Report on an unannounced inspection visit to police custody in South Wales

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by

HM Inspectorate of Prisons and

HM Inspectorate of Constabulary

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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.

There was sound oversight at the strategic level for custody provision, with a management structure that was clear and robust. There were good processes for recording and learning from successful interventions and effective arrangements for disseminating good practice. While there were good quality assurance processes around custody record monitoring, this needed to be widened. Staffing arrangements were good and staff were very well trained.

There was a well-advanced strategy to improve the custody estate but the physical environment of the suites was very mixed. The suite at Pontypridd was a particular concern and needed urgent attention and we were concerned that some safety issues in the environment were not being effectively dealt with as a result of plans to close older suites. Staff interactions with detainees were professional, initial risk assessments were generally sound and health and safety procedures were well established. Staff development was needed to raise awareness of the specific needs of vulnerable detainees and shift handover processes needed improvement. The policy on the use of handcuffs needed clarification and, as we have found in many other forces, there was no effective process for monitoring use of force. Good use was made of posters reminding staff of their role in caring for detainees, although some issues still needed to be addressed.

An appropriate balance was maintained between progressing cases and the rights of individuals. Pre-release risk assessments needed improvement and should be included in the quality assurance regime. Arrangements at Cardiff Bay for diverting young offenders from the criminal justice process were well developed. Appropriate adult provision for vulnerable adults was new but among the best we have seen. The process around complaints was confused and needed clarification.

Health care provision was generally good but the service level agreement between the force and medical services provider needed to be more robustly managed. There were effective drug intervention services but mental health diversion provision was mixed. The number of Mental Health Act section 136[2] detainees held in police custody was high and needed to be reduced.

Overall, police custody provision in South Wales was good. There was clear strategic direction and good management arrangements but some important issues concerning the estate and mental health provision needed urgent attention. This report provides a small number of

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

[2] 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.

recommendations to assist the force and the Police Authority to improve provision further. We expect our findings to be considered and for an action plan to be provided in due course.

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HM Chief Inspector of Constabulary

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HM Chief Inspector of Prisons

January 2012

2. Background and key findings

2.1 HM Inspectorates of Prisons and Constabulary have a programme of joint inspections of police custody suites, as part of the UK's international obligation to ensure regular independent inspection of places of detention. These inspections look beyond the implementation of the Police and Criminal Evidence Act 1984 (PACE) codes of practice and *Safer Detention and Handling of Persons in Police Custody* 2011 (SDHP) guide, and focus on outcomes for detainees. They are also informed by a set of *Expectations for Police Custody*[3] 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, South Wales Police had seven 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. Three further standby custody suites were occasionally used to cover specific contingencies. There was a total cell capacity of 161. The force had held 41,389 detainees and 335 individuals detained for immigration matters in the year to November 2011.

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

• Cardiff Bay	60 cells
• Swansea	27 cells
• Merthyr Tydfil	14 cells
• Neath	9 cells
• Pontypridd	10 cells
• Bridgend	10 cells
• Ton Pentre	7 cells
• Aberdare (standby)	6 cells
• Port Talbot (standby)	8 cells
• Swansea, Cockett (standby)	8 cells
Total	159 cells

2.4 HM Inspectorate of Prisons (HMIP) researchers and HM Inspectorates of Constabulary (HMIC) inspectors carried out a survey of prisoners at HMP Cardiff who had formerly been detained at custody centres in the force area to obtain additional evidence (see Appendix II).[4]

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

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

[4] **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.*)

Strategic overview

2.6 The assistant chief constable with portfolio responsibility for custody was well engaged with strategic partners. Relationships between the South Wales Police Authority and the force were good. There was an active independent custody visitor scheme.

2.7 Custody was managed centrally and arrangements were particularly clear and robust. There was a well-advanced programme to address issues with the estate, although we were very concerned about the condition of some that were earmarked for closure once the estates strategy was complete. There was a good focus on learning lessons and training arrangements were very strong.

2.8 Staff working in custody were permanent and staffing levels were adequate.

Treatment and conditions

2.9 Staff interactions with detainees were professional and friendly. Custody detention officers were highly effective. There was mixed awareness of some diversity issues, although there were pockets of good practice. Many aspects of privacy were poor, which had implications for respectful treatment and the safety of detainees.

2.10 Initial risk assessments were adequate and risk management arrangements proportionate, although we considered that the prevalence of strip searching needed to be addressed. Staff understood the importance of rousing detainees where necessary. There was no CCTV coverage at some suites. Arrangements for staff handovers were reasonable but there was room for improvement. Information about risk was accurately transcribed on the prisoner escort record. New booking in arrangements at Cardiff Bay were still bedding in, causing some delays. Arrangements to oversee the use of force needed to be improved, including the prevalence of the use of handcuffing.

2.11 The physical environment of the custody suites was very mixed but all suites were clean and graffiti was minimal. We were very concerned about the condition of the suite at Pontypridd, which we considered to be particularly unsafe. Health and safety walk-throughs took place and these arrangements were good. We found ligature points in a number of cells.

2.12 There was a reasonable focus on care and welfare, although this was too reliant on detainees making requests.

Individual rights

2.13 Custody sergeants authorised custody and there was an examination of the necessity test and the beginnings of a focus on alternatives to custody. PACE was generally adhered to.

2.14 Detainees were not routinely asked if they had any obligations for dependants. Pre-release risk assessments were completed but the action taken was mixed. Detainees held for immigration matters were often detained for too long. Arrangements for providing appropriate adults for juveniles were reasonable and very good for vulnerable adults.

2.15 Court cut-off times were unpredictable and occasionally too early. Detainees were not told how to make a complaint and the arrangements for dealing with them were confused.

Health care

2.16 Governance arrangements were in place. Clinical rooms needed to be improved but the management of medications was generally good. All custody suites had resuscitation equipment and custody staff were trained in its use. Primary health care provision was generally good. Waiting times were reasonable but there were sometimes delays.

2.17 Arrangements for providing symptomatic relief for substance users were good and detainees could continue to receive prescribed medications. Substance use services were well developed, although there was only signposting to services for alcohol users and juveniles.

2.18 Mental health diversion services were very good in the south of the force but poor in the north. Too many detainees had been held in police custody under section 136 of the Mental Health Act 1983. Staff had received excellent mental health awareness training.

Main recommendations

2.19 Cells should be free of ligature points or, when resources do not allow this, the risks presented managed.

2.20 The conditions at the custody suite at Pontypridd should be significantly improved to address the safety issues presented.

2.21 Detainees with mental health problems (under section 136) should be diverted to the appropriate specialist services and police custody should be used only exceptionally for this purpose.

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 There was evidence of sound strategic leadership and planning of custody provision, with an assistant chief constable (ACC) as the strategic lead on custody issues. Custody was centrally managed by the Justice and Partnership Department (JPD), led by an assistant director. Day-to-day responsibility for custody provision and policy was the responsibility of a chief inspector.

3.2 The force had a clear estates strategy, which included medium-term plans for building two new custody suites, one in Bridgend and the other in the north of the force area. The force planned to rationalise its custody estate to four main hubs once these new suites were operational. We were concerned about the condition of some suites, particularly Pontypridd, which needed urgent investment to make it safe.

3.3 A proactive police authority lead for custody was well engaged with the estates strategy and custody issues. The authority had historically been supportive of custody and had funded a new police station and large custody suite in Cardiff Bay in the previous two years, allowing the force to close a number of smaller suites in the Cardiff area.

3.4 There was a police authority lead for the independent custody visitor (ICV) scheme, which was seen as an important independent oversight mechanism. The scheme was active and comprised two panels administered by the police authority. The police authority held quarterly meetings for panel coordinators with regional inspectors in attendance, published custody visiting newsletters and provided regular training events for ICVs. They also held annual ICV seminars attended by the ACC lead for custody.

