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

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by

HM Inspectorate of Prisons and

HM Inspectorate of Constabulary

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Contents

1. **Introduction** 5

2. **Background and key findings** 7

3. **Strategy** 11

4. **Treatment and conditions** 15

5. **Individual rights** 21

6. **Health care** 25

7. **Summary of recommendations** 31

Appendices

I Inspection team 35
II Summary of detainee questionnaires and interviews 36

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

This unannounced inspection looked at the custody suites run by Nottinghamshire police. At the time of the inspection the force operated three suites designated under the Police and Criminal Evidence Act (PACE). Each operated 24 hours a day and together they provided a total cell capacity of 120.

Management arrangements were convoluted, leading to confusion among staff. Quality assurance checks were minimal which meant that risks were potentially not identified and remedial action not taken. A lack of timely management information hindered performance monitoring and improvement of the custody function. There was a positive relationship with the Police Authority and an active independent custody visitors scheme. Good work had been undertaken to establish the *Safer Detention and Handling of Persons in Police Custody* 2006 (SDHP) compliance of custody suites, through the production of a Custody Estates Condition Document.

The physical environment of the suites was generally poor but Nottingham was a significant concern. The suite was filthy and covered in unpleasant graffiti and there was little evidence of a regular cleaning regime. This needed immediate attention. The use of a padded cell at the suite was also of concern, although we were told during the inspection that this had been taken out of commission. Health and safety procedures were inconsistent and the quality of CCTV needed improvement. We had a number of concerns about risk assessment and the management of those who were vulnerable, although interactions between staff and detainees were respectful and appropriate. The facilities at Nottingham for religious observance were excellent. Use of handcuffs was proportionate. As we have found elsewhere, there was a lack of appropriate monitoring of the use of force. Many elements of detainee care were by request only.

An appropriate balance was maintained between progressing cases and the rights of individuals, and PACE was generally adhered to. Ongoing work to develop alternatives to custody provision required further development and promotion, and custody officers needed to ensure that the 'necessity test' for arrest was meaningfully undertaken. Immigration detainees were too often held for lengthy periods. Arrangements for providing appropriate adults were good but arrangements for taking complaints were confused.

Primary health care provision was generally good, supported by robust medicines management. However, clinical governance arrangements needed improvement and medical rooms were dirty. Custody staff had enhanced resuscitation knowledge. Drug misuse services were generally sound. Mental health provision was variable with good diversion services available in the county basic command unit (BCU) but not, where most needed, in the city BCU. This was similar for direct support for those with alcohol-related issues. There was a lack

[1] Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.

of reliable management information regarding detention under Section 136 of the Mental Health Act, but it was accepted that police custody was too often being used for this.

Overall, police custody in Nottinghamshire at the time of the inspection was poor. The environment at Nottingham was unacceptable, and management, quality assurance and risk management arrangements needed urgent attention. Despite this staff interactions with detainees were good. We gave the force immediate feedback after our inspection and we are pleased to note they responded quickly and effectively to our concerns. A return visit to the Nottingham Bridewell soon after the main inspection found that significant improvements had already been made. We expect this progress to be sustained and this report provides a number of recommendations to assist the force and the Police Authority to improve the provision of custody in Nottinghamshire. 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.

Sir Denis O'Connor	**Nick Hardwick**
HM Chief Inspector of Constabulary	**HM Chief Inspector of Prisons**

October 2011

2. Background and key findings

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

2.2 At the time of this unannounced inspection, Nottinghamshire Police had three custody suites designated under PACE for the reception of detainees, operating 24 hours a day. These dealt with detainees arrested as a result of mainstream policing. A fourth suite at Newark was due to re-open in the near future, when the suite at Worksop closed. There was a total cell capacity of 120. The force provided total throughput figures of 39,012 detainees in the year to June 2011, and 145 detainees had been held for immigration matters in the year to the end of September 2011.

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

Custody suite	Basic command unit (BCU)	Number of cells
Nottingham Bridewell	City	72
Mansfield	County	32
Worksop	County	8
Newark (closed at the time of the inspection)	County	8
Total		**120**

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

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

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

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

Strategic overview

2.6 The assistant chief constable (ACC) with portfolio responsibility for custody was well engaged with strategic partners. Relationships between the Nottinghamshire Police Authority (PA) and the force were said to be generally positive. There was an active independent custody visitors (ICV) scheme.

2.7 Custody was managed centrally. There had been recent changes in the strategic structure which were not yet fully embedded. The estate was in the process of being rationalised, and some good work had been done to identify safer detention risks in the older suites. Day-to-day management arrangements were convoluted and confusing. Little, if any, quality assurance or 'learning the lessons' work took place locally. Staff were demotivated and said that they lacked effective leadership.

2.8 Staff working in custody were permanent and staffing levels were adequate. They completed relevant training before working in custody, and there was regular refresher training.

Treatment and conditions

2.9 Interactions with detainees were relaxed and friendly. Awareness of some diversity issues was mixed, although there were pockets of good practice. The multi-faith room at Nottingham was an excellent initiative. Many aspects of privacy were poor, which had implications for respectful treatment and the safety of detainees.

2.10 Initial risk assessments varied in quality but risk management arrangements were generally proportionate. Some intoxicated detainees were not being roused and recording of this was poor. The use of the 'padded cell' at Nottingham was unacceptable and dangerous. Arrangements for handovers were not sufficiently robust. Some information about risk was not being accurately transcribed on the prisoner escort record (PER). Despite a programme of upgrading, some closed-circuit television (CCTV) equipment was inadequate. Handcuffs were used proportionately. The arrangements to oversee the use of force needed improvement.

2.11 The physical environment of custody suites was generally poor. The Nottingham suite was particularly concerning; it was dirty, with many cells covered in graffiti. We were also concerned about the cell call bell system in use. We found some ligature points in cells but the force was aware of the majority of them. Staff were aware of fire evacuation arrangements but it was not clear if these had been practised. Health and safety walk-throughs were underdeveloped. Many elements of care were by request only.

2.12 We saw limited evidence that showers, outside exercise or reading materials were offered. Food was provided regularly but was of poor quality.

Individual rights

2.13 Custody sergeants authorised custody but there was little critical examination of the necessity test and insufficient focus on alternatives to custody. PACE was generally adhered to but few detainees were offered a free telephone call.

2.14 Detainees were not routinely asked if they had any dependency obligations. Pre-release risk assessments were completed but limited action was taken. Detainees held for immigration matters were often held for over-long periods. Arrangements for providing appropriate adults (AAs) were good for juveniles and vulnerable adults.

2.15 Court cut-off times were generally reasonable but were sometimes too early. Detainees were not told how to make a complaint and, when they did, the arrangements for dealing with them were confused.

Health care

2.16 Primary care services were provided by Medacs and clinical governance arrangements were adequate. Health care was provided by a combination of nurses and forensic medical examiners (FMEs). Most clinical rooms were in a poor state. The management of medications was robust. All the custody suites had resuscitation equipment, and custody staff were trained in its use, but some elements were missing. Health care provision was generally good. Waiting times were reasonable but delays sometimes occurred.

2.17 Arrangements for providing methadone and symptomatic relief for substance users were good and detainees could continue to receive their prescribed medications. Substance use services were well developed, although there was signposting only for those with alcohol-related issues.

2.18 Mental health diversion services were mixed, with good provision in the county basic command unit (BCU) but nothing in the city. The force indicated that a number of detainees had been held in police custody under section 136 of the Mental Health Act 1983[4] but was unclear about the precise number. Staff had received mental health awareness training.

Main recommendations

2.19 **The management information available, including quality assurance of near misses/adverse incidents, should be improved in order to ensure that outcomes for detainees are adequate.**

2.20 **Management arrangements should provide sufficient oversight to ensure clarity of roles, responsibility and required outcomes.**

2.21 **The quality and consistency of initial risk assessments should be improved to ensure the safety of detainees, and the use of closed-circuit television (CCTV) for 'constant' watches, where observation is intermittent, should cease.**

2.22 **Cells should be clean, free of graffiti, well maintained and properly heated and ventilated, and improvement of the environment at Nottingham should be treated as an urgent priority.**

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

3. Strategy

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

3.1 An ACC provided strategic leadership on custody issues and was also deputy chair of the Local Criminal Justice Board. The force operated a centralised custody model, with provision being managed by the Crime and Justice Directorate (C&JD) with responsibility for policy and procedure, staffing and estates. A chief superintendent led the C&JD and line-managed the Head of Criminal Justice, who in turn line-managed the head of custody.

