Report on an inspection visit to police custody suites in Merseyside

1 - 5 October 2012

by

HM Inspectorate of Prisons and

HM Inspectorate of Constabulary

Glossary of terms

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Printed and published by:
Her Majesty's Inspectorate of Prisons
Her Majesty's Inspectorate of Constabulary

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Contents

1. Introduction

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

Strategically, the force had a good grip of its custody work, and performance was actively monitored, with the support of active engagement by the Police Authority and the custody visitors. However, the day-to-day management of the suites was less convincing, as some were not sufficiently actively supervised by custody managers, and within the suites sergeants and detention officers did not work sufficiently as a team. Training and communication were effective but quality assurance measures were not fully developed.

Staff were polite and appropriate in their manner with detainees, and competent at handling difficult or disruptive people, but did not in all cases make proper provision for women and young people. The use of handcuffs and physical restraint was kept to a minimum. There was little to support the needs of those with disabilities, and the booking-in process was insufficiently private and sometimes too brief. The organisation of regular observation of those in cells, and of passing information from one shift to the next, was insufficiently systematic. Assessment and support in respect of pre-release needs was patchy.

The suites were generally clean but worn and shabby in appearance, with a large amount of graffiti. Provision of showers, and of food and drink were satisfactory but normal clothing was not issued to those whose own clothes were removed for any reason, so that many were walking around suites in paper suits or rip-proof smocks.

Force policy had moved towards a greater emphasis on detaining only those for whom it was necessary. Detention reviews were timely and in most cases thorough, all those detained had their rights explained, and staff worked to ensure that detainees arrived promptly at court. Those not speaking English well had good access to interpretation, in a confidential setting.

The very busy health care service had improved considerably in the previous year, aided by attention to governance issues and active monitoring of performance. It delivered a good standard of care, although waiting times were still too long in some cases. The health care facilities were in a reasonable condition and medical stock and medications, on the whole, were well controlled. Substance use and mental health services were performing well, and many detainees had been diverted into hospital care.

Altogether, there was a good strategic focus on the force's custody operation, which has borne fruit in areas such as health care and a re-emphasis on arresting only where it is necessary. This focus now needs to be sharpened through more rigorous ground-level attention to treatment and conditions in the suites themselves, including both physical conditions and the response to individual risks and needs. 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.

Thomas Winsor
HM Chief Inspector of Constabulary
December 2012

Nick Hardwick
HM Chief Inspector of Prisons

2. Background and key findings

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

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

2.3 There were five full-time designated custody suites in Merseyside, one part-time suite and two reserve suites, which were used only for special operations and peak dates, with a total cell capacity of 172. All custody suites were visited during the inspection. The force had held 57,537 detainees in 2011, and 358 detainees had been held for immigration matters in the 12 months to the end of August 2012.

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

Custody suite	Number of cells	Custody suite	Number of cells
St Anne Street, Liverpool	33	Southport (open Friday to Monday)	12
Belle Vale, Liverpool	20	Kirkby (special operations only)	9
St Helens	22	Wavertree (special operations only)	20
Wirral	32	Copy Lane, Liverpool	24
		Overall total	172

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

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

Strategy

2.5 There was effective strategic leadership of the custody operation, and the lines of accountability at senior level were clear. Capacity was sufficient, following a reduction in the number of suites, and staffing was adequate, with permanent sergeants and detention officers (DOs), all directly employed. There was insufficient coordination and communication between sergeants and DOs. The assistant chief constable (ACC) responsible for custody took an active lead, with quarterly, monthly and biweekly meetings to monitor and direct progress and performance. At several suites there was no evidence of active day-to-day management by custody managers, and although some staff focus groups had recently been convened, there had been no regular groups to enable staff to contribute to their views.

2.6 Quality assurance of custody records was systematic but not sufficiently detailed, nor linked to closed-circuit television (CCTV) or person escort record (PER) forms. Staff handovers were not quality checked. The force intranet was well suited for communication on custody issues, including policies and Independent Police Complaints Commission (IPCC) resources.

2.7 There was effective partnership working, especially through a monthly inter-agency meeting, and the panel of independent custody visitors (ICVs) was notably active and engaged. The police authority (PA) was also involved in custody policy and practice, with one member taking the lead, and a regular forum with the heads of NHS Trusts in the force area.

2.8 All staff working in custody had received appropriate training. Refresher training had not been delivered but was planned to start for sergeants within the next two months, although not for DOs.

Treatment and conditions

2.9 Staff were generally courteous and positive in dealing with detainees, and at most suites handled agitated or disruptive detainees well. Across all suites, apart from one or two teams, the work of sergeants and DOs was not integrated: each kept to their specific duties. In consequence, there was not always good communication, especially about risks and needs for individual detainees.

2.10 The treatment of juveniles in the suites was generally satisfactory, although pre-release arrangements were often lacking. In almost all suites, female detainees were allocated to a female DO. Preparation for release was sometimes inadequate for women. Staff did not routinely ask whether a detainee had any issues about dependants.

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

2.11 There was very little provision for people with disabilities. No suite had a hearing loop. There were no significant adaptations for those with mobility difficulties, such as low cell call bells. Provision for faith needs was very limited. In many suites the direction of Mecca had previously been displayed in cells but had been painted over. Religious items such as Qur'ans and prayer mats were available at some places, but often not stored respectfully.

2.12 There was insufficient privacy for booking in; when possible, sergeants used booking-in desks that were not next to each other but this did not happen in all cases. All suites had large whiteboards on the public side of the booking-in area, and in several these displayed details of offences and medications. Since Niche (the electronic case management system) provided an electronic whiteboard, this was unnecessary, as well as creating risks.

2.13 Booking-in was reasonably prompt. In some cases sergeants went through the questions on Niche very quickly and mechanically. Our custody record analysis showed that risk assessments sometimes lacked important information, and we found cases where police national computer (PNC) markers were not reflected in the custody record. However, we also saw sergeants probing detainees effectively and sensitively about alcohol or drug problems.

2.14 Arrangements for rousing detainees who had come into custody intoxicated were not clear, although DOs understood the requirements, and in a number of cases observations were late. The whiteboards often did not show the detainees who needed rousing, and the large red R signs were not always used on cell doors. Police officers carrying out constant observation sometimes did not concentrate fully on the task and were not adequately supervised.

2.15 There were no personal-issue anti-ligature knives for staff; each suite had at least one knife, but generally they were used for other purposes, and at two suites the staff did not know where the knife was kept.

2.16 Procedures for shift handover were inadequate, with just an individual sergeant briefing the sergeant who relieved them. DOs did not give a structured handover to those following them. DOs were not always clear on which sergeant was responsible for which detainee, and risk information was often not passed on to those who needed to know it. A useful written handover form was in use.

2.17 Pre-release risk assessments were completed on Niche but in many cases this was only procedural and important information was omitted, although we observed practical assistance given to some vulnerable people on release. There was a lack of information about support agencies, and no travel warrants or cash for bus fares were given; it was rare for police to give a vulnerable detainee a lift home.

2.18 Handcuffs were almost always removed on entry to the custody suite. Use of force was proportionate but was not always recorded on the relevant forms. Strip-searching was not common and was always based on evidence.

2.19 There was considerable graffiti at several suites, some with very inappropriate content. At the Wirral, the public entrance door to the custody suite itself had graffiti. Cleanliness was good in several suites, but in general the physical condition of the suites was shabby. Some van docks were very dirty. Regular cell checks were said to take place but there was almost no recorded evidence of them. We found ligature points in almost all suites.

2.20 Provision of clothing fell short of a decent standard. The practice was to issue paper suits or rip-proof smocks to detainees whose clothes were removed for any reason, including those who did not wish to have the cords cut in tracksuit trousers. Replacement clothing (T-shirts and

tracksuits) was only issued to those who had no other clothing in which to be released. Only rip-proof blankets were available. The provision of showers was better than we often find. Razors were not issued in any suites. The provision of food and drink was satisfactory.

2.21 Some exercise yards were in a poor state. The supply of reading material was inadequate in most suites. Although most suites had a closed visits room, in practice they were never used for domestic visits, even in exceptional circumstances.

Individual rights

2.22 A presumption in favour of arresting suspects had given way to a balanced approach at management level; all sergeants could give examples of cases where they had declined to detain someone, although some felt that if in doubt, they should arrest. The new national provisions for voluntary attendance, due in the month after the inspection, were expected to increase the proportion of voluntary attendance cases. The appropriate adult (AA) service in Liverpool was efficient and prompt (except at night); waiting times were longer in the other areas. Sergeants did not always check the suitability of a parent to act as an AA. As provided in PACE, AAs were not used for 17-year-olds.

2.23 There was good access to confidential interpreting in all suites. Attendance of interpreters was variable. There was little evidence of unreasonably long waits in police custody for immigration detainees. We observed UK Border Force staff attending within a few hours to issue the authority to detain notice, although we saw one 36-hour wait.

2.24 Most detention reviews were carried out by telephone, by a custody manager, and were generally reasonably thorough. Where reviews took place when the subject was asleep, not all of the custody records we analysed recorded that they had been informed about this on waking. Rights and entitlements were, on the whole, given promptly, with some exceptions.

2.25 There were good systems for prompt attendance at court. Court cut-off times were reasonable, and the escort contractor, GEOAmey, was ready to collect detainees in the afternoon in most instances. When police had to take a detainee to court, police managers raised the issue with GEOAmey to minimise the extent to which police officers would be called on to do this.

2.26 In general, and with a significant exception at Belle Vale, processes for handling DNA samples were efficient, with regular collections. Suite facilities for storing DNA were very clean, and all samples were within date.

