Report on an inspection visit to police custody suites in Staffordshire

28 May – 1 June 2012

by

HM Inspectorate of Prisons and

HM Inspectorate of Constabulary

Printed and published by:
Her Majesty's Inspectorate of Prisons
Her Majesty's 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. The inspections look at strategy, treatment and conditions, individual rights and health care.

This unannounced inspection looked at three 24/7 custody suites and two stand-by custody suites operated by Staffordshire Police. At the strategic level, we found an appropriate oversight of the custody function but insufficient clarity of structure at several points. A centralised custody model had been in place for almost two years, but was not fully embedded in consistent standards and practice. Systems of accountability for quality and safety needed to be clear, consistent and subject to monitoring by senior managers.

Custody staff treated people positively and respectfully. The custody suites were in good condition and clean, but there were some defects. Detainees' basic needs were met, although showers were relatively infrequent. Treatment of children, women and minority groups was acceptable on the whole, but there was little assistance for those with disabilities. Risk assessment and risk management, including pre-release issues, were good, but staff handovers, a key moment for passing on information about risks and needs, required better organisation. The use of force was proportionate.

Custody sergeants made appropriate decisions about detention, and reviews were carried out on time. However, many detainees were not informed of reviews that had been carried out, and there were some shortfalls in DNA procedures. There was insufficient provision of appropriate adults, especially for vulnerable adults in the south of the county, and there were some problems with the use of interpreting services. Early court cut-off times disadvantaged detainees, and there was no clear, shared understanding of how to deal with complaints.

The system of organisation and delivery of health services was outdated, although custody staff did their best to work around the shortcomings. A new system was planned, but at the time of inspection clinical governance was informal at best, while clinical rooms and many aspects of medical equipment and medicines management were not up to standard. There was a reasonably good substance misuse service, but unequal mental health provision across the county.

In summary, Staffordshire Police was providing decent conditions of detention, and the centralising of this function was leading to improvements. As the force moved to a fully centralised and corporate organisation of custody, it needed to focus on consistent quality of delivery, monitored and reinforced by managers locally and at senior level. There should also be attention to some particular areas, such as health services, which need to be established on more secure foundations than at the time of inspection. 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
HM Chief Inspector of Constabulary

Nick Hardwick
HM Chief Inspector of Prisons

July 2012

2. Background and key findings

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

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

2.3 Staffordshire police had three full-time ('tier 1') designated custody suites and two reserve suites ('tier 2'), with a total cell capacity of 99. The inspection team visited all the custody suites. The force had held 29,581 detainees in the year to 31 March 2012, and 155 detainees for immigration matters in the same period.

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

Custody suite	Number of cells
Northern area custody facility (Stoke-on-Trent)	50
Burton-on-Trent	17
Watling House, Gailey (near Stafford)	15
Stafford (tier 2)	8
Tamworth (tier 2)	9
Total	99

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

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

Strategy

2.6 The force had centralised its custody provision two years previously, and senior management oversight was effective. Two chief inspectors managed custody in the north and south areas respectively, but the lines of management accountability were not entirely clear. There was a sound structure of regular oversight meetings. Staffing levels and the provision of training (apart from refresher training) were generally adequate.

2.7 Quality assurance of custody records was thorough but needed reinforcing through central coordination and checks by senior managers. Routine safety checks were also not systematic enough. Communication to staff through the intranet was hampered by systems that were not sufficiently clear, but there was good feedback from operational experience into training.

2.8 There was good partnership working, especially with the independent custody visitors (ICVs), and some promising developments in joint working on mental health.

Treatment and conditions

2.9 Staff treated detainees respectfully, and in general the suites were calm and well ordered. Some suites, but not all, provided reasonable privacy for carrying out initial risk assessments at the custody desk. Juveniles were treated appropriately on the whole, although young women were not always allocated a female member of staff. There was proper provision for female detainees but we noted some significant lapses in their care. There was insufficient account taken of the needs of people with disabilities, and provision for religious observance was limited.