3.2 The force had recently restructured to two BCUs, and the custody function was included in tranche 2 of the force reorganisation programme to meet a budget reduction of £43 million.

3.3 The force had an estates strategy, which involved reopening the Newark custody suite and closing Worksop, thereby maintaining three designated full-time custody suites. It had looked at the estate on the basis of need, cost and risk. There was considerable confusion among staff and managers about the timescale for these changes. Good work had been undertaken to establish the SDHP compliance of custody suites through a custody estates condition survey, and to take remedial action if resources allowed. There was a clear plan, which prioritised the work that needed to be carried out, and decisions to shut suites had been based partly on issues around risk. Cell surveys found few major issues, and the force was already aware of and managing them.

3.4 There was a custody manager (inspector) from the C&JD for both BCUs. The line management of custody staff differed between the county and city BCUs, with the former managed by the custody manager and the latter by the PACE inspectors. The five PACE inspectors in the county BCU were line-managed by BCU staff and the five in the city BCU by Criminal Justice staff. Staff expressed a lack of clarity and leadership, and some conflict of roles, as the PACE inspectors in the county also had responsibility for other areas of BCU performance. It was unclear who was responsible for dealing with the day-to-day issues for custody. The management arrangements at this level were too complex and cumbersome, resulting in a lack of corporacy and leading to confusion (see main recommendation 2.20). Staff reported that senior managers, with the exception of the head of custody, were not visible and this was having a negative effect on morale.

3.5 Staffing within custody suites was adequate, and comprised permanent custody sergeants, supported by detention officers, who looked after the ongoing care and welfare of detainees. There appeared to be sufficient staffing resilience for custody staff to be moved between suites, providing flexibility.

3.6 The initial custody training lasted four to five weeks, depending on need. Staff had regular refresher training.

3.7 There were strategic structures for discussing custody issues, although mainly by exception reporting. It appeared that this was disconnected from delivery; for example, the quality assurance regime in custody, which the ACC said that he relied on, did not operate. The potential for major custody-related issues to be raised at the strategic level was not being realised.

3.8 It was not clear that the custody user group meeting, due to be held monthly, was taking place. The criminal justice management group met weekly. The PACE inspectors in the C&JD met fortnightly. There was no forum for the PACE inspectors in the county BCU to meet. There was no performance management framework for the custody function and little current management information, so the force had great difficulty in providing us with the information we required.

3.9 The PA had a specific lead member with responsibility for custody. While relationships were generally good, it was reported that communication about recent changes in custody had not been as clear as previously experienced. The PA lead met the head of the C&JD quarterly but this had lapsed and not taken place for six months. The PA lead was also the lead for the ICV scheme, which was seen as an important independent oversight mechanism. The PA held quarterly meetings for panel coordinators, chaired by the PA lead and attended by the Criminal Justice Inspector.

3.10 Partnership arrangements were described as good, with active engagement with relevant criminal justice and health partners. The ACC was the deputy chair of the regional Criminal Justice forum, the remit of which included looking at ways to collaborate between forces.

3.11 An overarching policy for custody was on the local area network. A monthly newsletter, which contained information about risks, and Independent Police Complaints Commission (IPCC) 'learning the lessons' information were emailed to custody staff. Staff were not aware of where the latter information was archived and were therefore unable to research previous circulations. Action had been taken in response to the IPCC investigation of a death in custody in 2010, with the PA providing oversight of the action taken. There was no single page or central repository on the force intranet where learning lessons information was held for future reference.

3.12 A near-miss and adverse incident process existed but no trend data were analysed or developed from the information. An electronic form was available on the custody system which was automatically forwarded to the occupational health department. Further notification took place only on an ad hoc basis. It was unclear where the threshold was set with regard to recording near misses and adverse incidents, and it appeared that the bar was set very high for serious self-harm (see main recommendation 2.19).

3.13 No structured dip-sampling of custody records had taken place for around six to 12 months, exposing the force and detainees to unnecessary risk. There was no process for dip-sampling CCTV; the system requiring considerable investment to bring it up to standard. It was also unclear how these processes, when undertaken, informed decision making within the governance process for custody.

Housekeeping points

3.14 The meeting structure should support governance arrangements which allow the escalation of unresolved issues to the appropriate level within the organisation.

3.15 A custody-specific area on the force intranet site should be developed to store all lessons learned information previously circulated.

Good practice

3.16 *Good work had been undertaken to establish the Safer Detention and Handling of Persons in Police Custody 2006 (SDHP) compliance of custody suites, and to take remedial action if resources allowed.*

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 detainees were brought to the custody suites in police cars. The vehicles we looked at were clean and in good condition. Custody staff were respectful in their interactions with detainees, using first names routinely, and it was clear that staff had a detailed knowledge of some detainees from previous visits to custody. Detainees told us that staff treated them well and were mostly helpful and considerate.

4.2 The booking-in desks were of a reasonable height to facilitate communication between custody staff and detainees. However, we observed detainees being processed in the full hearing of other detainees, who were allowed to stand in the vicinity of the person being booked in. We were told that there were no facilities for detainees to disclose sensitive information in private. We saw some poor management of the custody areas, with detainees, staff and visitors standing around with little, if any, challenge from the custody officers about why they were in the area.

4.3 There was mixed awareness of the distinct needs of various groups. There were notices in the custody suites informing female detainees of the availability of hygiene packs and of the option to see a female officer. A custody officer at Nottingham told us that it was force policy to offer transgender detainees a choice of being searched by male or female staff. Staff had not received any specific awareness training for dealing with juveniles and told us that they generally treated them in the same way as adult detainees. At Mansfield we observed a 16-year-old detainee sitting on a bench waiting for an AA and for interview, rather than being held in a cell. It was positive that ICVs had made the decision to focus on females and juvenile detainees during their visits.

4.4 Prayer mats and holy books were available, although at Worksop staff had difficulty locating the prayer mat. We observed a detainee at Mansfield requesting a Bible, and this was quickly located and provided. At Nottingham, there was a comfortable multi-faith room, containing a wide range of holy books, including the Bible and Qur'an. There was a prayer mat and a compass for determining the direction of Mecca, all stored respectfully in a filing cabinet. Staff assured us the room was often used for religious observance.

4.5 There was little provision for the hard of hearing, with no hearing loops installed, although some staff were trained in the use of sign language. Custody sergeants at Nottingham were unaware of the Home Office online resources for booking in deaf detainees. Two cells at Nottingham, but none elsewhere, had wide doors and lowered call bell buttons, and a wheelchair was available. We found a small stock of thick mattresses at Nottingham which were designed to increase the height of the bed plinths for those with mobility issues, although staff did not seem to know of their existence or function.

Recommendation

4.6 **Booking-in areas should provide sufficient privacy to facilitate effective communication between staff and detainees and there should be clear policies and procedures to meet the specific needs of juvenile detainees and those with disabilities.**

Good practice

4.7 *The facilities at Nottingham for religious observance provided by the multi-faith room and its contents were excellent.*

Safety

4.8 Custody sergeants carried out initial risk assessments but sometimes failed to question further when there was information about risk that should have raised concerns. The variable quality of risk assessments was confirmed by our custody record analysis. This showed that there had been instances when detainees' previous disclosures of self-harm and suicide attempts had not appeared to have been taken into account when they had been brought into the custody suite again a few days later (see main recommendation 2.21). Police National Computer (PNC) markers about previously identified risks were considered during risk assessment. Custody sergeants requested, via email, that custody clerical officers put new markers onto the PNC but it was unclear whether the reliability of this system was subject to management checks.