2.27 The common practice in all suites was to advise detainees who wished to make a formal complaint about their detention to return to the front desk or nearest police station after release.

Health care

2.28 The contracted-out health service had improved considerably over the previous year and was actively monitored by the force. Clinical governance structures were in place and working well, and the lead forensic medical examiner (FME) paid attention to the quality of the service and training and supervision for doctors.

2.29 The medical rooms were adequate, although most lacked natural light, and they required attention to reduce the likelihood of infection. The senior nurse had introduced some improvements and undertook infection control audits. Rooms were generally clean. The

allocation of emergency equipment between the custody sergeants' desks and medical rooms required rationalisation, and airway management equipment was incomplete. Clinical stock supply was lean, and out of date or duplicated in some suites. Control of scheduled drugs was very tight, with one exception. The cabinets used for medicines storage were insufficiently secure. We found out-of-date reference material in most rooms.

2.30 There had been approximately 19,000 calls to the health care provider in the previous year. Response times had improved, although custody staff told us of long waits; in our custody record analysis, the average wait was 2 hours 48 minutes, with the longest wait an unacceptable 11 hours 30 minutes.

2.31 The quality of the service was good and patients told us that they were satisfied with the care that they had received. There was relevant National Institute for Health and Clinical Excellence (NICE) guidance in most rooms. Symptomatic relief for withdrawal from substances was available and, rarely, methadone.

2.32 Clinical records were good, and audited, but storage in some suites did not comply with the Data Protection Act. Care plans were scanned into Niche and care instructions were given to custody staff, although our analysis of records showed that not all care plans were scanned.

2.33 The force did not have an active strategic grip on substance misuse services. The three service providers were well regarded by custody staff and all provided conventional support to detainees in custody suites and courts. Clients were signposted to alcohol services. There was good advanced care planning for recurrent detainees. Juveniles were signposted to young persons' services.

2.34 The majority of custody officers had been trained in mental health awareness in 2012. Merseycare NHS Trust was part of the national diversion-from-custody pilot scheme, providing in-reach services to police custody over extended hours. An impressive number of detainees had been diverted into hospital care. Police cells were rarely used as places of safety under section 136 of the Mental Health Act 1983,[3] although it was common for police officers to wait at NHS units for eight hours for detainee assessment.

Main recommendations

2.35 Detainee risk assessment and care planning should be prioritised, with effective quality assurance, to ensure that all significant risks are identified and managed.

2.36 Staff should be trained and supported to recognise and provide for the individual needs of detainees, particularly women and those who are vulnerable or have disabilities.

National issues

2.37 Appropriate adults should be available at all times to support without undue delay detained juveniles aged 17, provided that informed consent has been given.[4]

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

[4] Although this met the current requirements of PACE, in all other UK law and international treaty obligations, 17-year-olds are treated as juveniles.

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 ACC provided strategic leadership on custody issues, with a centralised custody function through the corporate criminal justice (CCJ) department. A police chief superintendent was head of CCJ, and a chief custody manager was head of custody in the CCJ department.

3.2 There were five full-time designated custody suites in Merseyside Police, plus a designated suite open at weekends at Southport. In addition, there were two stand-by suites at Kirkby and Wavertree, used for planned operations. No occasions had required the unplanned use of suites or neighbouring forces.

3.3 The force estates strategy had led to the reduction in the number of suites to the current six. The 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 no requirement for back-up from operational resources. There were permanent custody sergeants and police staff DOs employed by Merseyside Police. Custody resources were managed under the centralised CCJ management structure. 'Acting sergeants' were not used for custody duties. DOs looked after the ongoing care and welfare of detainees and were not involved in booking them in. DOs operated with little or no direction from custody sergeants but were proactive and professional in providing care and welfare for detainees. Communication between custody sergeants and DOs was often inadequate, particularly around shift handovers, and there was a need for greater clarity and direction of role. There was a cell allocation process at peak times, with a dedicated custody manager coordinating cell space across the force area.

3.5 There were clear arrangements for custody management, with dedicated custody managers for the custody suites reporting to the head of custody. The custody managers line-managed custody sergeants, who in turn line-managed DOs.

3.6 The ACC lead for custody held a biweekly meeting with the head of CCJ, where previously unresolved custody issues could be raised by the head of CCJ for resolution. The ACC held a monthly meeting to review progress against an action plan developed in response to the expectations in the HMIP and HMIC inspection programme. The ACC also held a monthly operational performance meeting where custody performance was discussed. A daily performance email was circulated to all staff, detailing bail/re-bail, booking-in times and numbers in custody. The head of custody, superintendent and chief superintendent from CCJ met informally each day. There was a monthly custody managers meeting, chaired by the head of custody. The recent focus groups with custody staff, facilitated through the strategic development department, were positive and could be the basis for a custody users forum where staff would be able to raise issues with managers. Staff in some suites reported little visibility of senior managers. There was evidence of appropriately intrusive management of staff at St Helens but this was not reflected in the other custody suites.

Housekeeping points

3.7 There should be clarity on working practices and communication between custody sergeants and detention officers to improve the effectiveness of custody provision and the outcomes for detainees.

3.8 The force should introduce a forum where custody staff and managers can discuss custody issues.

Partnerships

3.9 Partnership arrangements were good, with active engagement with relevant criminal justice partners at the strategic level. The ACC lead for custody represented Merseyside Police on the Local Criminal Justice Board and chaired a monthly criminal justice strategy meeting with the Crown Prosecution Service, courts, probation and the youth offending service. There was a forum with the NHS Trust chief executive to explore the reasons for the delays for officers remaining at hospital with section136 Mental Health Act detainees.

3.10 There was a coordinator in the PA for the ICV scheme. The scheme was active and comprised five panels covering the force area, providing bi-weekly visits to larger suites and weekly visits to smaller ones. ICVs said that they were generally admitted to custody suites quickly and were confident in challenging staff. There were bi-annual meetings for ICVs with the PA, with consistent police attendance.

Learning and development

3.11 All custody sergeants and DOs had undergone custody-specific training. There was a three-week course for custody sergeants, followed by two-week mentoring, and mandatory training in first aid and personal protection equipment (PPE). The current course was linked to the National Police Improvement Agency (NPIA) national custody officer learning programme (NCOLP). There was no current refresher training for custody sergeants, but one-day courses for them were planned to start in November 2012. CCJ had an input into refresher course content. DOs received a five-week initial course but there was no refresher training and none planned. Code G PACE training was delivered across the force.

3.12 The force had a comprehensive custody policy and custody working practices manual, based on the NPIA's SDHP and accessible to all staff on the force custody policy intranet page. The policy was due for review with the publication of the NPIA's *Authorised Professional Practice for Custody*. The IPCC 'Learning the Lessons' document was available on the custody team computer drive. Staff showed good awareness of this drive and often received emails with information about adverse incidents.

3.13 There was a thorough process for reporting adverse incidents, with a report completed at the time of the incident. Copies of the report were forwarded to relevant departments, such as the professional standards department (PSD), force incident manager and the command team. The head of custody allocated the incident for investigation, and then forwarded the report on it to the PSD with recommendations, along with detailing the learning points. Learning or developmental points from adverse incidents were circulated to custody staff, and the investigating custody manager would speak to the staff involved in the incident directly.

3.14 There was a quality assurance process for dip-sampling custody records. Across the force area, a custody manager sampled three custody records per shift, using a corporate template which was accessible on the custody team intranet drive and was auditable. The dip-sampling was overseen by the head of custody. The custody manager gave feedback in person to the relevant staff member, and custody sergeants told us that they had received feedback from the dip-sampling process. However, the process was not used to produce management information and was not sufficiently detailed: for example, the content of records was never checked against the relevant CCTV recordings or PERs. There was no quality assurance of shift handovers.

Recommendation

3.15 The force should introduce regular custody refresher training for custody sergeants and detention officers.

Housekeeping point

3.16 Quality assurance measures should include person escort records and cross-referencing to closed-circuit television as part of the dip-sampling of custody records, and the monitoring of the quality of staff handovers.

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 Most custody staff treated detainees politely and considerately, addressing them by their first names when appropriate. At most suites, they managed agitated or disruptive detainees well, although there were notable exceptions (see section on detainee care). Most of the detainees we spoke to said that they felt well-treated. There was little focused provision for women, young people or detainees with disabilities, although there was a wheelchair at Wirral and work had been done to make provision for a disabled person at St Helens (see main recommendation 2.36).

4.2 Staff in all suites told us that female detainees were offered the opportunity to speak to a woman, who would tell them that feminine hygiene products were available, but our analysis of 60 custody records confirmed our impression that the opportunity to speak to a female officer was not routinely offered. At St Helens, female detainees were not asked as part of the booking-in process if they wished to speak to a female member of staff, but they were assigned to a female DO. All suites had designated cells for female detainees. We observed a 17-year-old female being booked in at St Anne Street who disclosed that she was 16-weeks pregnant. She had previously been interviewed about the matter at home and had now been arrested and brought into custody to be charged, even though it appeared she could easily have been reported for summons instead. However, the custody sergeant correctly lodged her in a glass-fronted holding room to minimise her anxiety. Some custody staff told us that they would ask a transgender detainee whether they would prefer to be searched by a male or female officer, but others were less clear about how to search transgender detainees.

4.3 None of the suites had a hearing loop. At St Anne Street, staff told us that they could call on police officers trained in signing to help book in detainees who were hard of hearing. There were no cells adapted for detainees with disabilities, and at St Anne Street and Belle Vale the call buttons were placed very high on the cell wall.