2.10 Risk assessments of arriving detainees were thorough and were updated as the detainee's circumstances changed. Detention officers understood the requirements for observing detainees in the cells, although the frequency of their visits tended to be based on routine rather than risk, and visits were sometimes missed. All detention staff carried anti-ligature knives, but some other emergency equipment was not readily available.

2.11 The quality of staff handovers from one shift to the next varied widely, from the thorough to the superficial, and from one-to-one conversations to whole-team discussions. There was some good practice in preparing people for release and, in several cases, in helping vulnerable people to get home.

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

2.12 The use of force was proportionate, as far as we could find in the absence of systematic records. Detainees brought in to the suites were frequently not handcuffed, although we observed a case of apparent inappropriate practice, and strip searching was rare.

2.13 The suites were generally in good condition, although a few improvements would have made a significant difference. Emergency procedures, especially in case of fire, were not clear or well understood in all suites. Bedding, clothing and hygiene provision were satisfactory, but not all detainees who needed a shower could have one. There was reasonable provision of food and drink, but limited evidence of outside exercise for those held for many hours.

Individual rights

2.14 Sergeants rarely refused detention, although there was some evidence of greater use of alternatives to custody. Staff were helpful to legal advisers. The availability of appropriate adults was restricted, especially for vulnerable adults in the south of the county. As in other forces, appropriate adults were not provided for 17 year olds. There were some difficulties with a new contract for interpreting services for non-English speaking detainees, and liaison by the UK Border Agency was not well developed.

2.15 Detention reviews were carried out on time, but those done in the night were often not reported to the detainee in the morning. Detainees were given information on their rights and entitlements, but this was not up to date or in accessible formats.

2.16 The latest times for court attendance were sometimes too early, and there was no court video link. Processes for handling DNA were flawed in some instances. The system for receiving and dealing with complaints was not clear or consistent, nor was there systematic monitoring or analysis of them, but the learning from the outcomes of some complaints was fed back to staff.

Health care

2.17 The force recognised that the current health care arrangements were inefficient, and there were plans for a new contract. The current service depended on experienced doctors, but there was no evidence of systematic clinical governance, and the average waiting times were too long. Most clinical rooms in the custody suites were not fit for purpose, with some equipment out of date

2.18 The management of medicines was not sufficiently secure, and systems for keeping clinical records were not satisfactory. There was a relatively good service for detainees with substance misuse issues, including assessment and intervention for alcohol problems. The mental health service provision was not consistent across the county, and arrangements for attendance out of normal hours were unclear. There was good partnership working in mental health, but the lack of an agreement on transfers between the two trusts in the county undermined the effective management of those detained under section 136 of the Mental Health Act.[3]

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

Main recommendations

2.19 Staffordshire Police should ensure clear lines of accountability, and systematic monitoring and control at inspector level and above.

2.20 The new health care arrangements should ensure sound clinical governance, prompt attendance by health care professionals, and secure handling of records and medicines.

National issues

2.21 Appropriate adults should be available to support without undue delay juveniles aged 17 and under in custody, including out of hours.[4]

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

3. Strategy

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

Strategic management

3.1 There was evidence that Staffordshire Police had strong strategic leadership on custody issues, with an assistant chief constable (ACC) as the strategic lead officer for custody. This ACC also sat on the Local Criminal Justice Board, which was chaired by the chief constable.

3.2 Custody was centrally managed through justice services, led by a superintendent, with responsibility for policy, procedure and staffing. The force had an estates strategy for custody, which it regularly reviewed.

3.3 There was a police authority lead officer for custody, who also had responsibility for independent custody visitors (ICVs) (see paragraph 3.14).