4.9 The frequency of detainee observations seemed proportionate and reasonable. However, at Nottingham, CCTV was being monitored at the front desk for what were described as 'constant' watches (see main recommendation 2.21). We saw CCTV being left unattended for several minutes while detainees were subject to such observation. The detention officer staffing this desk also attended to cell call bells. The CCTV systems at Mansfield and Nottingham were unsatisfactory. Images of some cells were blurred, and in some there were unacceptably large areas of the cell that were out of view. There was an action plan to address these issues which we were told was due for completion by the end of 2011.

4.10 Our custody record analysis showed that risk assessments were reviewed and amended appropriately during the detainee's stay. Detention officers understood the type of response they should obtain when doing rousing checks, although few such checks were noted in custody records, even when they had been prescribed. In several custody records recording that detainees had been intoxicated on arrival in custody, rousing had not been prescribed by the custody officer; it was not clear why.

4.11 The carrying of anti-ligature knives was *ad hoc* and was not enforced by custody officers. At Worksop, a large anti-ligature knife was stored behind the booking-in desk but this was not the case at Mansfield.

4.12 Arrangements for shift handovers were poor. There were separate staff handovers for custody sergeants and detention officers. At Nottingham, we observed each custody sergeant receiving a handover concerning only those detainees in the few cells for which they were responsible, without taking into account the fact that the delegated responsibilities for some of the detainees might change during the shift. The handover was delivered in the vicinity of a detainee being booked in, who could overhear confidential information about other detainees. The handover we observed at Mansfield was chaotic, with 12 custody staff behind the booking-

in desk at the same time, and it was difficult to understand how individual staff members could contribute to the overall briefing.

4.13 All custody staff received regular, high-quality first-aid training.

Recommendations

4.14 **The quality of the CCTV at Mansfield and Nottingham should be improved.**

4.15 **Intoxicated detainees should be roused, and this should be clearly recorded in the custody record and log.**

4.16 **Handovers should be comprehensive and attended by detention officers and police custody staff, with the area in which the handover takes place cleared of other staff and detainees.**

Housekeeping point

4.17 All custody staff should carry anti-ligature knives while carrying out their duties in the custody suite.

Use of force

4.18 Most police officers we spoke to told us that they would only use handcuffs when it was proportionate and necessary. This was borne out in our analysis of custody records, which recorded few detainees arriving at custody suites in handcuffs.

4.19 We were told that all uses of force in the custody suite were recorded using the online reporting system. However, staff and managers did not receive any feedback from this, and the force was unable to provide evidence that the information submitted was being monitored.

Recommendation

4.20 **Nottingham police should collate the use of force in accordance with the Association of Chief Police Officers policy and National Policing Improvement Agency guidance.**

Physical conditions

4.21 At Worksop, there were some older cells, shared with the court service, which were in a poor state of decoration and cold. However, with the exception of the men's showers, they were all clean and mainly free of graffiti. At Mansfield, the CCTV-equipped cells had large amounts of dried toilet paper and newspaper on and around the camera, which appeared to have been there for some time. Some detainees complained of the cells being cold. Conditions at Newark were reasonable.

4.22 The physical conditions of two of the three floors of cells at Nottingham were very poor. Cells were filthy, with evidence of body fluids, food and other materials on the walls, floors and ceilings. A toilet in a cell that was ostensibly ready for the next detainee contained faeces and some toilets did not flush properly. In most cells, food, toilet paper and other detritus had been

thrown at the CCTV cameras and not cleaned off. Several cells had cracks in the glass windows in the doors, and many smelt foul. All contained extensive graffiti, some of it offensive. Ventilation grilles were covered with a thick layer of dust, and some cells that had been vacated were littered with used food containers and polystyrene cups. These issues were echoed in our survey, where only 10% of responders rated the cleanliness of the cell they had been kept in as good, which was considerably worse than the 32% comparator. Furthermore, 84% of responders, against the 54% comparator, indicated that there had been graffiti in their cell. Custody staff were often relied on to clean cells after occupation, including the removal of body fluids. There was no proper cleaning routine and staff told us that deep cleaning was rare (see main recommendation 2.22). During the inspection, the force indicated a desire to rectify these issues as a priority.

4.23 There was a padded cell at Nottingham which was being used for constant observations (a member of staff at the door), even though senior managers told us that it was no longer in use. The cladding covering the walls was filthy, covered in graffiti and damaged to the point of being dangerous. It was a fundamentally dehumanising and disrespectful environment in which to hold detainees, not least those with additional vulnerabilities. When we pointed out the continued use of this cell senior managers told us it would be taken out of use immediately.

4.24 We were told that pre- and post-occupancy cell checks took place but there was no systematic means to ensure that this happened. There were weekly ligature point checks with a narrative report but no structured template to guide the process. We were told that the facilities manager carried out some checks but staff were not clear what these entailed and said that there were long delays in getting general maintenance work done. In the city BCU, weekly, monthly and quarterly health and safety checks were carried out by sergeants. The monthly check involved the facilities department, custody manager and health and safety representative and was carried out in accordance with a template. The process for the county BCU was unclear. The force was aware of the ligatures we found during our safety inspection.

4.25 There was a fire evacuation policy but it was not possible to ascertain when the most recent fire drill had taken place. At Worksop, no one could recall a drill ever being undertaken, and at Mansfield we were told that one had taken place about 12 months earlier. However, staff had an understanding of their duties in such an event. We were told at Nottingham that, as the custody suite was too large and busy for practice fire evacuations to be held, there had been regular 'table top' fire drills, the most recent taking place in March 2011.

4.26 We saw staff explaining the use of call bells to some, but not all, detainees when taking them to cells. We observed a pregnant woman with asthma, who could not speak English and who had not previously been in custody, being taken to a cell without an explanation of the use of the call bell. Most detainees we spoke to indicated that the response to the call bell was good. The call bell system at Nottingham was old and a cause for concern. Call bells activated on the upper floors could only be answered on the ground floor and staff found the system difficult to use.

Recommendations

4.27 **The padded cell at Nottingham should be permanently taken out of use.**

4.28 **Health and safety walk-through arrangements should be thorough and consistently applied at all custody suites and should include a structured approach to the identification of ligature points as part of the daily cell checks.**

4.29 **The call bell system at Nottingham should be replaced or refurbished.**

Housekeeping points

4.30 Fire evacuation drills should be carried out in all custody suites.

4.31 Correct use of call bells should be explained to all detainees.

Personal comfort and hygiene

4.32 All cells were provided with a mattress and most with a pillow, although not on the ground floor at Nottingham, where the latter were deemed safety hazards. These were wiped down after each use at Mansfield and Worksop, but not Nottingham, where some were covered in flakes of paint which had been scraped from walls. Blankets were provided at night or when requested. There was a structured laundering service in place.

4.33 A small supply of toilet paper was provided but in some cells containing CCTV coverage the toilet area was not sufficiently obscured on monitors.

4.34 Several of the showers at Nottingham were out of use. Staff told us that there was a problem with the hot water at the weekend because it was supplied from the neighbouring magistrates' court hot water system, which only operated on weekdays. The showers that were functioning were dirty. At Mansfield and Worksop, the showers were in good order but some were dirty. Many of the showers afforded little privacy, particularly for female detainees. In our survey, only 6% of detainees, against the 9% comparator, said that they had been offered a shower. This finding was supported by our analysis of custody records. A supply of soap and toothbrushes was available but no razors. There were also no mirrors, so male detainees were not able to shave before attending court.

4.35 There was a good supply of replacement clothing for detainees whose clothing had been seized or soiled. These included various sizes of jogging bottoms, T-shirts, underwear, socks plimsolls and slippers. In our survey, 73% of responders indicated that they had been given replacement clothing at the police station, which was considerably better than the 43% comparator.

Recommendation

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

Housekeeping points

4.37 The CCTV system should effectively obscure the toilet area in cells.

4.38 Pillows should be provided to all detainees.

4.39 There should be facilities for male detainees to have a shave before attending court.

Catering

4.40 In our survey, only 5% of detainees said that the quality of the food they had been offered was good or very good. The ambient microwave meals were of low calorific value. However, there was a good choice available and it catered for special diets such as halal and vegetarian. Drinks were provided on request. All detention officers had received food handling training, and the temperature of each meal was checked with a heat probe before serving.