4.4 At all suites, staff tried to avoid placing vulnerable young people in cells for prolonged periods. We saw them being allowed to wait in consultation and holding rooms with their AAs, and in the booking-in areas. In one suite, we observed a 13-year-old girl being booked in after being arrested for an assault. The custody sergeant did not explain the process to the child, who was clearly upset and did not seem to understand what was happening. However, shortly afterwards her father arrived and the process was repeated. She was allowed to sit with her father in the glass-fronted holding area. Most juvenile detainees were placed in detention rooms, which were little different from general cells. At St Helens, a custody sergeant dealt with a challenging juvenile detainee well, reprimanding him about his poor behaviour towards his mother.

4.5 We were told that foreign national detainees often had to wait two or three days to be moved to more suitable facilities. We observed a foreign national detainee being booked in at St Helens. He could understand English but was given the option of having an interpreter if he felt he required one during his detention. When he told the custody sergeant that he was Muslim, the

custody sergeant asked him if he wished to conduct any religious observance while he was in custody.

4.6 All suites had some items for religious observance, but not all were satisfactory. There was one Bible in St Helens custody suite and no other religious books. Two prayer mats were available there but they were not stored respectfully and there were no instructions on their handling. DOs could not recall when they had last been used. At St Anne Street, a prayer mat, Qur'an and several copies of the Bible were stored respectfully in a box, although at Copy Lane they had been placed carelessly on a shelf. There was no compass to determine the direction of Mecca at any suite. We were told that in some suites, a few cells had previously had a symbol on the ceiling to indicate the direction of Mecca, but that these had been painted over.

4.7 Booking-in areas gave little privacy, although the design of the suites, which enabled solicitors to enter the consultation rooms without going through the booking-in area, minimised the number of people who might overhear detainees being booked in. There were alternative rooms available for the initial interviews, and signs advising detainees that they could ask to speak to an officer in private. Nevertheless, detainees were normally expected to disclose sensitive personal information while other detainees were also being booked in and could overhear. Access to the cells was restricted to custody staff. At Copy Lane, the walls of the booking-in area were covered in sound-absorbing tiles, which helped to preserve privacy. At the busy Wirral and St Anne Street suites, the lack of privacy was a major issue. We saw several detainees being processed at the same time, including juveniles.

4.8 At Belle Vale, two sergeants used computer terminals at opposite ends of the desks for booking in, which facilitated privacy, but at St Anne Street we saw sergeants using adjacent terminals when they could have been spaced further apart. All suites had large whiteboards in the booking-in areas that showed detainees' names, as well as specific information about offences and medication that should not have been on open display. We saw several detainees studying the whiteboards. At Belle Vale, 'indecent exposure' was written next to one detainee's name. It was only after we drew attention to the risks this presented that a DO was instructed to amend it to 'IE'. Since the Niche computer system provided an electronic whiteboard, the use of these public whiteboards was unnecessary as well as undesirable.

4.9 Images of toilet areas in the CCTV cells were obscured. Some staff told us that they informed detainees that they could not be watched using the toilet, but one detainee in a CCTV cell at St Anne Street told us she could not recall being told that.

Recommendations

4.10 A hearing loop should be available in all booking-in areas and all custody staff should know how to use it.

4.11 Whiteboards should be removed from booking-in areas or placed where they cannot be seen by detainees.

Housekeeping points

4.12 Each suite should have a suitable range of items for religious observance, which should be stored respectfully, and the direction of Mecca should be indicated.

4.13 Staff should inform all detainees placed in CCTV cells that they cannot be viewed when using the toilet.

Safety

4.14 The standard of risk assessments was variable. Custody sergeants told us that they would always explain the reasons for asking questions about health and self-harm, yet we observed several instances when no such explanations were offered. We heard a custody sergeant at Belle Vale tell a detainee, '*some of these questions are stupid, all right, but I've got to ask them*'. Custody sergeants followed the prompts on the Niche computer programme and many risk assessments were mechanistic, with custody sergeants simply reading from the list. Although some asked supplementary questions about health and emotions, especially when there were indications of self-harm, others attempted little further exploration of risks. We observed a 13-year-old-girl who suffered from behavioural problems being booked in at St Anne Street. The sergeant was thorough in his approach to risk assessment, but he asked the standard Niche questions about mental health issues and depression, which she did not appear to understand fully.

4.15 Most custody sergeants we observed checked the PNC for flagged self-harm markers at the start of the booking-in process, but in one instance the PNC was not checked for warning markers until after the detainee had been taken to a cell. Our custody record analysis found that initial risk assessments were generally clear, with appropriate levels of observations. Risk assessments were reviewed appropriately as circumstances changed. However, we found some inconsistent practice in risk assessments and care plans. For example, an issue not mentioned in the risk assessment would appear in the care plan, or vice versa. In some instances, a risk that had not been mentioned in the risk assessment or care plan – for example, a dependency on heroin – was mentioned in the custody record.

4.16 At Belle Vale we came across a highly intoxicated female detainee who was not subject to rousing checks. The custody record analysis showed a general failure to record in care plans when rousing checks were necessary. Of the 18 detainees who had come into custody intoxicated, in only one instance had rousing explicitly been mentioned in the care plan. There were several mentions of 'level two' observations, but not all detainees who were intoxicated were placed on this level. Conversely, detainees who did not require rousing were also placed on level two observations, so it could not be inferred from the custody records that this level referred to a requirement for rousing. Checks were generally carried out on time but there was seldom any reference to the detainee being woken or spoken to. In every instance where a detainee was intoxicated and sleeping, the records stated, 'DP asleep, seen breathing, all correct' or 'DP asleep, all in order'. All suites had magnetic 'R' signs to be placed on the doors of those subject to rousing checks, but at Southport there was none on the cell door of an intoxicated detainee subject to rousing checks. The need for rousing checks was not specified in his care plan or marked on the whiteboard.

4.17 The custody record analysis also found nine instances where observations had lapsed. Examples included 60-minute observations that lapsed to two hours, 30 minutes that lapsed to one hour, and 15 minutes that lapsed to 30 minutes. In four cases, lapses had involved detainees who were intoxicated, two of whom were juveniles. The use of 15-minute observations was, nevertheless, higher than we normally find: 27% of detainees were subject to 15-minute observations, often without any clear reason.

4.18 We observed several constant observations at St Anne Street. In one case, we saw the nightshift police officer playing a game on his mobile telephone while conducting the watch.

When an officer arrived to relieve him, the detainee was left on his own, with the cell door open. The officer who had been carrying out the constant observations was unable to advise his colleague of the detainee's name without referring to his notebook. None of the custody sergeants on duty briefed the relieving officer on their role, describing this as the responsibility of the officer's own supervisor. Later, we saw another police officer using a mobile telephone (not to make a call) while conducting a similar watch.

4.19 We saw some female detainees asked if they had dependants, but most detainees, including all the men, were not asked that question. Some custody sergeants claimed that concerns about dependants would be picked up by the question 'is there anything else that may affect your welfare?' We spoke to one man at St Anne Street who was anxious about picking up his son from school, which he had not mentioned during booking-in.

4.20 The use of strip-clothing was excessive and far more frequent than we have observed elsewhere. One day at Belle Vale about half of the 10 detainees in the suite during the day were wearing safety smocks, which are short-sleeved dressing gowns in material that is difficult to tear. They included a man with mental health problems but no history of suicide attempts, who had been put in a smock because his behaviour was described as 'unpredictable', and a 15-year-old-girl whose clothing had been removed because she was too intoxicated to participate in the risk assessment. She was placed in a cell without a mattress because she had been aggressive on arrest and the custody sergeant thought she might throw a mattress around. At St Anne Street, a woman who had tried to harm herself over a year previously was placed in a smock, although she said she had no intention of harming herself. She told us that she found it undignified and distressing to be in a smock and without her underwear. Many detainees had to suffer the indignity of attending consultations with legal advisers and health care personnel while dressed in their smocks. Footwear was generally not issued in the custody suite, although we saw some slippers in use at Belle Vale. On more than one occasion, we saw people being escorted around the suites for interviews wearing smocks and barefoot, sometimes also with their underwear taken away. Our custody record analysis found that 18 of the sample (30%) had had their clothing removed. No reason had been recorded in four instances. Seven of the 15 detainees who had been given paper suits or safety smocks appeared to have spent over 17 hours in them; one had spent 43 hours without his clothes.

4.21 Risk management seemed more proportionate at St Helens than at the other suites. Custody sergeants told us that they did not use rip-proof smocks for detainees who were not at risk of self-harm. During the inspection, although there were some very vulnerable detainees in custody, the smocks were not issued and risks were managed in other ways.

4.22 Anti-ligature knives were not carried by staff or attached to cell keys. Although all suites kept a knife capable of cutting thick ligatures in a suicide intervention kit in the booking-in area, staff at Copy Lane were unsure about its location and took several minutes to find it. At many suites, including the Wirral and Southport, anti-ligature knives were regularly used to cut cords in clothing, which could have left them too blunt to cut a ligature.

4.23 Provision for shift handovers was inadequate in all suites, with just an individual staff member briefing the person who was to relieve them. At several suites, we observed up to four separate handovers within an hour because staff came in at different times. Our impression was that custody sergeants and DOs worked separately instead of as part of a team. At Belle Vale, a detainee was anxious about informing his girlfriend that he was in custody and angry that he had not been allowed to telephone her, but this important information was not handed over and the length of time in which he was held *incommunicado* was unnecessarily prolonged. Incoming sergeants only received information about detainees booked in by the

sergeant from whom they were taking over, even though they may have been assuming responsibility for other detainees as well. We observed one handover in which the incoming custody sergeant visited each detainee for whom he was accepting responsibility, but this was not usual practice.