3.4 Custody provision across Staffordshire was split geographically into two areas, north (Stoke-on-Trent) and south (Burton, Watling House, Tamworth and Stafford), each with a chief inspector responsible for custody. These chief inspectors were not justice services staff and were line managed through local policing management structures; they also had other operational policing responsibilities. However, the chief inspectors did line manage a custody manager in each area, who was an inspector. Each custody manager line managed a deputy custody manager, who was a sergeant. There had recently been a change from one to two chief inspectors with custody responsibility and this had not been communicated effectively to staff, leading to some confusion on management arrangements.

3.5 There was a good custody-related meeting structure, with custody issues discussed at regular force meetings. These included a bimonthly strategic force custody group, chaired by the ACC lead for custody, and a tactical custody group, chaired by one of the custody chief inspectors and attended by custody inspectors and other key custody stakeholders. The minutes showed that these meetings were proactive and well attended.

3.6 Custody suites were staffed by permanent custody sergeants supported by civilian detention officers (CDOs), and at Stoke-on-Trent custody assistants, provided by G4S, who looked after the ongoing care and welfare of detainees. However, there was no back up in the permanent team, and this had to be provided by trained staff from local policing teams when required.

3.7 Although the number of sergeants appeared adequate, there were not enough CDOs to provide an effective service. Stoke had a cell capacity of 50, divided into two wings (B and E) but only three CDOs per shift.

3.8 The force had a system to record, monitor and learn from near-misses/adverse incidents. Relevant incidents were discussed at the strategic force custody group, and there were regular meetings between one of the custody chief inspectors and the training department to ensure that learning was fed into training.

3.9 The force had comprehensive and regularly reviewed custody policies, accessible to all staff through a dedicated custody 'team room' page on its computer system, which also published

updates and held a large amount of information. The page was difficult to navigate and some staff said that they were unsure how to access the information, which raised a risk that important information could be missed. Although custody managers were based in custody suites, there was an over-reliance on email and the team room page to deliver key information.

3.10 The ACC lead for custody had recently made a structured inspection of the force's three main custody facilities, resulting in an action plan to address identified issues.

3.11 There were health and safety checks at all suites, although the recording of the daily, weekly and monthly checks was inconsistent and lacked structure. Where issues were identified, there was little recording of who was to respond and the actions taken. Custody managers did not oversee these checks.

3.12 The deputy custody managers made quality assurance checks and carried out dip sampling of custody records. These checks followed a corporate template and were of good quality, included handovers and prisoner escort records (PERs), and were cross-referenced with CCTV recordings. Although the quality assurance checks were adequate, there was not enough involvement by the custody managers or central coordination and oversight from justice services to identify and share learning points.

Partnerships

3.13 Partnership arrangements were described as good, with active engagement with relevant criminal justice and health partners, especially the mental health trusts, at strategic and tactical levels.

3.14 The ICV scheme was active, with three panels. The police authority ran training events for ICVs throughout the year. ICVs told us that they were generally admitted to custody suites quickly and had a good relationship with custody staff. Custody managers or their deputy attended quarterly panel meetings.

Learning and development

3.15 All custody staff had received role-specific training before working in custody, including first aid and personal safety training. Courses included Police and Criminal Evidence Act (PACE) legal responsibilities, risk assessments and handovers. Refresher training had been re-introduced 18 months previously, and staff could choose modules to suit their assessed training need. It was evident that some custody sergeants had not received custody training for several years, and there needed to be greater management oversight of the refresher training programme.

Recommendations

3.16 The format of the 'team room' computer page should be made more accessible, and staff should be given the necessary training to use it effectively.

3.17 All staff working in custody should receive regular refresher training, with effective management oversight of this process.

Housekeeping point

3.18 Regular health and safety checks should be carried out to a consistent standard and with greater involvement by the custody managers.

4. Treatment and conditions

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

Respect

4.1 Custody staff were polite to detainees, using their first names when appropriate. Most detainees told us they felt well treated.