Recommendation

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

Activities

4.42 All custody suites had outside exercise yards but staff told us that they were rarely used. This was supported by our observations and review of custody records. There was a large amount of graffiti in the yard at Mansfield.

4.43 Each suite had a small selection of magazines, newspapers and books, which were issued on request, but there was nothing in any languages other than English or suitable for limited literacy skills.

4.44 We were told that visits were rarely, if ever, offered, even for children and juveniles.

Recommendation

4.45 **Detainees, particularly those held for more than 24 hours, should be offered exercise, and the exercise yards should be made fit for purpose.**

Housekeeping point

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

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 custody sergeants checking the circumstances of the individual's offence but few asked arresting officers about the necessity to detain. Several custody officers indicated that the awareness of many arresting officers about the 'necessity test' was poor and that the use of alternatives to custody could be improved. We were given anecdotal examples of occasions when sergeants had refused to accept detainees because the grounds for detention had not been clearly established but we did not observe this during the inspection. We were advised that the force was developing some work to encourage a focus on the 'necessity test' and alternatives to custody.

5.2 Custody sergeants were clear about their obligations to ensure that cases proceeded quickly but custody staff and solicitors alike told us that delays were experienced regularly at Nottingham. We were told, and observed, that investigating staff sometimes needed prompting by custody officers to ensure that there were no unnecessary delays but the volume of detainees being processed in the suite, and additional factors such as the design of the building and the staffing structure required to operate it, were also believed to contribute to delays. At Worksop, we observed a man being arrested in the early evening but not interviewed until lunchtime the following day; he was then charged but, having missed the afternoon court times, remained in custody until the following morning – a detention of approximately 36 hours. We could find no evidence that the unacceptably long period of time he was held in custody had been challenged during inspector reviews which took place during this time. Mansfield was cited by a solicitor we spoke to as being particularly good at expediting time spent in custody. We were concerned that PACE inspectors did not challenge these issues sufficiently when reviewing continued detention.

5.3 Custody staff reported good relationships with the UK Border Agency but we were told that some immigration detainees waited several days to be collected. Data supplied by the force showed that, over the previous 12 months, more than 40% of immigration detainees had been held over 24 hours, with the longest being over four days.

5.4 Despite our survey results being negative in this regard, we observed detainees being provided with a detailed leaflet summarising their rights and entitlements, and saw examples of custody staff checking detainees' understanding. Custody sergeants downloaded and printed information for non-English-speaking detainees about rights in their own languages. A professional telephone interpreting service was readily available and also a good face-to-face interpreting service, catering for foreign languages and sign language.

5.5 Detainees were asked on arrival if they wanted someone to be told of their whereabouts. Although our custody record analysis showed that seven (23%) detainees had wanted someone to be informed of their arrest, custody staff had attempted to contact the nominated person in only five of these cases. Telephone calls were made in public areas, affording little privacy. Our survey showed that free telephone calls had been provided in only 33% of cases,

which was much worse than the comparator, and this was borne out by our analysis of custody records.

5.6 Children and young people were not usually held in custody under Section 46 of the Children Act 1989.[5]

5.7 We observed staff asking about possible dependency obligations but this was limited to asking women about their childcare responsibilities. Staff told us that they believed that detainees would volunteer information about other dependants, such as elderly or infirm relatives. Detainees' concerns about this issue were not recognised as a risk factor that could affect their behaviour or well-being while in custody.

5.8 A pre-release risk assessment was completed but the custody records we reviewed reflected that a 'tick-box' approach was adopted, even in a number of cases where potential vulnerabilities might have been taken into consideration. In one case, a 20-year-old female had been released at 4am, with no consideration as to how she would return home. However, it was clear that custody sergeants considered the needs of most vulnerable detainees about to be released, although the main intervention was to assist them with travel arrangements. We were advised of one case at Mansfield where the custody sergeant had taken money out of petty cash to allow a 60-year-old male who had been arrested at his home some distance away to travel home, as he had no funds. This action had been taken in the absence of any clear directive to staff following the recent closure of a number of custody suites. Vulnerable detainees on release were given a list of useful contacts and telephone numbers for support organisations.

Recommendations

5.9 **Nottinghamshire police should further develop and promote alternative-to-custody approaches and custody officers should ensure that the 'necessity test' for arrest is meaningfully undertaken.**

5.10 **Nottinghamshire police should liaise at a senior level with the UK Border Agency to ensure that there are no undue delays in transporting immigration detainees to placements identified in the immigration custody estate.**

5.11 **Pre-release risk assessments should be detailed, meaningful and based on an ongoing assessment of detainees' needs while in custody, and the custody record should reflect the position on release and any action that needs to be taken.**

Housekeeping points

5.12 Subject to the limitations prescribed in PACE, a telephone call should be made when detainees request someone be informed of their arrest, and a free telephone call offered.

5.13 Custody staff should ensure that any dependency obligations of detainees while in custody are identified and, where possible, addressed.

[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.

Rights relating to PACE

5.14 PACE was generally adhered to. Our custody record analysis showed that when reviews had been undertaken while a detainee was asleep, it had been noted that he or she should be reminded of their right to free legal advice at a later time, although it was not clear if this had been followed up. All custody suites had an up-to-date copy of the PACE codes of practice available, and all detainees were told of their right to read it, but it was not routinely shown to detainees.

5.15 We found no examples of detainees being interviewed while under, or thought to be under, the influence of alcohol or drugs. We were told that a medical opinion was always sought if there was any doubt, and also, on occasions, as to whether an AA was required.

5.16 Custody records indicated that all detainees were offered legal representation, and a duty solicitor scheme enabled them to consult legal representatives free of charge. No note was usually made of the reasons for declining this, and in some cases it was not clear if the detainee had been reminded of this right. Defence solicitors reported good relationships with custody staff and the interactions we saw were professional. Defence solicitors were given copies of custody records when requested but told us that they routinely experienced delays of 30 minutes or more when visiting detainees at Nottingham.

5.17 Family members and friends were usually the first consideration when an AA was required. When this was not possible or appropriate, the arrangements for providing AAs were well established through a single provider, who catered for juveniles and vulnerable adults during the working day and up to 10.30pm. Staff told us that if an AA was not available, they would consider bailing the child, rather than keeping him or her in custody overnight. The force adhered to the PACE definition of a child (as a person under 18) instead of that in the Children Act 1989, which meant that those aged 17 were not provided with an AA unless they were deemed to be vulnerable.[6] There were no secure PACE beds available for juveniles held overnight who could not be bailed.

5.18 The handling and processing of DNA and forensic samples was good. There were clear procedures in respect of continuity of evidence and collection of samples. We identified only one issue, regarding some DNA samples which had been left in a freezer in the custody suite at Newark, which had been closed temporarily while refurbishment work was being completed.

5.19 Arrangements for getting detainees to court on time were efficient. Court cut-off times were around 2.15pm at Nottingham and Mansfield but at Worksop they were often as early as 12.30pm, with little flexibility.

Recommendation

5.20 **Appropriate adults should be provided for juveniles aged 17 and Nottinghamshire Police should engage with the local authority to ensure the provision of safe beds for juveniles who have been charged but cannot be bailed to appear in court.**

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

Housekeeping point

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

Rights relating to treatment

5.22 Detainees were not routinely told how to make a complaint about their treatment, and this information was not included in the comprehensive rights and entitlements leaflet provided. Practices in taking complaints varied among staff. Some staff said that any detainee who wanted to complain during their detention would be seen by the PACE inspector, who would note their complaint, but most staff advised detainees to make the complaint at their local police station on release. We could not ascertain how detainees who were going to court would be able to complain.

5.23 There was no local monitoring of complaints in order to identify any patterns or trends but we were assured that any concerns would be highlighted by the Professional Standards Department, which monitored all complaints across the force.

Recommendation

5.24 **Detainees should be routinely informed about how they can make a complaint about their care and treatment and be able to do this before they leave custody.**

6. Health care

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

Clinical governance

6.1 Nottinghamshire police contracted Medacs to provide health services to detainees, supplying both nurses and FMEs. Mental health services were provided by Nottinghamshire Healthcare NHS Trust. Substance use services were provided by probation services in the city BCU and by Nottinghamshire Healthcare NHS Trust in the rest of the county.