4.24 There was little information about support organisations for potentially vulnerable detainees being released, and pre-release risk planning was haphazard.

4.25 In many instances, custody sergeants ticked the 'no risks' box on the Niche pre-release page without exploring possible risks with detainees. In one record of a recent release at St Anne Street, the detainee, who had multiple problems including addictions and a history of self-harm, had been released with 'no issues' recorded. These concerns were echoed by the findings of our custody record analysis, in which 25 detainees in the sample (42%) had had some level of vulnerability on release that had not been addressed in the pre-release risk assessment. Generally, this related to detainees released late at night with no indication of how they were getting home, including three women released after midnight.

4.26 Custody sergeants knew the local arrangements for passing information about vulnerable detainees to social services. At Copy Lane, we observed a custody sergeant taking considerable trouble to explain to a Polish detainee being bailed where the court was situated and how to get there by public transport, but such helpfulness was exceptional rather than routine. We observed one custody sergeant contacting children's services to find accommodation for a 14-year-old whose parents did not want him to be returned home. Staff told us that they were unable to provide bus fares or travel warrants for detainees who could not get home, although a custody sergeant at Copy Lane said that he would, in exceptional circumstances, ask officers to drive a vulnerable detainee home (see main recommendation 2.36).

Use of force

4.27 Use of handcuffing was proportionate and we observed almost no detainees arriving at suites in handcuffs. One detainee we spoke to at St Anne Street told us that he had been handcuffed, but that his cuffs had been removed in the holding room before being booked in. We saw no detainees being strip-searched. Custody staff told us that strip-searching was used only occasionally, when there were suspicions that contraband might be concealed. The force gave us a spreadsheet listing every recent instance of strip-searching and the grounds on which it had been ordered, but there was no accompanying analysis indicating any trends to be addressed. We were told that detainees were seen by a health care practitioner after the use of force if they requested it, or if staff were concerned that injury might have been caused. Staff were able to describe ways in which they would use de-escalation techniques with non-compliant detainees, and we observed such skills in use.

4.28 At St Helens, we observed a juvenile who was confrontational. The custody sergeant warned him that he needed to calm down or he would be taken back to his cell, but he did not. The two custody sergeants took control of the detainee's arms and took him back to his cell. When we asked if they needed to complete the use of force form, the custody sergeant said that they would not need to do this because the incident had been recorded on CCTV and would be recorded on the detainee's custody record. The circumstances in which custody sergeants completed a use of force form were unclear. We witnessed a similar use of force at Copy Lane, when we were told that no form would be completed because the incident had taken place in the custody suite.

Recommendations

4.29 Staff should be trained in risk assessment, proportionate care planning and making observations.

4.30 Detainees should only be placed in safety smocks and paper clothing where strictly necessary, and detainees whose own clothing has been removed should be given normal replacement clothing where possible. The use of strip-clothing should be monitored and over use addressed.

4.31 There should be one handover for each shift change, which includes all staff working in custody and covers issues relevant to the detainees held.

4.32 The quality and consistency of pre-release risk assessments should be improved and made subject to dip-sampling.

4.33 Merseyside Police should collate use of force data in accordance with the Association of Chief Police Officers' policy and National Policing Improvement Agency guidance.

Housekeeping points

4.34 All detainees should be asked if they have dependency obligations during their period in custody.

4.35 Details of local support agencies should be given to potentially vulnerable detainees on their release.

4.36 Force used in the custody suite should be recorded on the required form.

Physical conditions

4.37 There was a considerable amount of graffiti at most suites, except St Helens, which was in better condition. Graffiti included swastikas and phrases such as '[name] is a grass' (see Appendix III). At St Anne Street and Belle Vale, the van dock was filthy. There were many vinyl examination gloves on the ground, which gave a poor and possibly intimidating first impression. At St Anne Street, two cells had badly stained ceilings (see Appendix III). Staff there told us that there were weekly cell checks but on 2 October there was no record of any since 12 September. At Copy Lane, the CCTV camera for one cell had been pelted with toilet paper that had not been properly cleaned off. At Copy Lane and Belle Vale, floor paint was flaking off, which made cleaning difficult, and the flakes were possibly sharp and hard enough to cut flesh. At some suites, the exercise yards were dirty, with used cups, cigarette ends, and overflowing cigarette disposal bins. We found a number of ligature points in almost all suites.

4.38 Call bells were answered promptly, with most staff responding helpfully to detainees, although a custody manager who answered call bells at St Anne Street responded curtly to requests. Staff at St Anne Street said that the call bells were unreliable, although cells were always put out of use when the bells failed. At Belle Vale, staff said that the call bells often broke down.

4.39 There had been no practice fire evacuations at any of the suites, although we were told that there had been 'walk-through' fire drills in each suite in recent months. All suites had an evacuation policy, which staff were familiar with, and adequate stocks of handcuffs were held,

except at Belle Vale. Staff there were aware of the fire evacuation procedure, which was displayed on the wall, but none had been involved in any fire drills.

Recommendations

4.40 Cells should be clean, free of graffiti and properly maintained.

4.41 Cell checks should be thorough, regular, documented and consistently applied at all custody suites.

4.42 Unreliable call bell systems should be replaced or refurbished.

Housekeeping point

4.43 Fire evacuation procedures should be practised and adequate stocks of handcuffs should be maintained at all suites.

Detainee care

4.44 There were ample supplies of clean bedding, including pillows, in all suites, but at Belle Vale mattresses were unnecessarily removed from cells between occupancies and detainees were only given blankets at night or on request. The rationale for the removal of mattresses from cells was unclear. At all suites staff told us that they wiped down mattresses and pillows with an anti-bacterial spray between uses.

4.45 Toilet paper was available only on request. Hygiene packs for female detainees were available but not routinely offered. All suites had showers that were well screened, of an adequate size and allowed privacy. Our custody record analysis confirmed that showers were offered regularly to detainees who had been in custody overnight. There were good stocks of cotton towels, toothpaste and soap but there were no razors or mirrors, so male detainees could not shave before attending court.

4.46 Most suites had adequate stocks of replacement clothing, in a range of sizes, including tracksuit bottoms and T-shirts. However, at Belle Vale on the first day of the inspection there was almost no replacement clothing left. Staff told us that they could obtain some from St Anne Street nearby, but when we returned two days later, supplies had not been replenished. Some suites had a small stock of paper underwear but this was not regularly offered. Paper suits were provided to detainees who did not want cords in their clothing removed. In our survey, 7% of respondents said that they had been offered a tracksuit to wear once their clothing had been taken, which was considerably lower than the national comparator of 40%. At St Helens, we saw a woman released with just a vest top, when she should have been given something more adequate, such as a T-shirt.

4.47 All suites had stocks of microwave meals and all were in date. They were of low calorific value, but staff told us that they would allow detainees to have two meals at a time if they still felt hungry, and would also provide meals at other times on reasonable request. There was adequate provision for halal and vegetarian diets. Cereal was provided at breakfast time. Hot drinks and water were freely available, and detainees at Belle Vale could also have Bovril or soup. Food preparation areas were hygienic and there were clean, commercial microwave ovens.

4.48 Exercise was available at all suites, although the yard at Belle Vale was flooded with sewage on the second day we visited it. Staff at Copy Lane had provided a football in the yard. Three detainees in our custody record analysis had been given outside exercise, and one who had been in custody for over 43 hours had been allowed to go outside to smoke. The exercise yard at St Helens was small but clean, and was monitored by CCTV. We did not observe any detainees in the exercise yard and some detainees we spoke to were not aware of this facility. Custody staff told us that detainees were supervised in the yard and so they could only let them use it when they were not busy. Some exercise yards had ligature points.

4.49 All suites had some books, but not all had magazines. Belle Vale and St Anne Street had no books in foreign languages, despite large local Iranian and Polish communities. Staff at Copy Lane did not allow detainees access to newspapers or magazines because of staples, regardless of risk assessment. There were no suites where reading materials were routinely offered. At Belle Vale, a woman detainee who had been in custody for 18 hours without being offered anything to read told us that she was 'climbing the walls' with boredom. The custody record analysis recorded few instances where reading materials had been offered, although some detention logs recorded 'detainee on bench, reading'.

4.50 All suites had a small closed visits rooms, although none allowed social visits, even in exceptional circumstances.

Recommendations

4.51 Mattresses, blankets and pillows should be routinely provided to all detainees.

4.52 There should be a stock of disposable razors for detainees who wish to shave before attending court, subject to risk assessment.

4.53 Replacement underwear should be available at all suites.

4.54 Detainees should be offered outside exercise, especially those held for longer periods, and all exercise yards should be kept clean and free from ligature points.

4.55 Custody suites should hold and offer a range of reading material, including books and magazines suitable for young people and in foreign languages.

4.56 Visits should be facilitated in exceptional cases for detainees held for long periods, particularly if they are vulnerable.

Housekeeping points

4.57 Subject to risk assessment, there should be a small supply of toilet paper in each cell.

4.58 Female detainees should routinely be offered hygiene packs.

5. Individual rights

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

Rights relating to detention

5.1 We observed that most detainees were booked in promptly on arrival. Custody sergeants checked the reasons for detention with arresting officers to ensure that there were appropriate grounds. One sergeant unwillingly accepted a detention for charging purposes, but he did so because a force instruction required detention in such cases. Several custody sergeants believed that there was a presumption in favour of arrest and they usually authorised detention, although they could all give examples of when they had refused to detain. Several told us that senior managers sometimes applied pressure to accept all detainees into custody.