3.5 Partnership arrangements were described as good, with active engagement with relevant criminal justice and health partners. The ACC lead for custody chaired the Safer South Wales partnership meetings and was the all-Wales lead for the Criminal Justice Efficiency Programme.

3.6 Staffing levels in custody suites were good and comprised permanent custody sergeants who were managed through JPD. There was sufficient capacity in the permanent team to avoid drawing on response teams. Custody sergeants were supported by civilian detention officers (CDOs) employed by G4S. CDOs looked after the ongoing care and welfare of detainees and had recently begun assisting custody officers by inputting arrest and detainee details onto the Niche custody computer system.

3.7 Management arrangements were good. Custody provision across South Wales was split into the north, west, and east regions. The north and west each had a custody inspector responsible for local management of the custody suites. In the eastern region (Cardiff Bay), four dedicated custody inspectors provided round the clock cover. Custody inspectors were line managed by the head of custody services. Day-to-day supervision of the CDOs was the responsibility of the custody sergeants but their line management was through G4S supervisors.

3.8 Custody issues were discussed at regular force meetings. These included a custody development board, chaired by the ACC lead for custody, and regional custody inspectors meetings chaired by the head of custody services. There was no forum where custody practitioners, such as custody sergeants and CDOs, could discuss custody issues although we were told this did happen during refresher training. The head of custody services chaired the Welsh regional custody forum and represented the region at the national forum chaired by the national Association of Chief Police Officers lead for custody, where custody issues across England and Wales are discussed.

3.9 Training for custody staff was good. All custody staff had received role-specific training before working in custody, including first aid and personal safety training. Although the content varied and the CDO course was not delivered by South Wales Police, both courses included PACE legal responsibilities, risk assessments and handovers. All staff received one-day refresher training every six months. CDOs were trained separately by G4S in personal safety training.

3.10 The force had comprehensive custody procedures, with policies accessible to all staff through the force IT system. Custody services managed an intranet-based central repository containing custody-related information, including policies, guidance, good practice and links to Independent Police Complaints Commission (IPCC) learning the lessons bulletins. Information was disseminated to staff by custody services as well as through face-to-face briefings. Regional inspectors assisted in cascading information to relevant staff, although there were varying levels of awareness among custody staff on what was available and where to find it.

3.11 There was a good centrally managed process for recording successful interventions in custody, with data collated and reviewed daily. The head of custody services chaired a bi-monthly meeting where successful interventions and health and safety issues were discussed. Identified learning points were fed into the training programme and disseminated to staff.

3.12 There were quality assurance checks by custody inspectors who carried out regular dip-sampling of custody records. The checks followed a set checklist provided by custody services but there was no dip-sampling of CCTV recordings. Custody services regularly dip-sampled records and management information to identify trends and training needs.

Housekeeping point

3.13 The force should include dip-sampling of CCTV recordings as part of their quality assurance processes.

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 cars and vans. Those we inspected were clean and in reasonable condition.

4.2 Staff treated detainees professionally, using their first names or title and surname as appropriate. The approach adopted by CDOs was notable and they demonstrated a good degree of care for the welfare of detainees. Detainees said staff treated them well and responded to their needs. In our survey, 41% of respondents who had been in custody in South Wales, against a comparator of 23%, said they had been well treated.

4.3 The booking-in areas in most suites offered little privacy for detainees, who were asked to disclose sensitive personal information often when other detainees were also being booked in or in the general vicinity. Some attempts had been made to screen areas but privacy remained an issue when the suites were busy and noisy, particularly at Cardiff Bay.

4.4 At Swansea, CDOs undertook the booking-in procedure and this was well embedded. This had very recently commenced at Cardiff Bay, which was a new experience for many and we detected some resistance to it among staff. It resulted in long delays at Cardiff Bay while staff navigated their way around the computer system.

4.5 There was limited awareness of diversity issues. Detention rooms, which were cells without toilets, were used for juveniles at some suites and were usually closer to the custody desk but the one at Bridgend had been converted into a storeroom. Otherwise, there was little difference in the way juveniles were dealt with outside the requirements of PACE. A few custody sergeants said they had received some child protection awareness training

4.6 We saw a good stock of holy books catering for a range of religions, as well as prayer mats and compasses. All were stored respectfully. Not all suites had hearing loops. At Ton Pentre, CDOs used a helpful booklet with visually impaired and non-English speakers to explain the services on offer through pictures and Braille. There was a lower booking-in desk at Cardiff Bay suitable for wheelchair users.

4.7 Although staff said they routinely offered female detainees the opportunity to speak to female staff, there was little evidence from our observations or from the custody record analysis to confirm this.

Recommendations

4.8 Staff should be trained to recognise and provide for the individual needs of detainees, particularly those who are vulnerable, juveniles and women.

4.9 Booking-in desks should allow effective and private communication between detainees, staff and their legal representatives.

Safety

4.10 Staff undertook systematic risk assessments with detainees on arrival, working through a series of questions prompted by the Niche custody system. Questioning was reasonably thorough, with some supplementary questions asked when necessary.

4.11 The level of observations specified seemed appropriate. We found evidence of care plans being revisited and updated in light of new information and others where the process seemed haphazard. For example, an intoxicated woman at Bridgend was found to have a blanket wrapped around her neck. The blanket was taken away but her risk assessment was not amended and she was not put in a cell with CCTV. At Swansea, a detainee had been placed in anti-rip clothing because he had disclosed an attempt to kill himself two years previously but had told staff he did not feel suicidal now. He had been in custody overnight in a cell without CCTV. This mixed picture was also evident in our custody record analysis.

4.12 In our custody record analysis, a high 17% of detainees were strip searched as part of the booking-in process and custody officers at some suites estimated that they authorised strip searches more than this. Decisions to do so were often based on a history of drug misuse and/or a previous history of attempting to secrete drugs, telephones or dangerous items. A strip search in a custody suite usually resulted in a strip search taking place on subsequent detentions. Strip searches were conducted in appropriately private rooms or in a cell without a CCTV camera.

4.13 Unusually, the custody suites at Pontypridd, Neath and Ton Pentre did not have CCTV coverage either in the booking-in areas or in cells. Conversely, Cardiff Bay custody suite had CCTV cameras covering every aspect of the suite.

4.14 Custody staff carried ligature knives and were aware of the need to confirm a reasonable level of consciousness when undertaking rousing checks.

4.15 The staff handovers we observed at Cardiff Bay were thorough and CDOs had prepared notes on the detainees for whom they had responsibility. However, custody sergeants and CDOs handed over separately, which risked important information being missed.

4.16 At Cardiff Bay and Swansea, we saw unaccompanied operational police officers rather than custody suite staff using keys to escort detainees to or from their cells for interviews.

Recommendations

4.17 The risk assessment and care planning process should be to a consistent high standard.

4.18 The use of strip searching should be monitored and any potential over-use investigated and corrected.

4.19 All custody staff should be involved in the same shift handover and, wherever possible, this should be away from the booking-in area and recorded.

4.20 CCTV coverage should be installed at Pontypridd, Neath and Ton Pentre custody suites.

Housekeeping point

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

Use of force

4.22 Most detainees arrived at the custody suites in handcuffs, which were rarely removed without custody sergeant authorisation. We spoke to several police officers about their understanding of handcuffing detainees. Although some understood the need for it to be justified, necessary and proportionate, we felt there was a need for further refresher guidance to prevent the use of handcuffing becoming the norm regardless of a detainee's demeanour or antecedence.

4.23 At Cardiff Bay and Swansea, we saw many handcuffed detainees sitting in small holding booths. At Cardiff Bay, detainees were often held in these for periods of between 30 minutes and 75 minutes, which was far too long. We were told this was related to the recent change to CDOs doing the booking-in (see paragraph 4.4). A memorandum of understanding (MOU)[5] relating to the police working with a local hospital inferred that detainees could with suitable authorisation be handcuffed to hospital beds, which was not acceptable.