4.2 There was little privacy in the booking-in areas at the custody suites in the south of the county. The areas in Tamworth and Stafford were small and had no screening. Although the two suites were not open when we inspected them, they would have had little privacy for detainees asked to disclose sensitive or personal information. The booking-in terminals at Burton were very close together, which meant that detainees could overhear personal information. We saw a woman who was booked in and searched in the full view and hearing of a male detainee charged with sexual assault who had been allowed to observe the entire process.

4.3 At Stoke, the booking-in area was spacious and reasonably well screened for privacy. There was also a separate booking-in area for detainees arrested for serious offences so that the process could be conducted privately, and we observed this being used. The desk in this discrete area could be lowered to enable interviews with detainees in wheelchairs. We observed a detainee who was brought in for a serious offence, and the custody sergeant and arresting officers ensured that only custody staff were in the booking-in area to enable privacy for the detainee during the process.

4.4 Management of the custody area at Burton was a problem as police cells were shared with the local court and it was difficult for custody sergeants to control the number of police officers, lawyers and other personnel present. At Stoke, the custody sergeants had reasonable control over the booking-in area, and detainees did not spend too long in the holding rooms.

4.5 Staff in all the custody suites showed limited awareness of diversity matters. At Burton, staff were unaware that young women detainees should be in the care of a woman officer at all times. The designated cells for women detainees at Stoke were said to be on E wing, but this was not the case in practice. In our analysis of 30 custody records, all seven women detainees in the sample were given the opportunity to speak with a female member of staff, and we observed women detainees asked if they might be pregnant.

4.6 Burton had four detention rooms used for juveniles near the booking-in desks, but they were grim with no natural light. We were told that juveniles were sometimes allowed to wait in the holding rooms with the door open. In Watling House, the only place to hold potentially vulnerable detainees was a cell.

4.7 Custody sergeants at Stoke told us that juveniles were mainly located on E wing. However, on one day during the inspection a 13 year old was taken to a cell on B wing because the custody sergeant who had booked him in was responsible for that wing and wished to continue to oversee the juvenile while he was in custody. The juvenile refused to go into the cell on B wing and was finally located in a holding room in front of the custody desk. When we spoke to him, he told us he was afraid of being left in a cell on his own and preferred to be in the holding

room in view of staff. We were concerned that the custody sergeants did not take this action in the first instance, given the detainee's age and reluctance to be placed in a cell.

4.8 All detainees were asked during the booking-in process if they had any concerns for dependants, and we observed custody staff offering telephone calls to enable detainees to make arrangements for the care of their children. Custody sergeants were generally aware of safeguarding issues that could affect juveniles or vulnerable adults, and had a list of agencies to refer such individuals if they identified any concerns.

4.9 The suites had no adapted cells for older detainees or those with disabilities. The bed plinths in the cells were low, which made them difficult for detainees with limited mobility, and there were no extra-thick mattresses to raise the height of beds. All the call bells were at a high level. Staff in the Burton suite told us that lower call bells were not necessary because detainees with disabilities were placed in camera cells and told to put their hands up if they needed attention, which was not acceptable as CCTV is not continuously monitored for every cell. There were toilets adapted for people with disabilities at Stoke, Watling House and Burton but not at Stafford or Tamworth. The Tamworth suite had a big step to access it, and Burton also had a high step to the exercise yard, which made it inaccessible to detainees with mobility difficulties. In Stoke, there was a hearing loop in the secure visits room but not in the main booking-in area. Portable hearing loops were available at the Watling House and Burton custody suites.

4.10 Custody staff we spoke to at Stoke told us that they were aware of the particular needs of transgender detainees being searched, and would (correctly) allow the detainee to indicate their preference for the gender of searching staff. Staff at Watling House and Burton said that they were sensitive to the needs of transgender detainees, but they would be searched by staff of their biological gender rather than be allowed to express a preference.

4.11 Watling House and Burton had prayer boxes with items to facilitate Muslim observance, which were stored and handled respectfully. There was also a Bible but no holy books for other religions at any of the custody suites. There were prayer mats at Stoke but only one copy of the Qur'an and Bible available, which was potentially insufficient for the size of the custody suite. Nevertheless, the items were stored properly, with clear instructions to staff to prevent unwitting offensive handling. We could not locate such items at Stafford or Tamworth, but these suites were not open during the inspection.