6.2 Medacs had adequate clinical governance arrangements, although some were underdeveloped. There were monthly clinical governance meetings and a clear clinical governance policy. We saw a wide range of clinical protocols. There was a new contracts manager. At the time of the inspection, there was a vacancy in the nurse lead role. The absence of this post holder had led to some uncertainty and we saw some practice that was not compliant with the clinical governance policy. We noted that there had been no clinical meetings, clinical supervision or clinical audit since the previous post holder had left the position. FMEs were generally self-employed but contracted to Medacs and accountable to the national medical lead. Training opportunities were available via Medacs and also the Faculty of Forensic Legal Medicine.

6.3 There was a comprehensive induction programme for new nurses, and staff had access to a range of continuing professional development. Nursing and medical staff had a wide range of relevant knowledge and their individual learning needs had been assessed; however, there was no access to minor injuries training, and some nurses were not confident about assessing mental health needs. There were no minor injuries triage algorithms.

6.4 The contracts manager attended monthly performance management meetings with the head of custody who held the portfolio lead; they also had regular informal contact. Medacs investigated any complaints or contract breaches that were bought to their attention. Custody staff we spoke to were aware of the procedure and whom to contact when Medacs failed to meet their contract obligations.

6.5 The state of the clinical rooms varied throughout the custody estate. We were told that infection control audits had been undertaken; however, these were not made available at the time of the inspection and we were concerned about the risk of cross-infection, especially in the Nottingham suite. The ground floor clinical room at Nottingham was not cleaned every day; it was dusty, the floor was dirty and the environment was not suitable to undertake clinical procedures such as dressings. The room on the second floor had no sink and lacked the range of equipment required to undertake forensic examinations. We were told that this room was mainly used for mental health assessments.

6.6 No sharps bins were secured to the wall or signed and dated on start of use, and some sharps bins and clinical waste sacks contained domestic rubbish. Generally, no paper roll couch covers were seen. The rooms were left unlocked when not in use. Medical literature was out of date. Patient information leaflets were available in some, but not all, the custody suites.

6.7 Medicines were stored in locked cupboards and there was a robust ordering process, managed by a member of the administrative team in the headquarters. Health services staff had to be contacted if a detainee required any medication. Nurses were able to supply and administer a wide range of medications using patient group directions, and FMEs dispensed medications to be administered at a later date by custody staff.

6.8 All custody officers had been trained in intermediate life support but nurses were trained only in basic life support. There was a wide range of emergency equipment in the custody suites, including an automated external defibrillator, oxygen, suction and a pulse oximeter (a device to measure oxygen levels). There were no ambu bags (part of the resuscitation kit used to ventilate a patient when they are not breathing). All equipment was checked regularly; although we noted that some equipment was out of date at the Newark suite, which had been closed for refurbishment.

Recommendations

6.9 **Clinical meetings should be reinstated, clinical supervision should be available for all clinical staff and a programme of clinical audit should be established to monitor the quality of patient care.**

6.10 **Action should be taken to refurbish the environment and reduce infection control risks. Cleaning services in health care should meet professional standards of cleanliness and infection control.**

6.11 **Nurses should be trained to use the full range of resuscitation equipment.**

Housekeeping points

6.12 There should be a full range of training, including access to minor injuries training and mental health training for nursing staff.

6.13 Medical information, such as the British National Formulary, should be up to date.

6.14 Patient information leaflets should be accessible in the custody suites.

6.15 Ambu-bags should be made available in the resuscitation kits.

Good practice

6.16 *Custody staff had enhanced resuscitation knowledge, which would facilitate a swift response in an emergency situation.*

Patient care

6.17 Health services professionals worked 12-hour shifts and provided a 24-hour service. Medacs aimed to provide two nurses and one FME across the force area during the day, reducing to one nurse and one FME at night. Staff were nominally allocated to specific suites but were directed anywhere in the force area if required. On occasions, the rota was not fully staffed, which led to delays in treating detainees. Medacs provided the force with monthly statistics relating to their Service Level Agreement. We were told that Medacs had achieved a 92%

response rate across the force area in the previous month, although monitoring data were not available to review. Custody staff at the Nottingham and Mansfield suites expressed overall satisfaction with the fast responses of nurses, as they were generally on site. At Worksop, custody staff said that they often had to wait a long time for a nurse to respond.

6.18 Nurses led the clinical care, with telephone reference to the FME when they had clinical concerns or queries, or required a prescription. Female detainees could not be guaranteed to see a female doctor if needed, although a chaperone would be made available. There was always access to a female doctor for victims of sexual offences. Information sharing was appropriate, and there was access to interpreting services if required. We highlighted one case to the force of a detainee who had not received adequate care. A health care professional had indicated that he should be sent to hospital, and that it was possible that he had a head injury, but it was some hours later before this finally happened and it emerged he had a broken hand. This delay could have had serious consequences for the detainee.

6.19 Nine (30%) detainees in our sample of custody records reported being on medication on arrival in custody. Five of these detainees had been seen by a health services professional, and a consultation had been requested for another who was on methadone, although he had been released before seeing a nurse or doctor. Of the remaining three detainees who had not been seen, two had been held for approximately six hours, and one female detainee who was asthmatic had been held for over 15 hours without seeing a health services professional. Custody staff made attempts to retrieve medications, including methadone, from detainees' homes or a pharmacy if required.

6.20 Health services professionals used paper records to record their contemporaneous notes about a consultation; the nurses used a proforma document. Usually, nurses' records were stored in a locked filing cabinet in their base custody suite before being taken to Medacs central offices, where they were stored in line with Caldicott guidelines.[7] FMEs kept their own records and often stored them in their homes, which did not provide sufficient compliance with the Data Protection Act. We found numerous clinical records in an unlocked filing cabinet and an unattended and unlocked medical room in the Nottingham suite. There had been no record-keeping audit since the lead nurse had left the position, and in the selection of nurses' records that we saw, the standard of record-keeping was variable.

Housekeeping point

6.21 All medical and nursing records should be subject to audit and remain compliant with the Data Protection Act and Caldicott guidance at all times.

Substance use

6.22 Substance use services were offered to adults aged 18 or above and referrals were made to ensure that juveniles had contact with services for young people. In our survey, 46% of respondents said that they had a drug or alcohol problem. Of these, 29%, against the 43% comparator, had been offered the chance to see a substance use worker.

6.23 In Nottingham, services were provided from 8am to 8pm, seven days a week. In the county BCU, services were available from 9am to 10pm, seven days a week, although at weekends, provision after 5pm was available as an on-call service.

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[7] The Caldicott review (1997) stipulated certain principles and working practices that health care providers should adopt to improve the quality of, and protect the confidentiality of, service users' information.

6.24 In the county BCU, there were two teams: the arrest referral team and the aftercare team. The arrest referral team undertook cell sweeps and held an identified caseload of detainees to ensure ongoing support on release from custody. There were good working relationships with Face It, a charitable service for younger people.

6.25 At Mansfield, working relationships between custody and mental health services staff were excellent, as the Criminal Justice Liaison pilot project (see below) was based there. Relationships were not as positive in Nottingham, as there was no mental health worker there, although there were good working relationships with the dual diagnosis team. Court work was undertaken and, where appropriate, reports were shared with the detainee, their solicitor and the Crown Prosecution Service. There were good working relationships with substitute prescribing services across all custody suites. There was good access to needle exchange services in the custody suites.

6.26 In Nottingham, drug workers were part of the Criminal Justice Intervention Team and provided first and initial assessments, support and information. There was a coordinated approach to working with substance users. There were limited alcohol services in the city BCU and the alcohol nurse specialist role had been removed from the Nottingham suite following organisational change, although the drug workers offered some programmes and signposted to relevant services. In the county BCU there was an identified alcohol worker, based at Mansfield.

Mental health

6.27 The force had good strategic links with Nottinghamshire Healthcare NHS Trust. However, custody staff at Nottingham were critical of the lack of services at Nottingham and told us that they made fewer referrals to mental health workers than at other sites.