4.24 There was no central recording of the use of force in custody, with only a record made in the custody record and officers' notebooks. South Wales Police was therefore unable to analyse use of force in custody easily to identify trends and effectiveness of trained use of force techniques.

Recommendations

4.25 The policy on handcuffing should be clarified to avoid this becoming the norm and cuffs should be removed as soon as possible after arrival at the custody suite.

4.26 South Wales Police should collate the use of force data in accordance with the Association of Chief Police Officers policy and National Policing Improvement Agency guidance, and the memorandum of understanding with health partners should exclude handcuffing to beds.

Housekeeping point

4.27 The booking-in processes at Cardiff Bay should be reviewed to minimise the waiting time of detainees in holding booths.

Physical conditions

4.28 The condition of the custody estate ranged from a modern suite in Cardiff Bay to Victorian cells in Ton Pentre. All suites were kept reasonably clean and well maintained. There was minor graffiti on bed plinths in some cells. Many exercise yards we saw were in very poor condition.

[5] Memorandum of Understanding (MOU) in respect of working together to deliver on the Combating Drugs Priority as identified by the Swansea Community Safety Partnership and the new drugs toilet facility at Morriston Hospital

4.29 There was an effective process for carrying out regular health and safety checks. CDOs carried out checks of their facilities at least once a day and these had been completed consistently. Regional custody inspectors carried out regular structured inspections of their facilities, with oversight of this process by the head of custody services.

4.30 Cells were checked between use for illicit items and in most but not all cases mattresses were wiped down between use. CDOs said they would clean up small amounts of body fluids. They could also call out a contractor for deep cleaning, who usually arrived within an hour. Maintenance arrangements were reported to be satisfactory, with defects responded to promptly by the contractor.

4.31 There were no cells adapted for detainees with disabilities, which occasionally led to difficulties. One detainee with a disability had been given a chair in their cell as it was impossible for them to get on or off the plinth to sit or lie down.

4.32 Pontypridd custody suite was tired, run-down and had numerous ligature points. Once booked-in, detainees had to be taken up steep stairs to the cell area. These stairs were a health and safety risk, especially if the detainee was not compliant or was intoxicated, and we heard several stories of staff and detainees falling down. There were two very dilapidated interview rooms up a further flight of stairs. No part of the suite was covered by CCTV. We considered that the suite had some fundamental issues that made it potentially unsafe. Subsequent to the inspection, the force notified us of a number of changes to the suite, which they felt had improved the safety issues we had identified.

4.33 Apart from Cardiff Bay, all suites had cells containing ligature points and a number of cells had T-bar handles that posed a significant risk should the cell door hatch fail or be left open. There was an apparent under-investment in those suites due for closure under the estates strategy.

4.34 All suites had a fire evacuation box containing torches, reflective bibs and plastic handcuffs. Apart from Pontypridd and Merthyr Tydfil suites where staff readily produced records of fire drills, few custody staff could recall any fire practice evacuations, although they knew the procedure to be followed in an emergency. Staff at Swansea had been involved in a real fire that had necessitated an evacuation.

4.35 We were particularly impressed by the posters and labels in custody suites reminding staff to explain the use of the call bells, although some detainees said this had not happened. All detainees we talked to said the call bells were responded to within a reasonable timeframe.

4.36 Survey respondents said their cells had been clean, well ventilated and warm.

Housekeeping points

4.37 Mattresses should always be wiped down between use.

4.38 Regular fire practice evacuations should be conducted and recorded.

Good practice

4.39 *A range of attractive posters reminded staff to offer blankets, hygiene packs, to test the call bells and generally reinforced that their role was to care for detainees.*

Personal comfort and hygiene

4.40 Most mattresses were clean and in a reasonable condition, although thin. Mattresses at Pontypridd were worn and in need of replacement. Not all suites had enough pillows. There were ample supplies of clean standard and safety blankets. In our survey, 63% of respondents, similar to the comparator, said they had been given clean bedding.

4.41 Not all cells had toilets. At Bridgend, only two cells had toilets and none had in-cell hand washing facilities, whereas all cells at Cardiff Bay had these. Toilet paper was available only on request. At Swansea and Merthyr Tydfil, the CCTV images of toilet areas were not obscured so staff could observe detainees, including women, using the toilet. Signs on cell doors reminded staff to offer women hygiene packs but we were not convinced that this always happened. Toothpaste was available but not all suites provided razors.

4.42 Cardiff Bay had several large clean private showers but Bridgend had just two cramped and rickety shower cubicles in the corridors with no private area in which to undress. The lack of privacy was an issue in several suites but all were clean. Cotton rather than paper towels were provided. Most staff said they would allow a shower if a detainee asked for one, was going to court or was held over a weekend. However, just two detainees in our custody record analysis had been offered a shower or washing facilities. Three detainees had been held for over 24 hours and four had gone to court without being offered a shower. In our survey, 22% of respondents against a comparator of 9% said they had been offered a shower.

4.43 Most suites provided ample replacement clothing for detainees whose own clothes had been taken or were soiled. Most replacement clothing at Bridgend was paper suits and we saw more detainees than usual wearing these at both Bridgend and Swansea. Some appeared cold and were wearing blankets to consultations with solicitors. Staff said the replacement clothing could not be laundered economically and its use was therefore restricted. Paper underwear was usually available.

Recommendations

4.44 CCTV images of toilet areas should be obscured.

4.45 All detainees held overnight, or who require one, should be offered a shower and should be able to use one in reasonable privacy.

4.46 The use of paper suits should be reduced by making more track suit tops and bottoms available.

Housekeeping points

4.47 Female detainees should routinely be offered hygiene packs.

4.48 Toilet paper should be routinely provided in each cell.

4.49 Worn mattresses and pillows should be replaced and pillows routinely provided.

Catering

4.50 Detainees were offered drinks at regular intervals. Poor quality microwave meals were also offered and there were good stocks, including meals suitable for Halal and vegetarian diets. Staff said they tried to provide meals at recognised meal times but were also prepared to provide them at other times as necessary.

4.51 Most respondents to our survey said they had been offered reasonable quality food and drink but all but one of those interviewed at Cardiff Bay described the food as poor. The custody record analysis showed that refreshments and meals were provided appropriately.

Activities

4.52 All suites had an exercise yard but they were little used. The yard at Ton Pentre was particularly dismal and had a large amount of graffiti. Many exercise yards we observed were in poor condition. None of the detainees in the custody record analysis had been offered exercise even though five had been detained for longer than 24 hours.

4.53 The provision of reading materials varied considerably. There were no reading materials at all at Bridgend and virtually nothing at Cardiff Bay despite its size. Merthyr Tydfil and Pontypridd contained a reasonable assortment of magazines and books, although only in English.

4.54 Family visits were rarely facilitated even though some suites had good closed visit rooms available.

Recommendation

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

Housekeeping points

4.56 A range of reading materials should be available and routinely offered, including books and magazines suitable for young people and for those whose first language is not English.

4.57 Visits should be facilitated for juveniles or those held for long periods.

5. Individual rights

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

Rights relating to detention

5.1 We observed custody sergeants questioning arresting officers about the reasons and necessity for detention. Although most said they very rarely refused to detain, we saw one custody officer do so. Voluntary attendance was in use and said to be an increasing option but voluntary attendees were still brought into the custody suite area to be 'booked-in' for recording purposes. This not only often led to delays in processing people but also was inappropriate in that people attending voluntarily to be interviewed under caution should not be brought before the custody officer in the same way as an arrested person.

5.2 Few detainees were asked any questions about dependents or caring responsibilities. Custody staff said detainees would normally volunteer information about any responsibilities towards children but there was no evidence of this happening.