5.2 There was little evidence of staff using alternatives to detention. The force had introduced training for custody and operational staff on the new code G PACE codes of practice about voluntary attendance, which was due to be introduced in the following month. Some custody sergeants told us that they thought this would lead to a large reduction in the number of detainees entering the custody suites, although others felt that a change in culture was needed for the code G to be effective.

5.3 Custody sergeants were clear about their obligations to ensure that cases proceeded quickly. In our custody record analysis, nine detainees (15%) had been held for more than 24 hours, of whom three had been held for over 40 hours, but this had been over a weekend. Thirty-five detainees (58%) had been held in custody overnight, including those who had arrived during the night and not been released until the morning. Twenty-three (38%) had been held for less than six hours.

5.4 Staff interviewed detainees out of hours where necessary and we saw a detainee being interviewed in the presence of his solicitor at 1am on a Saturday morning at Southport. Nevertheless, there were some delays in processing detainees, including when several finished their rest period at the same time and were ready to be interviewed. On one occasion at St Anne Street, we saw a detainee being brought in intoxicated at 1am and placed on an eight-hour rest period until 9am, when the arresting officer was unavailable to deal with them, and the investigation support team (IST) was also unable to progress the case in the morning. At 2pm, an IST officer looked at the case to consider if more information was needed, before interviewing the detainee later that afternoon. A custody sergeant told us that this was an unavoidable delay, and that, usually, if they could not get an officer to interview a detainee and deal with the matter promptly, the detainee was bailed, if the circumstances of the alleged offence allowed.

5.5 We were told that staff had a good relationship with UK Border Agency staff and our observations supported this view. Most immigration detainees were collected within a short time, although we observed two men who had been held at Copy Lane for over 36 hours while transport arrangements were finalised. At St Helens and the Wirral, custody sergeants told us that Border Force officers attended promptly and that immigration detainees rarely stayed in custody longer than 24 hours. We saw no notices in any suite promoting the Immigration Legal Service Commission's police station advice helpline.

5.6 Staff assured us that the custody suites were never used as a place of safety for children under section 46 of the Children Act 1989.[5]

5.7 Merseyside Police adhered to the PACE definition of a child instead of that in the Children Act 1989, which meant that those aged 17 were not provided with an AA unless they were otherwise deemed vulnerable (see recommendation 2.37). Family members were usually contacted initially to act as an AA, although this contributed to delays in detention while they were awaited. In our custody record analysis, there were five young people in the sample (10%) aged under 17. They had all had an AA present during their interview, but two had had to wait over seven hours for their AA to attend. When it was not possible to contact a relative, social services or the local youth offending team (YOT) were asked to provide an AA.

5.8 The service in Liverpool was normally efficient and prompt, although staff at Copy Lane and Belle Vale told us that it was very rare to get an AA at night, and almost impossible to obtain alternative overnight accommodation from the local authority for juveniles who had been denied bail and had to appear in court the next morning. In Southport, waiting times for AAs were reported to be long. If an AA was required during the late evening, staff said that the social services emergency duty team (EDT) was unlikely to provide one until office hours on the next day. At St Anne Street and St Helens, AA arrangements were good. At St Anne Street, we interviewed two AAs who were employed by the YOT. They dealt with vulnerable adults and juveniles and were positive about their relationship with custody staff and how they dealt with juvenile detainees. The AAs worked mainly up until 10pm but would remain with a detainee until they were no longer needed. Outside of this, the EDT was contacted. At St Helens, the YOT was contacted to deal with juveniles during office hours, and we observed them attending the custody suite promptly to act as AA for a 14-year-old whose parents refused to attend the police station.

5.9 At the Wirral, we observed a 13-year-old girl being booked in who indicated that she was in local authority residential care. Her father attended the station after he was contacted by a teacher, and the sergeant accepted him as an AA, without any checks to establish why the child was in care. At St Anne Street, we observed a man arrested on a warrant locked inappropriately in a glass-fronted holding room that was already occupied by a vulnerable male and his mother, who was acting as his AA.

5.10 Custody staff contacted social services to act as AAs for vulnerable adults. During the inspection, a social worker was called to a custody suite to support a vulnerable adult. They were given prompt access to the custody record and spoke positively about the professionalism of the custody staff. At St Anne's Street, custody staff told us that EDT provision for vulnerable adults outside office hours was unsatisfactory.

5.11 During booking-in, staff gave all detainees a leaflet summarising their rights and entitlements. This could also be downloaded and printed off in foreign languages. During the inspection, the force distributed several copies of a pictorial version of the rights and entitlements for detainees with learning difficulties or limited literacy. Some suites displayed a useful poster that enabled non-English-speaking detainees to indicate their language, but this was not in every suite. In our custody record analysis, three detainees (5%) had been foreign nationals but it was unclear from the records if any had been given their rights and entitlements in their own language. At Copy Lane, we observed an interpreter attend for an interview with a detainee and she stayed to translate after a decision had been made on his disposal and discharge. Interpreters had been booked for two detainees at Belle Vale, but the service was

[5] Section 46(1) of the Children Act 1989 empowers a police officer, who has reasonable cause to believe that a child would otherwise be likely to suffer significant harm, to remove the child to suitable accommodation and keep him/her there.

unable to supply a Georgian interpreter in time for one, who was bailed to return at a later date.

5.12 All custody suites had private telephone booths in the booking-in area that enabled confidential three-way conversations between custody sergeants, detainees and the interpreting service. Staff said that there was a good face-to-face interpreter service available to facilitate investigative interviews, but that there had been some delays in attendance, depending on the language required.

5.13 All suites had private consultation rooms for detainees to speak to legal representatives, and private booths for telephone consultation, although we were told that there were sometimes delays at very busy times at St Anne Street. We saw copies of client custody records routinely printed out and offered to legal representatives.

Recommendation

5.14 Merseyside Police should engage with the local authority to ensure the provision of secure and non-secure beds for juveniles who have been charged to appear in court but cannot be bailed.

Housekeeping points

5.15 Police should check the suitability of family members before they are involved as appropriate adults.

5.16 Detainees should not be placed in holding rooms already occupied by a detainee and their appropriate adult.

5.17 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

5.18 Detainees' right to free legal representation was clearly explained to them. Those who refused the offer were asked the reasons why and reminded that they could change their mind at any time. In our custody record analysis, 26 detainees (43%) had accepted the offer of legal advice. Of the remaining 34 detainees (57%) who had initially declined the offer, the reason had rarely been noted. We found some examples of detainees who had waited an excessively long time to be read their rights, including one detainee at Southport who had been arrested at 7.30pm but not given his rights until 10.20am the next day. Although he had been intoxicated, such a long delay was unacceptable.

5.19 There was a duty solicitor scheme but across the force we found only two posters at Copy Lane (one in Welsh, one in 12 foreign languages) advertising it. Solicitors told us that custody staff facilitated legal consultations. Detainees were told that they could consult the PACE codes of practice, but the force was still using the 2006 version. Staff told us that the 2012 version had not been distributed to any of the custody suites.

5.20 We observed detainees being told that they could inform someone of their arrest. In our custody record analysis, all nominated people had been contacted, except in three cases, where an entry on the custody log indicated that the chosen person had not been informed. In

addition, 17 detainees (28%) had made a telephone call during their time in custody. We saw staff failing to allow a telephone call to a detainee who had earlier been held *in communicado* (see paragraph 4.23).

5.21 Reviews of detainees in custody were undertaken by a custody manager or, if they were unavailable, the critical incident manager (CIM). The majority of reviews we observed were on time, but were carried out by telephone, and many were reasonably thorough; at St Anne Street, a custody manager was very thorough during a review and referred the detainee to the nurse following his complaint about an injury. However, another custody manager at the same suite rushed through the review, giving the detainee little opportunity to make any representation. In our custody record analysis, the recording of face-to-face reviews was of good quality.

5.22 Eight-hour rest periods were rigorously observed. In our custody record analysis, when reviews had taken place while the detainee was asleep, it was not always clear from the custody record if the detainee had been informed of the review on waking. One detainee had been told at 9.19am that he had been reviewed at 12.54am, just one minute before his next review was due.

5.23 In general, processes for handling DNA samples were efficient, with regular collections. Suite facilities for storing DNA were very clean, and all samples within date.

5.24 Court cut-off times were reasonable, at 2pm and 3pm at all the suites, with some flexibility, and GEOAmey staff were usually ready to collect detainees in the afternoon and transport them to court on time. A prisoner escort contractor (PEC) was available for transportation for both morning and afternoon courts. If the PEC was unable to meet the contract for transportation to afternoon courts, police officers told us that they would take detainees in police vehicles, to ensure that they did not remain in custody longer than necessary. At the Wirral we observed a prisoner subject to recall who had been in custody for over 24 hours waiting for transportation to prison.

Housekeeping points

5.25 Detainees should receive their rights at the earliest opportunity.

5.26 There should be sufficient up-to-date copies of the PACE codes of practice in all custody suites.

5.27 Detainees should be informed promptly on waking of any reviews carried out while they were asleep.

Rights relating to treatment

5.28 Arrangements for detainees to make complaints were inadequate. If a detainee wanted to raise any issues, they were usually advised to make a complaint at a police station front desk on leaving custody (not all the custody suites were in a police station that was in use). The only exception was if the complaint was about being assaulted; staff said that in such cases the custody manager or CIM was advised and medical and photographic evidence obtained. Our custody record analysis showed two cases where detainees had wished to make a complaint about injuries sustained during arrest, but no complaint had been taken from either. One detainee had been advised to ‘sort it out later’, and the other detainee was to be ‘advised of

the complaints procedure when he leaves custody'. No notices about the complaints procedure were on display but some suites had copies of IPCC leaflets available on request.