6.28 Approximately 150 detainees had been assessed across all sites over the previous year; however, the provision of mental health services varied. There were no primary mental health services provided by Medacs. There was access to section 12-approved doctors. Until recently, there had been a mental health nurse lead at the Nottingham custody suite; however, this nurse had been redeployed to support the Criminal Justice Liaison pilot project going into its third phase at Mansfield, Worksop and Newark suites as a Department of Health pathfinder project. This project had been running for six months, at the start of which mental health services had been available across all custody suites and provided clinics in the city and county BCUs, with the support of probation services. Service provision included face-to-face assessment; advice to custody staff, courts and prisons; liaison with community services; and follow-up support for detainees with mental health problems and learning disabilities, to ensure that ongoing services could be established within a four-week period. This provision was still available in the county BCU, but had ceased in the Nottingham suite. The project was in the process of recruiting staff, and consisted of mental health nurses, a support worker and a forensic psychologist.

6.29 There were two section 136 suites: one suite with two beds at Queens Medical Centre in Nottingham and one facility consisting of a seated area at Kings Mill Hospital in Sutton-in-Ashfield. At the time of the inspection, we were told that the number of section 136 assessments had increased over the two years that the suites had been in place.

6.30 There was a memorandum of understanding for the provision of section 136 suites which included clear instructions for staff about when a detainee should be taken to an accident and emergency department rather than a section 136 suite, and when a police custody suite was a

suitable venue. However, we were told that there could be a lack of clarity as to the inclusion and exclusion criteria for the section 136 suites. This resulted in inappropriate referrals to the section 136 suites or people being detained in police custody inappropriately. Individual referrals were discussed and any discrepancies ironed out but neither we nor the force were clear about how successful this was at an operational level.

6.31 The monitoring data for the section 136 suite at Queens Medical Centre were unclear and there was no overall yearly summary to support robust monitoring. We were concerned that the lack of consistency in data contributed to the overall uncertainty expressed by operational staff. Neither the force nor the trust could provide us with up-to-date information on the number of section 136 detainees who had been held in police custody, or the appropriateness of its use for these individuals. However, everyone we talked to agreed that police custody was being used inappropriately for these purposes.

6.32 Police officers received training on the section 136 policy, any changes and use of the suites. Regular mental health awareness training was available.

Recommendation

6.33 **The mental health needs of detainees should be met across all custody suites and the criteria for referral to the section 136 suites, and any unresolved concerns, should be communicated regularly to operational staff to ensure that detainees are treated in the most suitable environment; police custody should only be used for this purpose as a last resort.**

7. Summary of recommendations

Main recommendations — To Nottinghamshire Police

7.1 The management information available, including quality assurance of near misses/adverse incidents, should be improved in order to ensure that outcomes for detainees are adequate. (2.19)

7.2 Management arrangements should provide sufficient oversight to ensure clarity of roles, responsibility and required outcomes. (2.20)

7.3 The quality and consistency of initial risk assessments should be improved to ensure the safety of detainees, and the use of closed-circuit television (CCTV) for 'constant' watches, where observation is intermittent, should cease. (2.21)

7.4 Cells should be clean, free of graffiti, well maintained and properly heated and ventilated, and improvement of the environment at Nottingham should be treated as an urgent priority. (2.22)

Recommendation — To the Home Office and Nottinghamshire Police

7.5 Appropriate adults should be provided for juveniles aged 17 and Nottinghamshire Police should engage with the local authority to ensure the provision of safe beds for juveniles who have been charged but cannot be bailed to appear in court. (5.20)

Recommendations — To Nottinghamshire Police

Treatment and conditions

7.6 Booking-in areas should provide sufficient privacy to facilitate effective communication between staff and detainees and there should be clear policies and procedures to meet the specific needs of juvenile detainees and those with disabilities. (4.6)

7.7 The quality of the CCTV at Mansfield and Nottingham should be improved. (4.14)

7.8 Intoxicated detainees should be roused, and this should be clearly recorded in the custody record and log. (4.15)

7.9 Handovers should be comprehensive and attended by detention officers and police custody staff, with the area in which the handover takes place cleared of other staff and detainees. (4.16)

7.10 Nottingham police should collate the use of force in accordance with the Association of Chief Police Officers policy and National Policing Improvement Agency guidance. (4.20)

7.11 The padded cell at Nottingham should be permanently taken out of use. (4.27)

7.12 Health and safety walk-through arrangements should be thorough and consistently applied at all custody suites and should include a structured approach to the identification of ligature points as part of the daily cell checks. (4.28)

7.13 The call bell system at Nottingham should be replaced or refurbished. (4.29)

7.14 All detainees held overnight, or who require one, should be offered a shower, which they should be able to take in private. (4.36)

7.15 Food offered to detainees should be of adequate quality and calorific content to sustain them for the duration of their stay. (4.41)

7.16 Detainees, particularly those held for more than 24 hours, should be offered exercise, and the exercise yards should be made fit for purpose. (4.45)

Individual rights

7.17 Nottinghamshire police should further develop and promote alternative-to-custody approaches and custody officers should ensure that the 'necessity test' for arrest is meaningfully undertaken. (5.9)

7.18 Nottinghamshire police should liaise at a senior level with the UK Border Agency to ensure that there are no undue delays in transporting immigration detainees to placements identified in the immigration custody estate. (5.10)

7.19 Pre-release risk assessments should be detailed, meaningful and based on an ongoing assessment of detainees' needs while in custody, and the custody record should reflect the position on release and any action that needs to be taken. (5.11)

7.20 Detainees should be routinely informed about how they can make a complaint about their care and treatment and be able to do this before they leave custody. (5.24)

Health care

7.21 Clinical meetings should be reinstated, clinical supervision should be available for all clinical staff and a programme of clinical audit should be established to monitor the quality of patient care. (6.9)

7.22 Action should be taken to refurbish the environment and reduce infection control risks. Cleaning services in health care should meet professional standards of cleanliness and infection control. (6.10)

7.23 Nurses should be trained to use the full range of resuscitation equipment. (6.11)

7.24 The mental health needs of detainees should be met across all custody suites and the criteria for referral to the section 136 suites, and any unresolved concerns, should be communicated regularly to operational staff to ensure that detainees are treated in the most suitable environment; police custody should only be used for this purpose as a last resort. (6.33)

Housekeeping points

Strategy

7.25 The meeting structure should support governance arrangements which allow the escalation of unresolved issues to the appropriate level within the organisation. (3.14)

7.26 A custody-specific area on the force intranet site should be developed to store all lessons learned information previously circulated. (3.15)

Treatment and conditions

7.27 All custody staff should carry anti-ligature knives while carrying out their duties in the custody suite. (4.17)

7.28 Fire evacuation drills should be carried out in all custody suites. (4.30)

7.29 Correct use of call bells should be explained to all detainees. (4.31)

7.30 The CCTV system should effectively obscure the toilet area in cells. (4.37)

7.31 Pillows should be provided to all detainees. (4.38)

7.32 There should be facilities for male detainees to have a shave before attending court. (4.39)

7.33 Reading materials suitable for a range of detainees, including young people, those whose first language is not English and those with limited literacy skills, should be made available. (4.46)

Individual rights

7.34 Subject to the limitations prescribed in PACE, a telephone call should be made when detainees request someone be informed of their arrest, and a free telephone call offered. (5.12)

7.35 Custody staff should ensure that any dependency obligations of detainees while in custody are identified and, where possible, addressed. (5.13)

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

Health care

7.37 There should be a full range of training, including access to minor injuries training and mental health training for nursing staff. (6.12)

7.38 Medical information, such as the British National Formulary, should be up to date. (6.13)

7.39 Patient information leaflets should be accessible in the custody suites. (6.14)

7.40 Ambu-bags should be made available in the resuscitation kits. (6.15)

7.41 All medical and nursing records should be subject to audit and remain compliant with the Data Protection Act and Caldicott guidance at all times. (6.21)

Good practice

Strategy

7.42 Good work had been undertaken to establish the *Safer Detention and Handling of Persons in Police Custody* 2006 (SDHP) compliance of custody suites, and to take remedial action if resources allowed. (3.16)