5.3 There was a young offender triage system based at Cardiff Bay. Young persons aged between 10 and 17 years who were arrested and considered suitable for either a reprimand or final warning were referred to triage staff based in the police station. If that person admitted the offence and showed remorse, they were assessed and, if accepted, released with no further action regarding their offence and instead became part of the triage workers' caseload. This approach resulted in a young person spending less time in the custody suite and the force believed it was helping to reduce youth crime overall.

5.4 We were told that the custody suites were not used as a place of safety under the provisions of the Children Act 1989, although we were told of one incident where a 14 year girl found wandering the streets in the middle of the night was allowed to sleep in a cell until family could be contacted. This was well meaning but inappropriate as she should have been passed to the care of the local authority.

5.5 Custody staff explained to detainees their legal rights and entitlements and we saw detainees making telephone calls to solicitors and family members. These calls were seldom private as the telephone was usually near to the custody booking-in desk (see recommendation at paragraph 4.9). Information about rights and entitlements was available in many languages through the intranet but not all staff knew how to access it. In our survey, 71% of respondents against a comparator of 51% said they had been told about PACE rights.

5.6 Posters in all suites reminded detainees of their entitlement to free legal advice. Where legal advice was declined, detainees were told they could change their mind at any time and were usually asked why. Our survey showed that fewer detainees from South Wales than the national comparator accepted the offer of free legal advice. In our custody record analysis, only 10 detainees (30%) had accepted their right to free legal advice.

5.7 A professional telephone interpreting service was available and staff said the service was satisfactory. In most suites, the handset had to be passed between staff and the detainee, which made communication less efficient. Interpreters for interviews were provided by Welsh

Interpretation and Translation Services (WITS) and staff were positive about the service provided.

5.8 Data supplied by the force showed that in the 13 months prior to the inspection, 335 immigration detainees had been held in police custody. Staff said immigration detainees were moved on relatively quickly and reported good relationships with the UK Border Agency. However, the data indicated that 50% of immigration detainees remained in police custody for longer than 24 hours and a small number were held for five to six days. This was inappropriate.

5.9 We spoke to several solicitors, who said detainees were treated well and investigations were progressed reasonably promptly. The exception to this, in their opinion, was Cardiff Bay, where they said there were unnecessary delays and problems (see section on rights relating to PACE).

5.10 The completion of pre-release risk assessments was ensured by a prompt on the Niche system but usually consisted simply of transferring information from the initial risk assessment, which would not capture any new information that had arisen during custody. Some detainees were provided with transport home. In our custody record analysis, one detainee who threatened to commit suicide on release was detained in custody until his father was able to pick him up from the custody suite.

5.11 Detainees who had been charged or bailed were given the contact details of useful support agencies. This information was computer generated and attached to the back of their release paperwork (the charge or bail sheet). Staff did not always highlight that this information was included and detainees who were not charged or bailed did not receive it at all. Detainees who were alcohol or drug users were offered a referral to a specialist support service.

Recommendations

5.12 The quality and consistency of pre-release risk assessments should be improved.

5.13 Custody staff should always ensure that detainees' dependency obligations are routinely identified and, where possible, addressed.

Housekeeping points

5.14 All detainees should be made aware of the existence of support agency details available.

5.15 Custody staff should be reminded how to access the intranet to provide information about rights and entitlements in a range of languages and formats.

5.16 People attending police stations voluntarily to be interviewed under caution should not have to be brought before the custody officer.

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

Good practice

5.18 *On-site triage staff operating in Cardiff Bay Police Station on weekdays from 10am to 8pm allowed immediate referral for youths aged between 10 and 17 years in an effort to divert individuals from offending behaviour.*

Rights relating to PACE

5.19 During booking-in, detainees were offered the PACE codes of practice, although some were in a poor condition. Our custody record analysis concluded that PACE reviews were timely. When the inspector was not on site, the review was conducted by telephone with the reasons for so doing or if delayed, recorded in the detention log. We observed an exemplary 24-hour review of detention at Bridgend. It was held in an interview room with the investigating officer, detainee and solicitor and the detainee was given plenty of opportunity to make representations.

5.20 Solicitors complained to us that they could not use the booths provided at Cardiff Bay to consult with detainees because of soundproofing concerns so had to be locked in other rooms with detainees, which was not always appropriate. They also said they could wait up to 45 minutes for staff to let them out of the rooms. Telephone consultations took place in private with calls passed to detainees in their cells but solicitors said their calls into the suite were not always answered. They were also unhappy with the communications between the five wings at Cardiff Bay, which made it difficult for them to let clients on different wings know they were there. Only one internal telephone was available in the solicitors' waiting room. Solicitors believed these processes and delays were responsible for detainees waiving their rights to free legal advice. The low take-up of these services indicated in our survey and custody record analysis may be relevant in this regard (see paragraph 5.6).

5.21 In common with all police forces, South Wales adhered to the PACE definition of a child (as a person under 18) instead of the Children Act definition, which meant those aged 17 were not provided with an appropriate adult unless they were otherwise deemed vulnerable. Where family members were unavailable, appropriate adults were provided for juveniles by the youth offending team during office hours and by the social services emergency duty team during evenings and at weekends. The service was not normally available after 11pm. The force had contracted Hafal, a registered charity, to provide an appropriate adult service for vulnerable adults and this was generally excellent. This service was relatively new and some custody staff were not clear about the arrangements. In our custody record analysis, two young people had been read their rights without an appropriate adult present and there was no indication that this had later been repeated in the presence of an appropriate adult.

5.22 Staff said that when a juvenile was refused bail they always contacted the local authority to locate alternative accommodation but in practice facilities were rarely available to place juveniles in PACE remand beds or remand foster placements. This sometimes resulted in children being held in custody overnight unnecessarily.

5.23 Custody records and our observations confirmed that detainees were not interviewed while intoxicated.

5.24 Court cut-off times were described as extremely variable. At Swansea, the court accepted detainees up to 3.30pm or noon on Saturdays, while at Bridgend we were told the cut-off time could be as early as 10am on weekdays. Staff said they tried to ensure that detainees arrived at court by the cut-off time, including arranging for officers to drive detainees to court if they

had missed the escort vehicle. However, this was not always the case, as illustrated by the case of a detainee arrested in Cardiff at 8.55am for a fail to appear warrant issued at Bridgend Magistrates Court. He was taken to Cardiff Bay custody suite, where detention was authorised at 9.12am and the prisoner escorting company was contacted to convey him the 22 miles to Bridgend Magistrates Court. The escort did not arrive and the police did not arrange alternative transport so the detainee was held in police custody overnight, eventually being taken to Bridgend the next morning.

5.25 We observed prisoner escort staff at Cardiff Bay arriving to convey two detainees to Cardiff Magistrates Court even though the force had advised them that four detainees were required to attend that court. Fortunately, the vehicle used was large enough to take all four detainees on that occasion but there might have been an unnecessary delay had it not been.

5.26 The force had clear policies on the management of DNA and forensic samples in custody and there was an effective process to transport detainee samples to HQ.

Recommendations

5.27 Senior police managers should engage with HM Court Service to ensure that early court cut-off times do not result in unnecessarily long stays in custody and police custody staff should ensure that detainees are taken promptly to court either by the prisoner escorting company or, where there are delays, by alternative transport.

5.28 South Wales Police should review the arrangements in place at Cardiff Bay custody suite to facilitate detainees being able to consult legal representatives in private and to ensure that existing processes are not acting as an inhibitor.

5.29 Appropriate adults should be available out of hours for juveniles and to support juveniles aged 17.

5.30 South Wales 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.

Housekeeping point

5.31 All custody staff should be aware of and fully conversant with the arrangements for contacting appropriate adults.

Good practice

5.32 *Hafal, a registered charity contracted to provide an appropriate adult service for vulnerable adults, offered an excellent service that ensured these detainees were properly supported.*

Rights relating to treatment

5.33 Detainees were not routinely told how to make a complaint in line with the Independent Police Complaints Commission 2010 statutory guidance[6]. The process for making a complaint was

[6] IPCC statutory guidance (2010)

unclear. In some suites, we were told that a detainee who wished to complain would have to go to the police station front desk (assuming the detainee had been released) to speak to an inspector. Elsewhere, we were told it would be dealt with while the detainee was still in custody, whenever possible. Data from complaints were not collated so there was no capacity to learn from them.