Recommendation

5.29 Detainees should be able to make a complaint about their care and treatment, and be able to do so before leaving 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 services. Merseyside police were in the second wave of early adopters for NHS commissioning of services; preparation work was to begin shortly after the inspection.

6.2 Monitoring arrangements were good, with regular clinical governance and contract performance meetings underpinned by reporting of response times. A senior police officer was responsible for ensuring fidelity to the contract. Medacs health care professionals included a lead FME and lead nurse. The lead FME provided clinical direction of the service. There were two nurses and a doctor on duty at all times. Staff credentials were checked centrally with registration bodies, and Medacs offered appropriate training to its staff. Clinical supervision was becoming regularised but was not yet fully documented.

6.3 Medacs was called approximately 19,000 times per annum, with 7,000 visits by health care professionals to St Anne Street alone. There were several contracted response times, including 60 minutes (urgent) and 90 minutes (non-urgent). Performance data showed consistently improving response times in the previous year, although custody staff told us of long waits. In our custody record analysis, the average response time was two hours 48 minutes and the longest was 11 hours 30 minutes, which was unacceptable. At Belle Vale we heard of two recent cases where doctors had initially refused to see patients with chest pain because it would delay their next appointments elsewhere. Medacs had recruited two extra health care professionals to improve responsiveness, and they were to start shortly after the inspection.

6.4 Each custody suite had a medical room. Those at Kirkby and Wavertree were no longer in use, and at Southport were in partial use. The quality of the rooms was adequate but all (except Kirkby) lacked natural light. All had natural-light lamps next to examination couches, although the one at Kirkby did not work. All the rooms contained kitchen cabinetry and old office furniture. No room was fully compliant with infection control standards but the lead nurse had begun to audit these, and improvements had recently been made. Levels of cleanliness were generally acceptable, although the floor at Copy Lane was dirty and some rooms were dusty.

6.5 Oxygen and airway support equipment was available in each medical room but not all had suction units. The ambu-bag and mask (airway support equipment) were sited in the booking-in area at some suites. Automated external defibrillators (AEDs) were available, staff were trained to use them and they were checked regularly.

6.6 Wall notices indicated that detainees could see a health care professional of the gender of their choice. Interpreting services were available and occasionally used. Medical rooms had privacy curtains and we observed staff ensuring that patients' dignity was preserved.

Recommendations

6.7 There should be robust infection control procedures for all the clinical rooms, which should be regularly cleaned, appropriately equipped and able to be used to take forensic samples.

6.8 Resuscitation equipment in the medical rooms and in the booking-in areas in custody suites should be standardised.

Housekeeping point

6.9 Receipt of clinical supervision should be documented on each occasion.

Patient care

6.10 Detainees were asked if they wished to see a health care professional and were able to request to see one. The quality of the service was good and the treatments offered appeared appropriate. Detainees told us that they were satisfied with the service they had received. However, in the cases we sampled, a female detainee, who had been in custody for three hours in total, had disclosed that she was five months pregnant and dependent on methadone and heroin, yet a health care professional had not been contacted on her arrival.

6.11 Relevant National Institute for Health and Clinical Excellence (NICE) guidance was available in each medical room. In all suites there was an absence of wound glue, which reduced therapeutic options.

6.12 Clinical records were made in writing on standardised templates, which resulted in a care plan. We saw evidence of clinical audit. Care plans were scanned onto the Niche computer programme and care instructions were given to custody staff, although we found some cases where care plans had not been scanned. Records were usually stored in compliance with the Data Protection Act, although at Copy Lane, Southport and Wavertree we found some records stored insecurely.

6.13 Twenty-seven per cent of detainees self-reported being on medication on arrival in custody. Clinical stocks were lean, appropriate and mostly well managed, and could be supplied by a doctor or nurse using patient group directions. However, the medicine cabinets were insufficiently secure. There were out-of-date items in some custody suites and, in the booking-in areas, some over-stocking of first-aid supplies which were out of date. The unused medical rooms at Kirkby and Wavertree contained multiple stocks, many of which were out of date. Police officers made attempts to retrieve detainees' prescribed medicines from their homes if necessary. Methadone maintenance was available, although symptomatic relief was usually offered. Nicotine replacement therapy was not available. We found out-of-date editions of the British National Formulary in most medical rooms and in the booking-in areas at Belle Vale.

6.14 Medacs staff recorded all medicines used in a stock control book. We observed no discrepancies in stock levels for scheduled drugs, except at Kirkby. Medicines to be given to detainees were kept in evidence bags clipped to boards placed above detainees' lockers. Some evidence bags containing medications were unlabelled.

6.15 The system used by custody staff to dispose of unused or discarded medicines was insecure and not auditable. Medacs had begun a process to resolve these issues.

Recommendations

6.16 All clinical options associated with treatment of wounds, and all clinically indicated medications, should be available.

6.17 Clinical records should be kept in accordance with legal requirements.

6.18 Medicine cabinets should be constructed and installed to the required standards.

6.19 Dispensed medications should be supplied in labelled containers and stored securely.

Housekeeping points

6.20 Clinical supplies in the medical rooms at Kirkby and Wavertree should be removed for use elsewhere or be discarded.

6.21 Out-of-date pharmacological reference materials should be discarded.

Substance misuse

6.22 There was no force-wide strategic forum to discuss substance misuse issues, although a meeting to begin the process had been arranged to take place following the inspection. Generally, the force was satisfied with the services that were available. In our custody record sample, 30% of detainees had been intoxicated on arrival in custody and 8% had seen a substance misuse worker, although these data were incomplete.

6.23 There were three providers of substance misuse services to the custody suites: Addaction in St Anne Street, Belle Vale and St Helens; Arch in Wallasey; and the Crime Reduction Initiative (CRI) at Copy Lane and Southport. All offered conventional support to courts and police custody during the week, including daily visits to custody suites and cells, and telephone response at other times; the police could also make appointments out of hours. Detainees were offered the services of drug arrest referral workers where appropriate, and were referred to community drugs/alcohol teams as necessary. Intensive programmes with extended hours over the full week, and test-on-arrest, were offered at Copy Lane, St Anne Street and Wallasey. Programmes involving appointments with a drug worker as a condition of bail were used in several custody suites. There was evidence of advanced joint care planning between Medacs, substance misuse providers and recurrent detainees.

6.24 Detainees with alcohol problems were referred to community programme providers, which included Addaction and CRI. Clean needles and harm minimisation advice and supplies were available from local services. Juvenile detainees were signposted to specialist services and to YOT workers.

Good practice

6.25 *The use of advanced care plans enabled an agreed plan of care to be instituted when an individual re-entered custody.*

Mental health

6.26 In our custody record sample, 13% of detainees self-reported mental health problems. However, it was commonly believed by both the police and health care staff that most detainees had mental health problems. Most custody officers in the Liverpool custody suites had received mental health awareness training in 2012; elsewhere, the pattern was more variable. All the custody officers we spoke to expressed confidence in their ability to refer detainees appropriately to mental health practitioners.

6.27 Three NHS trusts provided mental health services to custody suites: 5 Boroughs Partnership NHS Trust in St Helens; Cheshire and Wirral Partnership NHS Foundation Trust in Wallasey; and Merseycare NHS Trust elsewhere. A process had begun, via the police lead, to bring strategic issues to the attention of the chief executives of these Trusts. Police liaison officers contacted the Trusts to address detainee-specific issues as they arose. A variety of protocols were under review and in revised draft form at the time of the inspection, including those for section 136 and information sharing.

6.28 Every custody suite had access to mental health criminal justice teams during office hours, and to emergency duty teams out of hours. All three trusts checked to see if detainees passing through police custody suites were known to them and provided follow-up as necessary. Custody officers telephoned for assistance as required. Beyond that, service models varied. In all custody suites (except St Helens), mental health practitioners visited daily during the week to offer support and check on detainees. In Liverpool, Merseycare was piloting a diversion-from-custody scheme, to divert people with mental illness away from the criminal justice system. This involved several suites (with St Anne Street as the base), seven days a week, over extended hours, and included providing in-reach services to detainees. In the four months since the pilot started, 30 detainees had been diverted into hospital care from police custody and the courts, compared with 24 in the previous full year. Custody officers were generally happy with out-of-hours arrangements but occasional long delays were cited.

6.29 Police data on the use of section 136 of the Mental Health Act 1983 were incomplete as there were no returns for Knowsley and Southport basic command units. The data available showed that 173 persons had been taken to an NHS place of safety under section 136 in 2011/12, and only six to a custody suite. However, we were frequently told of operational police officers being stationed at NHS units for up to eight hours, waiting for a detainee assessment; in one case there had been a wait of 48 hours. The police were considering their options to deal with these unacceptable waits.

