)	10 (27%)	9 (24%)	2 (5%)

Section 4: Health care

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

Yes	11 (29%)
No	25 (66%)
Don't know	2 (5%)

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

	Yes	*No*
Doctor	8 (24%)	25 (76%)
Nurse	13 (37%)	22 (63%)
Paramedic	1 (4%)	25 (96%)

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

Yes	5 (14%)
No	21 (57%)
Don't know	11 (30%)

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

Yes	17 (45%)
No	21 (55%)

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

Not taking medication	21 (55%)
Yes	5 (13%)
No	12 (32%)

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

Yes	17 (44%)

No 22 (56%)

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 22 (56%)
Yes 4 (10%)
No 13 (33%)

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

I didn't have any drug/alcohol problems 22 (56%)
Yes 4 (10%)
No 13 (33%)

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%)	3 (8%)	5 (14%)	4 (11%)	3 (8%)

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

Yes 12 (32%)
No 25 (68%)

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

Yes 11 (29%)
No 27 (71%)

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 27 (71%)
Yes 1 (3%)
No 10 (26%)

Prisoner survey responses for Gwent police custody 2012

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

Key to tables

		Gwnt police custody	Police custody comparator
	Any percentage highlighted in green is significantly better		
	Any percentage highlighted in blue is significantly worse		
	Any percentage highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
Number of completed questionnaires returned		40	2076
SECTION 1: General information			
3	Are you under 21 years of age?	**28%**	**10%**
4	Are you transgender/transsexual?	**0%**	**0%**
5	Are you from a minority ethnic group (including all those who did not tick white British, white Irish or white other categories)?	**8%**	**30%**
6	Are you a foreign national?	**9%**	**15%**
7	Are you Muslim?	**8%**	**10%**
8	Are you homosexual/gay or bisexual?	**2%**	**2%**
9	Do you consider yourself to have a disability?	**27%**	**19%**
10	Have you been in police custody before?	**90%**	**92%**
SECTION 2: Your experience of this custody suite			
11	Were you held at the police station for over 24 hours?	**78%**	**68%**
12	Were you told your rights when you first arrived?	**67%**	**81%**
13	Were you told about PACE?	**39%**	**52%**
For those who had their clothing taken away:			
14	Were you given a tracksuit to wear?	**25%**	**41%**
15	Could you use a toilet when you needed to?	**82%**	**91%**
16	If you used the toilet, was toilet paper provided?	**24%**	**48%**
17	Would you rate the condition of your cell, as 'good' for:		
17a	Cleanliness?	**18%**	**34%**
17b	Ventilation/air quality?	**20%**	**23%**
17c	Temperature?	**17%**	**17%**
17d	Lighting?	**22%**	**45%**
18	Was there any graffiti in your cell when you arrived?	**68%**	**54%**
19	Did staff explain the correct use of the cell bell?	**12%**	**23%**
20	Were you held overnight?	**94%**	**92%**
For those who were held overnight:			
21	Were you given any items of bedding?	**71%**	**84%**
For those who were held overnight and were given items of bedding:			
22	Were these clean?	**38%**	**63%**
23	Were you offered a shower?	**8%**	**9%**
24	Were you offered a period of outside exercise?	**22%**	**6%**
25a	Were you offered anything to eat?	**88%**	**81%**
25b	Were you offered anything to drink?	**70%**	**84%**
For those who had food/drink:			
26	Was the quality of the food and drink you received good/very good?	**7%**	**12%**
27	Was the food/drink you received suitable for your dietary requirements?	**26%**	**44%**

Key to tables

		Gewnt police custody	Police custody comparator
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	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?	**2%**	**7%**
29	Were you offered anything to read?	**6%**	**14%**
30	Was someone informed of your arrest?	**50%**	**43%**
31	Were you offered a free telephone call?	**32%**	**50%**
If you were denied a free telephone call:			
32	Was a reason given?	**10%**	**15%**
33	Did you have any concerns about:		
33a	Who was taking care of your children?	**20%**	**14%**
33b	Contacting your partner, relative or friend?	**65%**	**52%**
33c	Contacting your employer?	**17%**	**19%**
33d	Where you were going once released?	**35%**	**31%**
34	Were you offered free legal advice?	**88%**	**89%**
For those who were offered free legal advice:			
35	Did you accept the offer of free legal advice?	**66%**	**70%**
For those who were were interviewed and needed them:			
37	Was a solicitor present when you were interviewed?	**90%**	**80%**
38	Was an appropriate adult present when you were interviewed?	**35%**	**29%**
39	Was an interpreter present when you were interviewed?	**6%**	**14%**
SECTION 3: Safety			
41	Did you feel unsafe?	**50%**	**38%**
42	Has another detainee or a member of staff victimised you?	**51%**	**31%**
43	If you have felt victimised, what did the incident involve?		
43a	Insulting remarks (about you, your family or friends)	**33%**	**15%**
43b	Physical abuse (being hit, kicked or assaulted)	**22%**	**10%**
43c	Sexual abuse	**0%**	**2%**
43d	Your race or ethnic origin	**6%**	**2%**
43e	Drugs	**16%**	**9%**
43f	Because of your crime	**22%**	**11%**
43g	Because of your sexuality	**0%**	**1%**
43h	Because you have a disability	**0%**	**3%**
43i	Because of your religion/religious beliefs	**0%**	**2%**
43j	Because you are from a different part of the country than others	**6%**	**3%**
44	Were your handcuffs removed on arrival at the police station?	**74%**	**74%**
45	Were you restrained whilst in the police custody suite?	**16%**	**19%**
46	Were you injured whilst in police custody, in a way that was not your fault?	**20%**	**23%**
47	Were you told how to make a complaint about your treatment?	**6%**	**13%**
48	Were you treated well/very well by staff in the police custody suite?	**22%**	**37%**

Key to tables

		Gewnt police custody	Police custody comparator
	Any percentage highlighted in green is significantly better		
	Any percentage highlighted in blue is significantly worse		
	Any percentage highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
SECTION 4: Health care			
50	Did someone explain your entitlements to see a health care professional if you needed to?	**29%**	**35%**
51	Were you seen by the following health care professionals during your time in police custody:		
51a	Doctor	**24%**	**44%**
51b	Nurse	**36%**	**20%**
	Percentage seen by either a doctor or a nurse	**40%**	**51%**
51c	Paramedic	**3%**	**4%**
52	Were you able to see a health care professional of your own gender?	**13%**	**26%**
53	Did you need to take any prescribed medication when you were in police custody?	**45%**	**41%**
For those who were on medication:			
54	Were you able to continue taking your medication while in police custody?	**29%**	**34%**
55	Did you have any drug or alcohol problems?	**43%**	**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?	**24%**	**43%**
57	Were you offered relief or medication for your immediate withdrawal symptoms?	**24%**	**25%**
For those who were seen by health care:			
58	Would you rate the quality as good/very good?	**25%**	**30%**
59	Did you have any specific physical health care needs?	**33%**	**32%**
60	Did you have any specific mental health care needs?	**29%**	**24%**
For those who had any mental health care needs:			
61	Were you seen by a mental health nurse/psychiatrist?	**7%**	**15%**