Recommendation

5.34 Detainees should be routinely informed about how to make a complaint about their care and treatment and should 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 General health services for detainees in South Wales were provided by Reliance Medical Services (RMS), who had held the contract for several years. Mental health services were provided by the three local health boards and arrangements differed by area but trusts had their own relevant governance arrangements. Substance use services were provided by G4S in the west and Crime Reduction Initiative (CRI) in the east.

6.2 RMS senior managers said, and staff confirmed, that staff had a full induction and there was a plan for training and regular appraisals. There were also regular staff meetings and clinical supervision.

6.3 The force received daily reports from RMS and had regular meetings with them. Breaches of the contract were questioned informally but we were concerned that 'service credits' had never been invoked. There were a range of key performance indicators within the contract but in some instances the judgement about the level of achievement was made only by RMS staff (see below.)

6.4 The state of the clinical rooms varied and some needed attention. The room at Port Talbot was effectively a kitchen with a clinical couch, which was wholly unacceptable. The room at Pontypridd had a thick layer of dust on cupboard tops. The room at Cockett was dirty, poorly equipped and unsuitable for clinical use. None of the sharps bins in any of the suites were signed and dated when first used, some clinical waste bins contained domestic rubbish and none were foot operated. Infection control audits had resulted in RMS requesting several items from the force, such as replacement clinical waste bins, but these had not been provided and the actions had not been followed up. All the rooms had wooden couches and none had paper roll couch covers. RMS senior managers said the couches were only ever used if a detainee needed to provide forensic samples, which seemed a poor excuse for the lack of paper couch roll.

6.5 Medications were kept in wall storage cupboards in the medical rooms with access limited to nursing and medical staff using a combination lock and keys. There had been a number of discrepancies in stock medication balances in several of the western suites during the last few months but we found no discrepancies in other suites. Detainees' own medications, including those prescribed in custody, were kept in a separate cupboard in the clinical rooms to which custody staff had access.

6.6 We saw two current patient group directives (PGDs) covering diazepam and DF118. A directive for co-codamol was in development. The directives were not detailed and did not contain necessary information to guide nurses as to when it was appropriate to administer medication. The PGDs appeared to be retained by individual nurses.

6.7 There was an automated external defibrillator (AED) in each suite. Hand suction was also available but oxygen was not. There were red 'suicide intervention' bags in each suite. Daily

documented checks of the equipment had been carried out in all the suites and staff we spoke had all been trained in resuscitation, including use of the AED.

6.8 There was no evidence of formal information sharing policies between the police or any of the health care providers.

Recommendations

6.9 All clinical rooms should be fit for purpose and meet current infection control requirements.

6.10 There should be formal information sharing policies between South Wales Police and all providers of health services.

Housekeeping points

6.11 Patient group directions should conform to professional standards.

6.12 All sharps bins should be signed and dated when first used.

Patient care

6.13 When a detainee needed to see a health professional, custody staff called a central number and were given a reference number before the relevant health care professional called for more information to prioritise their work before attending the suite. Custody staff we spoke to were generally satisfied about waiting times for health care staff but those in outlying suites, such as Merthyr Tydfil, said they would 'think twice' before requesting a health care professional because they were likely to wait some time as health care staff were usually busy in one of the busier suites such as Cardiff or Swansea. They also said they would always call an ambulance if they were concerned about a detainee who they did not think could wait to be seen. The health professionals worked 12-hour shifts and provided 24-hour cover. At any one time, there were two nurses and one forensic medical examiner (FME) on duty. On occasions, the FME also covered the sexual assault referral centres.

6.14 In our survey, 33% of respondents said someone had explained their entitlement to see a health professional while in custody and only 33% had been seen by a health professional. In our survey of custody records, six (20%) detainees had been seen by a health care professional. The average wait was just over an hour, although one detainee was seen after one hour 40 minutes, two were seen after about an hour and another was seen after 36 minutes.

6.15 We also looked at the previous week's data, as supplied by RMS to South Wales Police. There were a total of 284 attendances by a health care professional to custody suites, of which 245 (86%) were responded to within the response times set out in the service level agreement (SLA). When delayed calls for the sexual assault referral centre and sudden deaths were included, 15% of all calls were delayed. The threshold set in the SLA before service credits were applied was 90% of calls to be attended within the agreed response times across each three-month period. Several of the delays were for the administration of medication. In one instance, a detainee had waited nearly six hours for the health care professional to attend. There was an 'escalation policy' to report delays but it was unclear how robustly this was used in reality.

6.16 We did not witness any clinical interventions between RMS staff and detainees but we did meet several nurses. None of those we met in custody suites were professionally dressed: some looked scruffy and one was wearing jeans. None had an obvious name badge. One detainee said she thought she had seen a cleaner rather than a nurse.

6.17 Custody staff tried to obtain medication for detainees by going to their home address, collecting it from a local pharmacy or taking the detainee to the pharmacy if he or she was on substitution medication that they collected daily. Fifty-two per cent of our prisoner sample reported drug or alcohol problems on arrival in custody and of those 13% were offered relief medication for their symptoms.

6.18 Health professionals used paper records to record their contemporaneous notes about a consultation. The records were stored in metal filing boxes, which were used to transport them to one of three 'base suites' for storage until they were collected to be taken to a central repository. We looked at a range of nurses' records and found some good histories and clinical entries but not all recorded the detainees' written consent, some were difficult to read and not all were signed. Following an assessment, the health professional entered a summary of the consultation onto Niche.

6.19 Swansea custody suite staff had developed a memorandum of understanding with Morriston Hospital for the care of detainees who had 'packed' drugs. This meant that the detainee remained under arrest but received appropriate care and attention in hospital until the packages were passed, whereupon he or she was returned to police custody.

Recommendation

6.20 South Wales Police should ensure that detainees held in custody needing to see a health care practitioner can do so within the agreed timescales.

Housekeeping points

6.21 Clinical staff should appear smart and professional at all times.

6.22 Detainee consent should be recorded on clinical records.

Substance use

6.23 Substance use services were provided by different agencies in different parts of the force area. In our survey, 52% of respondents said they had a drug or alcohol problem and 29% of these were offered or seen by a substance use worker.

6.24 Cardiff and Swansea were both drug intervention programme (DIP) intensive areas so detainees who had committed a trigger offence were automatically drug tested and refusal of a test constituted a further offence. There were plans to make all the force area DIP intensive in early 2012.

6.25 Drugs workers employed by CRI were available in the Cardiff Bay custody suites between 8am and 8pm on weekdays and 8am to noon at weekends to see detainees. When they were unavailable or off duty, custody staff made detainees appointments. Detainees attended the Cardiff Bay custody suite for their second appointment. This was an unusual arrangement but one we were told worked well. There were only a few breaches of appointments and the

arrangements helped with CRI resource issues. The workers did not see detainees with alcohol issues or juveniles but were able to signpost those with such issues to a local service. CRI workers also covered the suites at Merthyr Tydfil, Pontypridd, Ton Pentre and Aberdare. As they had access to NICHE, they were able to monitor activity at the suites and attend when needed if they were on duty.

6.26 Drug services in the west of the force area were provided by G4S, including dedicated court workers who provided diversion and harm minimisation and case workers for the custody suites who completed the initial assessments and follow-up contact. Drug workers visited the Swansea suite at 7am each weekday and during the day as required. All detainees were assessed and signposted as appropriate to other services. Other suites could contact the workers and make appointments as required.