Recommendation

6.30 There should be complete and accurate data on the use of section 136 of the Mental Health Act 1983.

Good practice

6.31 *The Merseycare diversion-from-custody scheme enabled early withdrawal of the mentally ill from the criminal justice system.*

7. Summary of recommendations

Main recommendations

7.1 Detainee risk assessment and care planning should be prioritised, with effective quality assurance, to ensure that all significant risks are identified and managed. (2.35)

7.2 Staff should be trained and supported to recognise and provide for the individual needs of detainees, particularly women and those who are vulnerable or have disabilities. (2.36)

National issues

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. (2.37)

Recommendations

Strategy

7.4 The force should introduce regular custody refresher training for custody sergeants and detention officers. (3.15)

Treatment and conditions

7.5 A hearing loop should be available in all booking-in areas and all custody staff should know how to use it. (4.10)

7.6 Whiteboards should be removed from booking-in areas or placed where they cannot be seen by detainees. (4.11)

7.7 Staff should be trained in risk assessment, proportionate care planning and making observations. (4.29)

7.8 Detainees should only be placed in safety smocks and paper clothing where strictly necessary, and detainees whose own clothing has been removed should be given normal replacement clothing where possible. The use of strip-clothing should be monitored and over use addressed. (4.30)

7.9 There should be one handover for each shift change, which includes all staff working in custody and covers issues relevant to the detainees held. (4.31)

7.10 The quality and consistency of pre-release risk assessments should be improved and made subject to dip-sampling. (4.32)

7.11 Merseyside Police should collate use of force data in accordance with the Association of Chief Police Officers' policy and National Policing Improvement Agency guidance. (4.33)

7.12 Cells should be clean, free of graffiti and properly maintained. (4.40)

7.13 Cell checks should be thorough, regular, documented and consistently applied at all custody suites. (4.41)

7.14 Unreliable call bell systems should be replaced or refurbished. (4.42)

7.15 Mattresses, blankets and pillows should be routinely provided to all detainees. (4.51)

7.16 There should be a stock of disposable razors for detainees who wish to shave before attending court, subject to risk assessment. (4.52)

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

7.18 Detainees should be offered outside exercise, especially those held for longer periods, and all exercise yards should be kept clean and free from ligature points. (4.54)

7.19 Custody suites should hold and offer a range of reading material, including books and magazines suitable for young people and in foreign languages. (4.55)

7.20 Visits should be facilitated in exceptional cases for detainees held for long periods, particularly if they are vulnerable. (4.56)

Individual rights

7.21 Merseyside Police should engage with the local authority to ensure the provision of secure and non-secure beds for juveniles who have been charged to appear in court but cannot be bailed. (5.14)

7.22 Detainees should be able to make a complaint about their care and treatment, and be able to do so before leaving custody. (5.29)

Health care

7.23 There should be robust infection control procedures for all the clinical rooms, which should be regularly cleaned, appropriately equipped and able to be used to take forensic samples. (6.7)

7.24 Resuscitation equipment in the medical rooms and in the booking-in areas in custody suites should be standardised. (6.8)

7.25 All clinical options associated with treatment of wounds, and all clinically indicated medications, should be available. (6.16)

7.26 Clinical records should be kept in accordance with legal requirements. (6.17)

7.27 Medicine cabinets should be constructed and installed to the required standards. (6.18)

7.28 Dispensed medications should be supplied in labelled containers and stored securely. (6.19)

7.29 There should be complete and accurate data on the use of section 136 of the Mental Health Act 1983. (6.30)

Housekeeping points

Strategy

7.30 There should be clarity on working practices and communication between custody sergeants and detention officers to improve the effectiveness of custody provision and the outcomes for detainees. (3.7)

7.31 The force should introduce a forum where custody staff and managers can discuss custody issues. (3.8)

7.32 Quality assurance measures should include person escort records and cross-referencing to closed-circuit television as part of the dip-sampling of custody records, and the monitoring of the quality of staff handovers. (3.16)

Treatment and conditions

7.33 Each suite should have a suitable range of items for religious observance, which should be stored respectfully, and the direction of Mecca should be indicated. (4.12)

7.34 Staff should inform all detainees placed in CCTV cells that they cannot be viewed when using the toilet. (4.13)

7.35 All detainees should be asked if they have dependency obligations during their period in custody. (4.34)

7.36 Details of local support agencies should be given to potentially vulnerable detainees on their release. (4.35)

7.37 Force used in the custody suite should be recorded on the required form. (4.36)

7.38 Fire evacuation procedures should be practised and adequate stocks of handcuffs should be maintained at all suites. (4.43)

7.39 Subject to risk assessment, there should be a small supply of toilet paper in each cell. (4.57)

7.40 Female detainees should routinely be offered hygiene packs. (4.58)

Individual rights

7.41 Police should check the suitability of family members before they are involved as appropriate adults. (5.15)

7.42 Detainees should not be placed in holding rooms already occupied by a detainee and their appropriate adult. (5.16)

7.43 Notices promoting the Immigration Legal Service Commission's police station advice helpline should be prominently displayed and immigration detainees encouraged to use it. (5.17)

7.44 Detainees should receive their rights at the earliest opportunity. (5.25)

7.45 There should be sufficient up-to-date copies of the PACE codes of practice in all custody suites. (5.26)

7.46 Detainees should be informed promptly on waking of any reviews carried out while they were asleep. (5.27)

Health care

7.47 Receipt of clinical supervision should be documented on each occasion. (6.9)

7.48 Clinical supplies in the medical rooms at Kirkby and Wavertree should be removed for use elsewhere or be discarded. (6.20)

7.49 Out-of-date pharmacological reference materials should be discarded. (6.21)

Good practice

Health care

7.50 The use of advanced care plans enabled an agreed plan of care to be instituted when an individual re-entered custody. (6.25)

7.51 The Merseycare diversion-from-custody scheme enabled early withdrawal of the mentally ill from the criminal justice system. (6.31)

Appendix I: Inspection team

Martin Kettle	HMIP team leader
Gary Boughen	HMIP Inspector
Peter Dunn	HMIP inspector
Angela Johnson	HMIP Inspector
Vinnett Pearcy	HMIP inspector
Fiona Shearlaw	HMIP inspector
Paul Davies	HMIC Inspector
Bob Edge	HMIC Inspector
Mark Ewan	HMIC Inspector
Paul Tarbuck	HMIP health services inspector
Rachel Murray	HMIP researcher

Appendix II: Summary of detainee questionnaires and interviews

A voluntary, confidential and anonymous survey of the prisoner population, who had been through a police station in the borough of Merseyside, 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 26 September 2012. A list of potential respondents to have passed through Belle Vale, Copy Lane, Kirkby, Southport, St Anne St, St Helens, Wavertree and Wirral police stations was created, listing all those who had arrived from Huyton, Liverpool, St Helens and Wirral magistrate courts within the past two months.

Selecting the sample

In total 71 respondents were approached. Seventeen respondents reported being held in police stations outside of Merseyside. On the day, the questionnaire was offered to 54 respondents; there were four refusals and three non-returns. All of those sampled had been in custody within the last two months.

Completion of the questionnaire was voluntary. Interviews were carried out with any respondents with literacy difficulties. No respondents were interviewed.

Methodology

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

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

- to fill out the questionnaire immediately and hand it straight back to a member of the research team;
- 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, 47 (87%) 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 58 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 is 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?**

Belle Vale – 15; Copy Lane – 11; St Anne – 12; St Helens – 6; Wirral – 2; Unknown – 1.

Q3 **How old are you?**

16 years or younger	0 (0%)	*40-49 years*	9 (19%)
17-21 years	2 (4%)	*50-59 years*	0 (0%)
22-29 years	17 (36%)	*60 years or older*	1 (2%)
30-39 years	18 (38%)		

Q4 **Are you:**

Male	47 (100%)
Female	0 (0%)
Transgender/Transsexual	0 (0%)

Q5 **What is your ethnic origin?**

White - British	38 (81%)
White - Irish	1 (2%)
White - other	1 (2%)
Black or black British - Caribbean	2 (4%)
Black or black British - African	3 (6%)
Black or black British - other	0 (0%)
Asian or Asian British - Indian	0 (0%)
Asian or Asian British - Pakistani	0 (0%)
Asian or Asian British - Bangladeshi	0 (0%)
Asian or Asian British - other	0 (0%)
Mixed heritage - white and black Caribbean	1 (2%)
Mixed heritage - white and black African	0 (0%)
Mixed heritage- white and Asian	0 (0%)
Mixed heritage - Other	1 (2%)
Chinese	0 (0%)
Other ethnic group	0 (0%)

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

Yes	3 (7%)
No	40 (93%)

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

None	5 (11%)
Church of England	17 (37%)
Catholic	17 (37%)
Protestant	2 (4%)
Other Christian denomination	3 (7%)
Buddhist	0 (0%)
Hindu	0 (0%)
Jewish	0 (0%)
Muslim	2 (4%)
Sikh	0 (0%)

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

Straight/heterosexual	47 (100%)
Gay/lesbian/homosexual	0 (0%)
Bisexual	0 (0%)

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

Yes	8 (17%)
No	39 (83%)

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

Yes	43 (91%)
No	4 (9%)

Section 2: Your experience of the police custody suite

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

Less than 24 hours	12 (26%)
More than 24 hours, but less than 48 hours (2 days)	22 (47%)
More than 48 hours (2 days), but less than 72 hours (3 days)	8 (17%)
72 hours (3 days) or more	5 (11%)

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

Yes	38 (84%)
No	3 (7%)
Don't know/Can't remember	4 (9%)

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

Yes	20 (43%)
No	23 (50%)
I don't know what this is/I don't remember	3 (7%)

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

My clothes were not taken	18 (38%)
I was offered a tracksuit to wear	2 (4%)
I was offered an evidence/ paper suit to wear	14 (30%)
*I was **only** offered a blanket*	8 (17%)
Nothing	5 (11%)

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

Yes	40 (85%)
No	7 (15%)
Don't know	0 (0%)

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

Yes	16 (36%)
No	29 (64%)

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

	Good	*Neither*	*Bad*
Cleanliness	12 (26%)	20 (43%)	14 (30%)
Ventilation/air quality	13 (29%)	12 (27%)	20 (44%)
Temperature	5 (11%)	8 (18%)	32 (71%)
Lighting	19 (42%)	12 (27%)	14 (31%)

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

Yes	28 (60%)
No	19 (40%)

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

Yes	7 (15%)
No	39 (85%)