Treatment and conditions

7.43 The facilities at Nottingham for religious observance provided by the multi-faith room and its contents were excellent. (4.7)

Health care

7.44 Custody staff had enhanced resuscitation knowledge, which would facilitate a swift response in an emergency situation. (6.16)

Appendix I: Inspection team

Sean Sullivan	HMIP team leader
Gary Boughen	HMIP inspector
Peter Dunn	HMIP inspector
Fiona Shearlaw	HMIP inspector
Paul Davies	HMIC inspector
Mark Ewan	HMIC inspector
Helen Carter	HMIP health care inspector
Michael Skidmore	HMIP researcher

Appendix II: Summary of detainee questionnaires and interviews

Detainee survey methodology

A voluntary, confidential and anonymous survey of the prisoner population, who had been through a police station in Nottinghamshire, 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 23rd August 2011. A list of potential respondents to have passed through Nottingham (Bridewell), Mansfield, Newark and Worksop police custody suites was created, listing all those who had arrived from Nottingham, Mansfield or Worksop Magistrates court within the previous two months.[8]

Selecting the sample

In total, 135 respondents were approached. Eighty respondents reported being held in police stations outside of Nottinghamshire. On the day, the questionnaire was offered to 55 respondents; there were five refusals and seven questionnaires were returned blank. All of those sampled had been in custody within the previous two months.
Completion of the questionnaire was voluntary. Interviews were offered to any respondents with literacy difficulties. Two respondents were interviewed.

Methodology

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

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

- 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, 43 (78%) respondents completed and returned their questionnaires.

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

Comparisons

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

Some questions have been filtered according to the response to a previous question. Filtered questions are clearly indented and preceded by an explanation as to which respondents are included in the filtered questions. Otherwise, percentages provided refer to the entire sample. All missing responses were 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 43 police areas since April 2008.

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

Summary

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

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

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

Survey results

Section 1: About you

Q2 What police station were you last held at?

Nottingham (Bridewell) - 30; Mansfield - 9; Worksop - 3; Unknown - 1.

Q3 How old are you?

16 years or younger	0 (0%)	*40-49 years*	4 (9%)
17-21 years	13 (30%)	*50-59 years*	1 (2%)
22-29 years	16 (37%)	*60 years or older*	0 (0%)
30-39 years	9 (21%)		

Q4 Are you:

Male	43 (100%)
Female	0 (0%)
Transgender/transsexual	0 (0%)

Q5 What is your ethnic origin?

White - British	36 (84%)
White - Irish	0 (0%)
White - other	0 (0%)
Black or black British - Caribbean	2 (5%)
Black or black British - African	0 (0%)
Black or black British - other	0 (0%)
Asian or Asian British - Indian	1 (2%)
Asian or Asian British - Pakistani	1 (2%)
Asian or Asian British - Bangladeshi	1 (2%)
Asian or Asian British - other	0 (0%)
Mixed heritage - white and black Caribbean	2 (5%)
Mixed heritage - white and black African	0 (0%)
Mixed heritage- white and Asian	0 (0%)
Mixed heritage - Other	0 (0%)
Chinese	0 (0%)
Other ethnic group	0 (0%)

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

Yes	3 (8%)
No	37 (93%)

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

None	20 (48%)
Church of England	14 (33%)
Catholic	2 (5%)
Protestant	0 (0%)
Other Christian denomination	2 (5%)
Buddhist	0 (0%)
Hindu	0 (0%)
Jewish	0 (0%)

	Muslim	3 (7%)
	Sikh	1 (2%)
Q8	**How would you describe your sexual orientation?**	
	Straight/heterosexual	43 (100%)
	Gay/lesbian/homosexual	0 (0%)
	Bisexual	0 (0%)
Q9	**Do you consider yourself to have a disability?**	
	Yes	12 (28%)
	No	31 (72%)
Q10	**Have you ever been held in police custody before?**	
	Yes	42 (98%)
	No	1 (2%)

Section 2: Your experience of this custody suite

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

Q11	**How long were you held at the police station?**	
	Less than 24 hours	13 (31%)
	More than 24 hours, but less than 48 hours (2 days)	15 (36%)
	More than 48 hours (2 days), but less than 72 hours (3 days)	10 (24%)
	72 hours (3 days) or more	4 (10%)
Q12	**Were you given information about your arrest and your entitlements when you arrived there?**	
	Yes	23 (53%)
	No	12 (28%)
	Don't know/can't remember	8 (19%)
Q13	**Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')?**	
	Yes	18 (42%)
	No	21 (49%)
	I don't know what this is/I don't remember	4 (9%)
Q14	**If your clothes were taken away, were you offered different clothing to wear?**	
	My clothes were not taken	22 (54%)
	I was offered a tracksuit to wear	14 (34%)
	I was offered an evidence/paper suit to wear	1 (2%)
	I was offered a blanket	2 (5%)
	Nothing	2 (5%)
Q15	**Could you use a toilet when you needed to?**	
	Yes	36 (86%)
	No	6 (14%)
	Don't know	0 (0%)
Q16	**If you have used the toilet there, was toilet paper provided?**	
	Yes	14 (35%)

No 26 (65%)

Q17 Did you share a cell at the police station?

Yes 0 (0%)
No 43 (100%)

Q18 How would you rate the condition of your cell:

	Good	Neither	Bad
Cleanliness	4 (9%)	12 (28%)	27 (63%)
Ventilation/air quality	4 (10%)	15 (38%)	21 (53%)
Temperature	3 (8%)	9 (23%)	28 (70%)
Lighting	18 (45%)	13 (33%)	9 (23%)

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

Yes 36 (84%)
No 7 (16%)

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

Yes 8 (19%)
No 35 (81%)

Q21 Were you held overnight?

Yes 38 (88%)
No 5 (12%)

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

Not held overnight.. 5 (12%)
Pillow 4 (9%)
Blanket 27 (63%)
Nothing.. 12 (28%)

Q23 Were you offered a shower at the police station?

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

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

Yes 2 (5%)
No 41 (95%)

Q25 Were you offered anything to:

	Yes	No
Eat?	35 (83%)	7 (17%)
Drink?	35 (85%)	6 (15%)

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

Very good	Good	Neither	Bad	Very bad	N/A
0 (0%)	2 (5%)	4 (9%)	7 (16%)	24 (56%)	6 (14%)

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

I did not have any food or drink.. 6 (19%)
Yes 9 (29%)
No 16 (52%)

Q28	**If you smoke, were you offered anything to help you cope with the smoking ban there?**	
	I do not smoke	2 (5%)
	I was allowed to smoke	1 (2%)
	I was not offered anything to cope with not smoking	39 (91%)
	I was offered nicotine gum	1 (2%)
	I was offered nicotine patches	0 (0%)
	I was offered nicotine lozenges	0 (0%)

Q29	**Were you offered anything to read?**	
	Yes	5 (12%)
	No	38 (88%)

Q30	**Was someone informed of your arrest?**	
	Yes	14 (33%)
	No	19 (45%)
	I don't know	5 (12%)
	I didn't want to inform anyone	4 (10%)

Q31	**Were you offered a free telephone call?**	
	Yes	14 (33%)
	No	28 (67%)

Q32	**If you were denied a free phone call, was a reason for this offered?**	
	My telephone call was not denied	17 (41%)
	Yes	3 (7%)
	No	21 (51%)

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

	Yes	*No*
Who was taking care of your children	5 (19%)	22 (81%)
Contacting your partner, relative or friend	25 (68%)	12 (32%)
Contacting your employer	8 (28%)	21 (72%)
Where you were going once released	12 (38%)	20 (63%)

Q34	**Were you interviewed by police officials about your case?**		
	Yes	36 (84%)	
	No	7 (16%)	If No, go to Q36

Q35 **Were any of the following people present when you were interviewed?**

	Yes	*No*	*Not needed*
Solicitor	24 (69%)	5 (14%)	6 (17%)
Appropriate Adult	0 (0%)	8 (47%)	9 (53%)
Interpreter	0 (0%)	7 (39%)	11 (61%)

Q36	**How long did you have to wait for your solicitor?**	
	I did not request a solicitor	9 (22%)
	2 hours or less	5 (12%)
	Over 2 hours but less than 4 hours	5 (12%)
	4 hours or more	22 (54%)

Section 3: Safety

Q38 Did you feel safe there?