6.27 We were told that the two agencies worked well together, sharing relevant information and covering for each other over bank holiday weekends. There were no needle exchange arrangements in the custody suites.

Housekeeping point

6.28 Detainees should be able to obtain clean needles and syringes on release from custody.

Mental health

6.29 Mental health services were provided by the local health boards. Aber Bro Morgannwg University Health Board provided services in the west of the force area, Cardiff and the Vale University Health Board covered Cardiff Bay and Cwm Taf Health Board were responsible for services in the north.

6.30 In Cardiff Bay, there was a 'Police Liaison and Diversion Scheme' mental health nurse. She had been in post for only two weeks but was part of the local forensic mental health team and had a wealth of experience in the field. As well as providing a service to detainees in custody, she attended a weekly police public protection unit referral meeting, which was also attended by probation, housing and social services. This meeting provided a forum for discussing cases involving missing persons, child protection issues, mentally disordered offenders and the management of sexual offenders at a level below formal referral to MAPPA and MARAC meetings.

6.31 Detainees were referred to the mental health nurse by RMS staff and she was able to provide advice or undertake a joint assessment with RMS staff.

6.32 In Swansea, an informal service level agreement with the health board funded by Welsh Assembly Government provided weekday access to a mental health nurse. The nurse visited the suite at 8am on weekday mornings to assess detainee referrals from the previous night. The service had been in place since 2006 and there was evidence of good collaboration between custody staff and mental health nurses. Referrals came from custody staff, the primary care nurses/doctors and from substance use workers. They were assessed either in the custody suite or, if needed, at the local hospital. Custody staff said this was a useful service that responded promptly.

6.33 In both Cardiff and Swansea, detainees were referred by RMS to local crisis teams when the mental health nurse was not available. In the north of the force area, this was the norm as there were no liaison or diversion schemes.

6.34 There were no Section 136 suites in the force area so any detainees arrested under a S136 were taken either to the local hospital accident and emergency department or the custody suites. In 2010, 269 S136 detainees had been taken to custody suites in the force area. In 2011 to date, the figure was 329. In both years, over 40% were taken to the Cardiff Bay suite. Force data for 2009/10 and 2010/11 indicated that similar numbers of S136 detainees were taken to hospitals but custody staff and others said hospital staff refused to accept a detainee who they considered to be intoxicated.

6.35 The training input on mental health and vulnerable persons in the custody officers training was comprehensive and relevant.

Recommendation

6.36 Detainees across the force area should have access to mental health liaison and diversion schemes.

Good practice

6.37 *The work of the community forensic mental health nurse in Cardiff Bay was an example of established partnership working.*

7. Summary of recommendations

Main recommendations

7.1 Cells should be free of ligature points or, when resources do not allow this, the risks presented managed. (2.19)

7.2 The conditions at the custody suite at Pontypridd should be significantly improved to address the safety issues presented. (2.20)

7.3 Detainees with mental health problems (under section 136) should be diverted to the appropriate specialist services and police custody should be used only exceptionally for this purpose. (2.21)

Recommendations

Respect

7.4 Staff should be trained to recognise and provide for the individual needs of detainees, particularly those who are vulnerable, juveniles and women. (4.8)

7.5 Booking-in desks should allow effective and private communication between detainees, staff and their legal representatives. (4.9)

Safety

7.6 The risk assessment and care planning process should be to a consistent high standard. (4.17)

7.7 The use of strip searching should be monitored and any potential over-use investigated and corrected. (4.18)

7.8 All custody staff should be involved in the same shift handover and, wherever possible, this should be away from the booking-in area and recorded. (4.19)

7.9 CCTV coverage should be installed at Pontypridd, Neath and Ton Pentre custody suites. (4.20)

Use of force

7.10 The policy on handcuffing should be clarified to avoid this becoming the norm and cuffs should be removed as soon as possible after arrival at the custody suite. (4.25)

7.11 South Wales Police should collate the use of force data in accordance with the Association of Chief Police Officers policy and National Policing Improvement Agency guidance, and the memorandum of understanding with health partners should exclude handcuffing to beds. (4.26)

Personal comfort and hygiene

7.12 CCTV images of toilet areas should be obscured. (4.44)

7.13 All detainees held overnight, or who require one, should be offered a shower and should be able to use one in reasonable privacy. (4.45)

7.14 The use of paper suits should be reduced by making more track suit tops and bottoms available. (4.46)

Activities

7.15 Detainees, especially those held for longer periods, should be offered outside exercise and all exercise yards should be kept clean and free from ligature points. (4.56)

Rights relating to detention

7.16 The quality and consistency of pre-release risk assessments should be improved. (5.12)

7.17 Custody staff should always ensure that detainees' dependency obligations are routinely identified and, where possible, addressed. (5.13)

Rights relating to PACE

7.18 Senior police managers should engage with HM Court Service to ensure that early court cut-off times do not result in unnecessarily long stays in custody and police custody staff should ensure that detainees are taken promptly to court either by the prisoner escorting company or, where there are delays, by alternative transport. (5.27)

7.19 South Wales Police should review the arrangements in place at Cardiff Bay custody suite to facilitate detainees being able to consult legal representatives in private and to ensure that existing processes are not acting as an inhibitor. (5.28)

7.20 Appropriate adults should be available out of hours for juveniles and to support juveniles aged 17. (5.29)

7.21 South Wales 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. (5.30)

Rights relating to treatment

7.22 Detainees should be routinely informed about how to make a complaint about their care and treatment and should be able to do this before they leave custody. (5.34)

Clinical governance

7.23 All clinical rooms should be fit for purpose and meet current infection control requirements. (6.9)

7.24 There should be formal information sharing policies between South Wales Police and all providers of health services. (6.10)

Patient care

7.25 South Wales Police should ensure that detainees held in custody needing to see a health care practitioner can do so within the agreed timescales. (6.20)

Mental health

7.26 Detainees across the force area should have access to mental health liaison and diversion schemes. (6.36)

Housekeeping points

Strategy

7.27 The force should include dip-sampling of CCTV recordings as part of their quality assurance processes. (3.14)

Safety

7.28 Custody staff should ensure that non-custodial staff do not visit detainees in cells unsupervised. (4.21)

Use of force

7.29 The booking-in processes at Cardiff Bay should be reviewed to minimise the waiting time of detainees in holding booths. (4.27)

Physical conditions

7.30 Mattresses should always be wiped down between use. (4.37)

7.31 Regular fire practice evacuations should be conducted and recorded. (4.38)

Personal comfort and hygiene

7.32 Female detainees should routinely be offered hygiene packs. (4.47)

7.33 Toilet paper should be routinely provided in each cell. (4.48)

7.34 Worn mattresses and pillows should be replaced and pillows routinely provided. (4.49)

Activities

7.35 A range of reading materials should be available and routinely offered, including books and magazines suitable for young people and for those whose first language is not English. (4.57)

7.36 Visits should be facilitated for juveniles or those held for long periods. (4.58)

Rights relating to detention

7.37 All detainees should be made aware of the existence of support agency details available. (5.14)

7.38 Custody staff should be reminded how to access the intranet to provide information about rights and entitlements in a range of languages and formats. (5.15)

7.39 People attending police stations voluntarily to be interviewed under caution should not have to be brought before the custody officer. (5.16)

7.40 Two-handset telephones should be provided in all suites to facilitate telephone interpretation. (5.17)

Rights relating to PACE

7.41 All custody staff should be aware of and fully conversant with the arrangements for contacting appropriate adults. (5.31)

Clinical governance

7.42 Patient group directions should conform to professional standards. (6.11)

7.43 All sharps bins should be signed and dated when first used. (6.12)

Patient care

7.44 Clinical staff should appear smart and professional at all times. (6.21)

7.45 Detainee consent should be recorded on clinical records. (6.22)

Substance use

7.46 Detainees should be able to obtain clean needles and syringes on release from custody. (6.28)

Good practice

Physical conditions

7.47 A range of attractive posters reminded staff to offer blankets, hygiene packs, to test the call bells and generally reinforced that their role was to care for detainees. (4.39)