Q20 **Were you held overnight?**

Yes	43 (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	22 (47%)
Blanket	33 (70%)
Nothing	8 (17%)

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

Not held overnight / Did not get any bedding	12 (27%)
Yes	13 (30%)
No	19 (43%)

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

Yes	7 (15%)
No	40 (85%)

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

Yes	1 (2%)
No	46 (98%)

Q25 **Were you offered anything to:**

	Yes	*No*
Eat?	34 (72%)	13 (28%)
Drink?	39 (87%)	6 (13%)

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%)	11 (24%)	10 (22%)	16 (35%)	6 (13%)

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

I did not have any food or drink	6 (15%)
Yes	15 (38%)
No	19 (48%)

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	15 (32%)
I was allowed to smoke	2 (4%)
I was offered a nicotine substitute	0 (0%)
I was not offered anything to cope with not smoking	30 (64%)

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

Yes	7 (15%)
No	40 (85%)

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

Yes	22 (47%)
No	10 (21%)
I don't know	5 (11%)
I didn't want to inform anyone	10 (21%)

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

Yes	22 (48%)
No	24 (52%)

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

My telephone call was not denied	30 (67%)
Yes	5 (11%)
No	10 (22%)

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

	Yes	*No*
Who was taking care of your children	3 (8%)	34 (92%)
Contacting your partner, relative or friend	23 (52%)	21 (48%)
Contacting your employer	1 (3%)	35 (97%)
Where you were going once released	8 (21%)	31 (79%)

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

Yes	39 (85%)
No	7 (15%)

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

Was not offered free legal advice	7 (16%)
Yes	20 (45%)
No	17 (39%)

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

Yes	35 (74%)	
No	12 (26%)	If No, go to Q41

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

Did not ask for a solicitor/was not interviewed	16 (34%)
Yes	24 (51%)
No	7 (15%)

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

Did not need an appropriate adult/was not interviewed	27 (59%)
Yes	3 (7%)
No	16 (35%)

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

Did not need an interpreter/was not interviewed	29 (63%)
Yes	1 (2%)
No	16 (35%)

Section 3: Safety

Q41 **Did you feel safe there?**

Yes	29 (64%)
No	16 (36%)

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

Yes	17 (36%)
No	30 (64%)

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

I have not been victimised	30 (65%)	*Because of your crime*	7 (15%)
Insulting remarks (about you, your family or friends)	9 (20%)	*Because of your sexuality*	0 (0%)
Physical abuse (being hit, kicked or assaulted)	6 (13%)	*Because you have a disability*	1 (2%)

Sexual abuse	0 (0%)	*Because of your religion/religious beliefs*	0 (0%)
Your race or ethnic origin	2 (4%)	*Because you are from a different part of the country than others*	1 (2%)
Drugs	3 (7%)		

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

Yes	31 (66%)
No	10 (21%)
I wasn't handcuffed	6 (13%)

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

Yes	7 (15%)
No	39 (85%)

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

Yes	8 (17%)
No	39 (83%)

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

Yes	3 (6%)
No	44 (94%)

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

Very well	*Well*	*Neither*	*Badly*	*Very badly*	*Don't remember*
3 (6%)	14 (30%)	15 (32%)	8 (17%)	6 (13%)	1 (2%)

Section 4: Health care

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

Yes	13 (28%)
No	28 (61%)
Don't know	5 (11%)

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

	Yes	*No*
Doctor	12 (31%)	27 (69%)
Nurse	12 (32%)	25 (68%)
Paramedic	0 (0%)	29 (100%)

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

Yes	8 (18%)
No	18 (41%)
Don't know	18 (41%)

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

Yes	13 (28%)
No	33 (72%)

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

Not taking medication	33 (72%)
Yes	3 (7%)
No	10 (22%)

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

Yes 11 (24%)
No 35 (76%)

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

I didn't have any drug/alcohol problems 35 (76%)
Yes 2 (4%)
No 9 (20%)

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

I didn't have any drug/alcohol problems 35 (76%)
Yes 0 (0%)
No 11 (24%)

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*
25 (54%)	2 (4%)	4 (9%)	10 (22%)	2 (4%)	3 (7%)

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

Yes 10 (22%)
No 35 (78%)

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

Yes 5 (11%)
No 41 (89%)

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

I didn't have any mental health care needs 41 (89%)
Yes 0 (0%)
No 5 (11%)

Appendix III: Photographs

Stained ceilings at St Anne Street

Graffiti in a suite naming someone as a ‘grass’

Prisoner survey responses for Merseyside 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

		2012 Merseyside Police	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		47	2116
SECTION 1: General information			
3	Are you under 21 years of age?	**4%**	**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)?	**14%**	**29%**
6	Are you a foreign national?	**7%**	**15%**
7	Are you Muslim?	**4%**	**10%**
8	Are you homosexual/gay or bisexual?	**0%**	**2%**
9	Do you consider yourself to have a disability?	**16%**	**20%**
10	Have you been in police custody before?	**92%**	**92%**
SECTION 2: Your experience of this custody suite			
11	Were you held at the police station for over 24hours?	**74%**	**68%**
12	Were you told your rights when you first arrived?	**85%**	**80%**
13	Were you told about PACE?	**43%**	**51%**
For those who had their clothing taken away:			
14	Were you given a tracksuit to wear?	**7%**	**40%**
15	Could you use a toilet when you needed to?	**86%**	**91%**
16	If you used the toilet, was toilet paper provided?	**35%**	**48%**
17	Would you rate the condition of your cell, as 'good' for:		
17a	Cleanliness?	**27%**	**34%**
17b	Ventilation/air quality?	**29%**	**23%**
17c	Temperature?	**11%**	**17%**
17d	Lighting?	**42%**	**45%**
18	Was there any graffiti in your cell when you arrived?	**60%**	**55%**
19	Did staff explain the correct use of the cell bell?	**15%**	**23%**
20	Were you held overnight?	**92%**	**92%**
For those who were held overnight:			
21	Were you given any items of bedding?	**82%**	**84%**
For those who were held overnight and were given items of bedding:			
22	Were these clean?	**41%**	**62%**
23	Were you offered a shower?	**14%**	**9%**
24	Were you offered a period of outside exercise?	**2%**	**6%**
25a	Were you offered anything to eat?	**72%**	**81%**
25b	Were you offered anything to drink?	**87%**	**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?	**44%**	**44%**

Key to tables

		2012 Merseyside Police	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?	**4%**	**7%**
29	Were you offered anything to read?	**14%**	**14%**
30	Was someone informed of your arrest?	**46%**	**43%**
31	Were you offered a free telephone call?	**48%**	**50%**
If you were denied a free telephone call:			
32	Was a reason given?	**31%**	**14%**
33	Did you have any concerns about:		
33a	Who was taking care of your children?	**8%**	**14%**
33b	Contacting your partner, relative or friend?	**52%**	**52%**
33c	Contacting your employer?	**3%**	**19%**
33d	Where you were going once released?	**20%**	**31%**
34	Were you offered free legal advice?	**85%**	**89%**
For those who were offered free legal advice:			
35	Did you accept the offer of free legal advice?	**54%**	**69%**
For those who were were interviewed and needed them:			
37	Was a solicitor present when you were interviewed?	**78%**	**81%**
38	Was an appropriate adult present when you were interviewed?	**15%**	**30%**
39	Was an interpreter present when you were interviewed?	**6%**	**13%**
SECTION 3: Safety			
41	Did you feel unsafe?	**35%**	**38%**
42	Has another detainee or a member of staff victimised you?	**36%**	**33%**
43	If you have felt victimised, what did the incident involve?		
43a	Insulting remarks (about you, your family or friends)	**20%**	**16%**
43b	Physical abuse (being hit, kicked or assaulted)	**12%**	**11%**
43c	Sexual abuse	**0%**	**2%**
43d	Your race or ethnic origin	**4%**	**3%**
43e	Drugs	**6%**	**9%**
43f	Because of your crime	**14%**	**12%**
43g	Because of your sexuality	**0%**	**1%**
43h	Because you have a disability	**2%**	**2%**
43i	Because of your religion/religious beliefs	**0%**	**2%**
43j	Because you are from a different part of the country than others	**2%**	**4%**
44	Were your handcuffs removed on arrival at the police station?	**75%**	**74%**
45	Were you restrained whilst in the police custody suite?	**15%**	**19%**
46	Were you injured whilst in police custody, in a way that was not your fault?	**16%**	**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?	**36%**	**36%**

Key to tables

		2012 Merseyside Police	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	**31%**	**43%**
51b	Nurse	**33%**	**21%**
	Percentage seen by either a doctor or a nurse	**48%**	**51%**
51c	Paramedic	**0%**	**4%**
52	Were you able to see a health care professional of your own gender?	**17%**	**26%**
53	Did you need to take any prescribed medication when you were in police custody?	**29%**	**42%**
For those who were on medication:			
54	Were you able to continue taking your medication while in police custody?	**21%**	**33%**
55	Did you have any drug or alcohol problems?	**25%**	**52%**
For those who had drug or alcohol problems:			
56	Did you see, or were offered the chance to see a drug or alcohol support worker?	**17%**	**43%**
57	Were you offered relief or medication for your immediate withdrawal symptoms?	**0%**	**25%**
For those who were seen by health care:			
58	Would you rate the quality as good/very good?	**27%**	**30%**
59	Did you have any specific physical health care needs?	**23%**	**32%**
60	Did you have any specific physical health care needs?	**10%**	**24%**
For those who had any mental health care needs:			
61	Were you seen by a mental health nurse/psychiatrist?	**0%**	**14%**