Yes	21 (51%)
No	20 (49%)

Q39 Had another detainee or a member of staff victimised (insulted or assaulted) you there?

Yes	20 (47%)
No	23 (53%)

Q40 If you have felt victimised, what did the incident involve? (Please tick all that apply to you.)

I have not been victimised	23 (53%)	*Because of your crime*	10 (23%)
Insulting remarks (about you, your family or friends)	11 (26%)	*Because of your sexuality*	2 (5%)
Physical abuse (being hit, kicked or assaulted)	7 (16%)	*Because you have a disability*	5 (12%)
Sexual abuse	1 (2%)	*Because of your religion/religious beliefs*	2 (5%)
Your race or ethnic origin	4 (9%)	*Because you are from a different part of the country than others*	1 (2%)
Drugs	4 (9%)		

Q41 Were your handcuffs removed on arrival at the police station?

Yes	26 (60%)
No	11 (26%)
I wasn't handcuffed	6 (14%)

Q42 Were you restrained whilst in the police custody suite?

Yes	8 (19%)
No	35 (81%)

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

Yes	14 (33%)
No	29 (67%)

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

Yes	3 (7%)
No	39 (93%)

Section 4: Health care

Q46 Did you need to take any prescribed medication when you were in police custody?

Yes	11 (26%)
No	31 (74%)

Q47 Were you able to continue taking your prescribed medication while there?

Not taking medication	31 (74%)
Yes	4 (10%)
No	7 (17%)

Q48 Did someone explain your entitlements to see a health care professional if you needed to?

Yes	12 (29%)
No	24 (57%)

Don't know	6 (14%)

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

	Yes	*No*
Doctor	9 (25%)	27 (75%)
Nurse	13 (33%)	27 (68%)
Paramedic	0 (0%)	30 (100%)
Psychiatrist	0 (0%)	30 (100%)

Q50 Were you able to see a health care professional of your own gender?

Yes	8 (20%)
No	22 (54%)
Don't know	11 (27%)

Q51 Did you have any drug or alcohol problems?

Yes	20 (47%)
No	23 (53%)

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

I didn't have any drug/alcohol problems	23 (56%)
Yes	5 (12%)
No	13 (32%)

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

I didn't have any drug/alcohol problems	23 (56%)
Yes	4 (10%)
No	14 (34%)

Q54 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*
24 (59%)	1 (2%)	3 (7%)	3 (7%)	4 (10%)	6 (15%)

Q55 Did you have any specific physical health care needs?

No	26 (62%)
Yes	16 (38%)

Q56 Did you have any specific mental health care needs?

No	27 (66%)
Yes	14 (34%)

Thank you for your time

Prisoner survey responses for Nottinghamshire Police 2011

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

Key	Description	Nottinghamshire Police 2011	Police custody comparator
(green)	Any percentage highlighted in green is significantly better		
(blue)	Any percentage highlighted in blue is significantly worse		
(orange)	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	43	1549
	SECTION 1: General information		
3	Are you under 21 years of age?	30%	9%
4	Are you transgender/transsexual?	0%	1%
5	Are you from a minority ethnic group (including all those who did not tick white British, white Irish or white other categories)?	16%	30%
6	Are you a foreign national?	7%	14%
7	Are you Muslim?	6%	11%
8	Are you homosexual/gay or bisexual?	0%	2%
9	Do you consider yourself to have a disability?	28%	20%
10	Have you been in police custody before?	98%	91%
	SECTION 2: Your experience of this custody suite		
	For the most recent journey you have made either to or from court or between prisons:		
11	Were you held at the police station for over 24 hours?	69%	67%
12	Were you given information about your arrest and entitlements when you arrived?	54%	74%
13	Were you told about PACE?	42%	52%
14	If your clothes were taken away, were you given a tracksuit to wear?	73%	43%
15	Could you use a toilet when you needed to?	86%	90%
16	If you did use the toilet, was toilet paper provided?	35%	49%
17	Did you share a cell at the station?	0%	3%
18	Would you rate the condition of your cell, as 'good' for:		
18a	Cleanliness?	10%	32%
18b	Ventilation/air quality?	11%	21%
18c	Temperature?	7%	15%
18d	Lighting?	45%	43%
19	Was there any graffiti in your cell when you arrived?	84%	54%
20	Did staff explain the correct use of the cell bell?	18%	22%
21	Were you held overnight?	88%	93%
22	If you were held overnight, were you given **no** clean items of bedding?	28%	30%
23	Were you offered a shower?	6%	9%
24	Were you offered a period of outside exercise?	4%	7%
25a	Were you offered anything to eat?	84%	81%
25b	Were you offered anything to drink?	85%	84%
	For those who had food:		
26a	Was the quality of the food and drink you received 'good'/'very good'?	5%	10%
26b	Was the food/drink you received suitable for your dietary requirements?	35%	44%
27	For those who smoke: were you offered **nothing** to help you cope with the ban there?	96%	93%
28	Were you offered anything to read?	12%	13%
29	Was someone informed of your arrest?	33%	42%
30	Were you offered a free telephone call?	33%	49%

Key to tables

		Nottinghamshire Police 2011	Police custody comparator
(green)	Any percentage highlighted in green is significantly better		
(blue)	Any percentage highlighted in blue is significantly worse		
(orange)	Any percentage highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
31	If you were denied a free call, was a reason given?	11%	14%
32	Did you have any concerns about:		
32a	Who was taking care of your children?	19%	14%
32b	Contacting your partner, relative or friend?	67%	53%
32c	Contacting your employer?	27%	20%
32d	Where you were going once released?	38%	31%
34	If you were interviewed were the following people present:		
34a	Solicitor	68%	73%
34b	Appropriate Adult	0%	7%
34c	Interpreter	0%	6%
35	Did you wait over 4 hours for your solicitor?	68%	65%
SECTION 3: Safety			
39	Did you feel unsafe?	49%	39%
40	Has another detainee or a member of staff victimised you?	46%	42%
41	If you have felt victimised, what did the incident involve?		
41a	Insulting remarks (about you, your family or friends)	26%	20%
41b	Physical abuse (being hit, kicked or assaulted)	16%	14%
41c	Sexual abuse	2%	2%
41d	Your race or ethnic origin	10%	5%
41e	Drugs	10%	15%
41f	Because of your crime	24%	17%
41g	Because of your sexuality	4%	1%
41h	Because you have a disability	12%	3%
41i	Because of your religion/religious beliefs	4%	3%
41j	Because you are from a different part of the country than others	2%	4%
42a	Were your handcuffs removed on arrival at the police station?	70%	75%
42b	Were you restrained whilst in the police custody suite?	18%	19%
43	Were you injured whilst in police custody, in a way that you feel is not your fault?	32%	24%
44	Were you told how to make a complaint about your treatment?	6%	13%
SECTION 4: Health care			
46	Did you need to take any prescribed medication when you were in police custody?	27%	48%
47	For those who were on medication: were you able to continue taking your medication?	39%	36%
48	Did someone explain your entitlement to see a health care professional if you needed to?	29%	35%
49	Were you seen by the following health care professionals during your time in police custody:		
49a	Doctor	24%	47%
49b	Nurse	33%	20%
	Percentage seen by either a doctor or a nurse	40%	54%
49c	Paramedic	0%	4%
49d	Psychiatrist	0%	3%
50	Were you able to see a health care professional of your own gender?	19%	28%
51	Did you have any drug or alcohol problems?	46%	55%
For those who had drug or alcohol problems:			
52	Did you see, or were offered the chance to see a drug or alcohol support worker?	29%	43%
53	Were you offered relief medication for your immediate symptoms?	24%	32%
54	For those who had been seen by health care, would you rate the quality as good/very good?	25%	29%
55	Do you have any specific physical health care needs?	39%	32%
56	Do you have any specific mental health care needs?	34%	24%