Rights relating to detention

7.48 On-site triage staff operating in Cardiff Bay Police Station on weekdays from 10am to 8pm allowed immediate referral for youths aged between 10 and 17 years in an effort to divert individuals from offending behaviour. (5.18)

Rights relating to PACE

7.49 Hafal, a registered charity contracted to provide an appropriate adult service for vulnerable adults, offered an excellent service that ensured these detainees were properly supported. (5.32)

Mental health

7.50 The work of the community forensic mental health nurse in Cardiff Bay was an example of established partnership working. (6.37)

Appendix I: Inspection team

Sean Sullivan	HMIP team leader
Gary Boughen	HMIP inspector
Peter Dunn	HMIP inspector
Bob Edge	HMIC inspector
Mark Ewan	HMIC inspector
Angela Johnson	HMIP inspector
Nicola Rabjohns	HMIP inspector
Fiona Shearlaw	HMIP inspector
Elizabeth Tysoe	HMIP health care inspector
Hayley Cripps	HMIP research officer

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 the jurisdiction area of the South Wales Police, was carried out for this inspection. The results of this survey formed part of the evidence base for the inspection.

The survey was conducted on 17 November 2011. In total 74 respondents were approached. Of these 18 respondents reported being held in police stations outside of South Wales. On the day, the questionnaire was offered to 56 respondents; there were six refusals, six questionnaires returned blank, three non-returns and three questionnaires returned regarding police custody suites outside the South Wales jurisdiction. 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. In total one respondent was interviewed, though this was due to sight rather than literacy difficulties.

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.

In total, 38 (68%) respondents completed and returned their questionnaires.

Comparisons

The following details the results from the survey. Data from each police area has 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 47 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 is cleaned to be consistent.

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

Police custody survey

Section 1: About you

Q2 Which police station were you last held at?

Cardiff Bay – 17
Merthyr – 10
Ton Pentre – 5
Pontypridd – 6

Q3 How old are you?

16 years or younger	0 (0%)	*40-49 years*	6 (16%)
17-21 years	5 (13%)	*50-59 years*	1 (3%)
22-29 years	15 (39%)	*60 years or older*	1 (3%)
30-39 years	10 (26%)		

Q4 Are you:

Male	38 (100%)
Female	0 (0%)
Transgender/transsexual	0 (0%)

Q5 What is your ethnic origin?

White - British	31 (82%)
White - Irish	0 (0%)
White - other	1 (3%)
Black or black British - Caribbean	1 (3%)
Black or black British - African	1 (3%)
Black or black British - other	0 (0%)
Asian or Asian British - Indian	0 (0%)
Asian or Asian British - Pakistani	1 (3%)
Asian or Asian British - Bangladeshi	0 (0%)
Asian or Asian British - other	0 (0%)
Mixed heritage - white and black Caribbean	0 (0%)
Mixed heritage - white and black African	0 (0%)
Mixed heritage- white and Asian	2 (5%)
Mixed heritage - Other	1 (3%)
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	0 (0%)
No	37 (100%)

Q7 What, if any, is your religion?

None	17 (49%)
Church of England	8 (23%)
Catholic	1 (3%)
Protestant	2 (6%)
Other Christian denomination	1 (3%)

Buddhist 2 (6%)
Hindu 0 (0%)
Jewish 0 (0%)
Muslim 4 (11%)
Sikh 0 (0%)

Q8 How would you describe your sexual orientation?
Straight/heterosexual 37 (100%)
Gay/lesbian/homosexual 0 (0%)
Bisexual 0 (0%)
Other (please specify): 3 (100%)

Q9 Do you consider yourself to have a disability?
Yes 6 (16%)
No 32 (84%)

Q10 Have you ever been held in police custody before?
Yes 37 (97%)
No 1 (3%)

Section 2: Your experience of the police custody suite

Q11 How long were you held at the police station?
Less than 24 hours 12 (32%)
More than 24 hours, but less than 48 hours (2 days) 14 (37%)
More than 48 hours (2 days), but less than 72 hours (3 days) 11 (29%)
72 hours (3 days) or more 1 (3%)

Q12 Were you told your rights when you first arrived there?
Yes 34 (89%)
No 4 (11%)
Don't know/can't remember 0 (0%)

Q13 Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')?
Yes 27 (71%)
No 7 (18%)
I don't know what this is/I don't remember 4 (11%)

Q14 If your clothes were taken away, what were you offered instead?
My clothes were not taken 28 (78%)
I was offered a tracksuit to wear 3 (8%)
I was offered an evidence/paper suit to wear 3 (8%)
*I was **only** offered a blanket* 2 (6%)
Nothing 0 (0%)

Q15 Could you use a toilet when you needed to?
Yes 38 (100%)
No 0 (0%)
Don't know 0 (0%)

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

Yes	18 (47%)
No	20 (53%)

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

	Good	*Neither*	*Bad*
Cleanliness	15 (39%)	9 (24%)	14 (37%)
Ventilation/air quality	10 (29%)	10 (29%)	15 (43%)
Temperature	10 (28%)	7 (19%)	19 (53%)
Lighting	15 (42%)	8 (22%)	13 (36%)

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

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

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

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

Q20 **Were you held overnight?**

Yes	35 (92%)
No	3 (8%)

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

Not held overnight	3 (8%)
Pillow	19 (50%)
Blanket	28 (74%)
Nothing	7 (18%)

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

Not held overnight/did not get any bedding	10 (27%)
Yes	17 (46%)
No	10 (27%)

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

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

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

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

Q25 **Were you offered anything to:**

	Yes	*No*
Eat?	30 (79%)	8 (21%)
Drink?	32 (84%)	6 (16%)

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

Very good	*Good*	*Neither*	*Bad*	*Very bad*	*N/A*
0 (0%)	4 (11%)	4 (11%)	14 (37%)	11 (29%)	5 (13%)

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

I did not have any food or drink	5 (14%)
Yes	18 (51%)
No	12 (34%)

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	0 (0%)
I was allowed to smoke	1 (3%)
I was offered a nicotine substitute	0 (0%)
I was not offered anything to cope with not smoking	37 (97%)

Q29 Were you offered anything to read?

Yes	5 (13%)
No	33 (87%)

Q30 Was someone informed of your arrest?

Yes	20 (53%)
No	11 (29%)
I don't know	2 (5%)
I didn't want to inform anyone	5 (13%)

Q31 Were you offered a free telephone call?

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

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

My telephone call was not denied	21 (60%)
Yes	2 (6%)
No	12 (34%)

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

	Yes	*No*
Who was taking care of your children	2 (7%)	25 (93%)
Contacting your partner, relative or friend	17 (57%)	13 (43%)
Contacting your employer	4 (16%)	21 (84%)
Where you were going once released	12 (44%)	15 (56%)

Q34 Were you offered free legal advice?

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

Q35 Did you accept the offer of free legal advice?

Was not offered free legal advice	4 (11%)
Yes	18 (49%)
No	15 (41%)

Q36 Were you interviewed by police about your case?

Yes 30 (81%)
No ..... 7 (19%) If No, go to Q41

Q37 Was a solicitor present when you were interviewed?

Did not ask for a solicitor/was not interviewed 11 (30%)
Yes 22 (59%)
No 4 (11%)

Q38 Was an appropriate adult present when you were interviewed?

Did not need an appropriate adult/was not interviewed 22 (59%)
Yes 6 (16%)
No 9 (24%)

Q39 Was an interpreter present when you were interviewed?

Did not need an interpreter/was not interviewed 23 (62%)
Yes 1 (3%)
No 13 (35%)

Section 3: Safety

Q41 Did you feel safe there?

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

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

Yes 11 (30%)
No 26 (70%)

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

I have not been victimised	26 (70%)	*Because of your crime*	4 (11%)
Insulting remarks (about you, your family or friends)	8 (22%)	*Because of your sexuality*	0 (0%)
Physical abuse (being hit, kicked or assaulted)	5 (14%)	*Because you have a disability*	0 (0%)
Sexual abuse	2 (5%)	*Because of your religion/religious beliefs*	0 (0%)
Your race or ethnic origin	1 (3%)	*Because you are from a different part of the country than others*	0 (0%)
Drugs	4 (11%)		

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

Yes 21 (57%)
No 12 (32%)
I wasn't handcuffed 4 (11%)

Q45 Were you restrained while in the police custody suite?

Yes 5 (14%)
No 32 (86%)

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

Yes	6 (17%)
No	30 (83%)

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

Yes	7 (19%)
No	30 (81%)

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

Very well	*Well*	*Neither*	*Badly*	*Very badly*	*Don't remember*
3 (8%)	12 (32%)	8 (22%)	6 (16%)	6 (16%)	2 (5%)

Section 4: Health care

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

Yes	12 (33%)
No	21 (58%)
Don't know	3 (8%)

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

	Yes	*No*
Doctor	8 (23%)	27 (77%)
Nurse	6 (20%)	24 (80%)
Paramedic	0 (0%)	29 (100%)

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

Yes	6 (17%)
No	15 (42%)
Don't know	15 (42%)

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

Yes	15 (42%)
No	21 (58%)

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

Not taking medication	21 (58%)
Yes	4 (11%)
No	11 (31%)

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

Yes	18 (51%)
No	17 (49%)

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	17 (49%)
Yes	5 (14%)
No	13 (37%)

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

I didn't have any drug/alcohol problems	17 (49%)
Yes	2 (6%)
No	16 (46%)

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*
23 (64%)	1 (3%)	3 (8%)	3 (8%)	2 (6%)	4 (11%)

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

Yes	10 (29%)
No	24 (71%)

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

Yes	5 (14%)
No	30 (86%)

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

I didn't have any mental health care needs	30 (86%)
Yes	2 (6%)
No	3 (9%)

Prisoner survey responses for South Wales 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

		South Wales Police Custody 2011	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		38	1680
SECTION 1: General information			
3	Are you under 21 years of age?	**14%**	**9%**
4	Are you transgender/transsexual?	**0%**	**0%**
5	Are you from a minority ethnic group (including all those who did not tick white British, white Irish or white other categories)?	**16%**	**30%**
6	Are you a foreign national?	**0%**	**15%**
7	Are you Muslim?	**11%**	**11%**
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?	**98%**	**91%**
SECTION 2: Your experience of this custody suite			
11	Were you held at the police station for over 24 hours?	**68%**	**66%**
12	Were you told your rights when you first arrived?	**90%**	**76%**
13	Were you told about PACE?	**71%**	**51%**
For those who had their clothing taken away:			
14	Were you given a tracksuit to wear?	**36%**	**38%**
15	Could you use a toilet when you needed to?	**100%**	**90%**
16	If you used the toilet, was toilet paper provided?	**48%**	**48%**
17	Would you rate the condition of your cell, as 'good' for:		
17a	Cleanliness?	**40%**	**32%**
17b	Ventilation/air quality?	**28%**	**21%**
17c	Temperature?	**28%**	**15%**
17d	Lighting?	**42%**	**44%**
18	Was there any graffiti in your cell when you arrived?	**56%**	**55%**
19	Did staff explain the correct use of the cell bell?	**29%**	**22%**
20	Were you held overnight?	**92%**	**92%**
For those who were held overnight:			
21	Were you given any items of bedding?	**80%**	**84%**
For those who were held overnight and were given items of bedding:			
22	Were these clean?	**63%**	**57%**
23	Were you offered a shower?	**22%**	**9%**
24	Were you offered a period of outside exercise?	**10%**	**6%**
25a	Were you offered anything to eat?	**78%**	**81%**
25b	Were you offered anything to drink?	**84%**	**83%**
For those who had food/drink:			
26	Was the quality of the food and drink you received good/very good?	**12%**	**9%**
27	Was the food/drink you received suitable for your dietary requirements?	**60%**	**44%**

Key to tables

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	Percentages which are not highlighted show there is no significant difference		
For those who smoke:			
28	Were you offered anything to help you cope with not being able to smoke?	**2%**	**7%**
29	Were you offered anything to read?	**14%**	**13%**
30	Was someone informed of your arrest?	**52%**	**42%**
31	Were you offered a free telephone call?	**56%**	**49%**
If you were denied a free telephone call:			
32	Was a reason given?	**16%**	**14%**
33	Did you have any concerns about:		
33a	Who was taking care of your children?	**8%**	**14%**
33b	Contacting your partner, relative or friend?	**56%**	**53%**
33c	Contacting your employer?	**15%**	**20%**
33d	Where you were going once released?	**44%**	**31%**
34	Were you offered free legal advice?	**90%**	**85%**
For those who were offered free legal advice:			
35	Did you accept the offer of free legal advice?	**55%**	**78%**
For those who were were interviewed and needed them:			
37	Was a solicitor present when you were interviewed?	**85%**	**74%**
38	Was an appropriate adult present when you were interviewed?	**40%**	**24%**
39	Was an interpreter present when you were interviewed?	**6%**	**22%**
SECTION 3: Safety			
41	Did you feel unsafe?	**33%**	**39%**
42	Has another detainee or a member of staff victimised you?	**31%**	**27%**
43	If you have felt victimised, what did the incident involve?		
43a	Insulting remarks (about you, your family or friends)	**22%**	**12%**
43b	Physical abuse (being hit, kicked or assaulted)	**14%**	**5%**
43c	Sexual abuse	**6%**	**3%**
43d	Your race or ethnic origin	**2%**	**3%**
43e	Drugs	**10%**	**5%**
43f	Because of your crime	**10%**	**5%**
43g	Because of your sexuality	**0%**	**0%**
43h	Because you have a disability	**0%**	**1%**
43i	Because of your religion/religious beliefs	**0%**	**1%**
43j	Because you are from a different part of the country than others	**0%**	**5%**
44	Were your handcuffs removed on arrival at the police station?	**64%**	**74%**
45	Were you restrained whilst in the police custody suite?	**14%**	**18%**
46	Were you injured whilst in police custody, in a way that was not your fault?	**17%**	**24%**
47	Were you told how to make a complaint about your treatment?	**18%**	**13%**
48	Were you treated well/very well by staff in the police custody suite?	**41%**	**23%**

Key to tables

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	Any percentage highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
SECTION 4: Health care			
50	Did someone explain your entitlements to see a health care professional if you needed to?	**33%**	**35%**
51	Were you seen by the following health care professionals during your time in police custody:		
51a	Doctor	**23%**	**46%**
51b	Nurse	**20%**	**20%**
	Percentage seen by either a doctor or a nurse	**33%**	**53%**
51c	Paramedic	**0%**	**4%**
52	Were you able to see a health care professional of your own gender?	**17%**	**27%**
53	Did you need to take any prescribed medication when you were in police custody?	**42%**	**44%**
For those who were on medication:			
54	Were you able to continue taking your medication while in police custody?	**25%**	**38%**
55	Did you have any drug or alcohol problems?	**52%**	**54%**
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?	**29%**	**42%**
57	Were you offered relief or medication for your immediate withdrawal symptoms?	**13%**	**13%**
For those who were seen by health care:			
58	Would you rate the quality as good/very good?	**29%**	**29%**
59	Did you have any specific physical health care needs?	**29%**	**33%**
60	Did you have any specific mental health care needs?	**15%**	**24%**
For those who had any mental health care needs:			
61	Were you seen by a mental health nurse/psychiatrist?	**43%**	**25%**