Recommendations

4.12 Booking-in areas should provide sufficient privacy.

4.13 Managers should ensure that the reasonable requirements of detained children, women and people with disabilities are met.

4.14 There should be hearing loops in the booking-in areas, and all custody staff should know how to operate them.

4.15 Staff should be given up-to-date guidance on the treatment of transgender detainees.

Safety

4.16 During booking-in, custody sergeants asked detainees the questions specified on the national strategy for police information system (NSPIS), and also asked some supplementary questions about their health and emotional state, especially when there were indications of self-harm.

They explained to detainees why such personal questions were necessary. In our custody record analysis, eight of the detainees (27%) had current or previous self-harm or suicide issues. In four cases, we noted police national computer (PNC) or force intelligence warning markers indicating violence or self-harm issues. There was evidence that custody sergeants risk assessed each case, with additional notes recording decisions about observation levels. Risk assessments were clear and considered, and were reviewed and revised appropriately. At Stoke, we observed a detainee who would not engage with the risk assessment process. He was placed on constant supervision due to mental health concerns. Custody sergeants told us that if they had concerns about a detainee who would not engage with risk assessment, they placed them in a camera cell or on constant supervision and contacted the forensic medical examiner (FME) to see them. This approach was proportionate, and included routinely checking the PNC for markers and gathering information from the arrest.

4.17 Although a few detainees were placed on 60-minute observations, in practice all detainees were observed every 30 minutes. This potentially lessened the value of 30-minute observations, which are intended to focus staff attention on detainees with particular needs or risks. A custody sergeant told us that the practice had been to put everyone on 30-minute observations, and that they had only recently been informed by senior managers that they could use 60-minute observations.

4.18 Our custody record analysis raised concerns that not all observations were completed at the required intervals. For example, in one case 30-minute observations had slipped to 46 minutes, and then to 85 minutes. This was unsatisfactory as the detainee, transferred while in police custody from Burton to Tamworth, was suffering from drug and alcohol withdrawal and had been prescribed relevant medication. At Burton, we were told that because the fire alarm system was unreliable, all detainees had to be checked at least every 30 minutes (see also paragraph 4.38 and recommendation 4.39).

4.19 Any detainee with a head injury or under the influence of alcohol was placed on rousing checks. Staff were aware of the need to get a response from the detainee during rousing checks, and detention officers had been trained in how to do this. Custody sergeants at Stoke told us that they expected the CDOs to tell them how well a detainee was rousing in order to inform their ongoing risk assessment.

4.20 All staff carried anti-ligature knives, apart from custody assistants at Stoke who did not have any detainee contact. There were no anti-ligature shears in the booking-in areas. Watling House had a suicide prevention kit, but this had no anti-ligature shears and was stored in a locked cupboard, with the first aid kit and defibrillator, so was not readily accessible in an emergency. There were good stocks of anti-rip blankets in all suites, but no anti-rip clothing. There was CCTV in 12 cells at Stoke, six at Watling House, four at Burton and one at Stafford. In Watling House, the CCTV images of toilet areas were not obscured.

4.21 Custody sergeants were emailed regular bulletins about near misses and adverse incidents in custody, which they found helpful in managing risk, although the distinctions between these terms were not always clear. They were also aware of the Independent Police Complaints Commission 'learning the lessons' information.

4.22 Staff handovers were of a very variable standard. At Stoke, some custody sergeants handed over on a one-to-one basis, as did CDOs, and some were thorough but others superficial. However, we did see some custody sergeants who were starting their shift going to the cells and introducing themselves to the detainees. At Burton and Watling House, some handovers were thorough and involved custody sergeants and detention officers. However, they all took

place in the booking-in areas, and not all were carefully prepared. Some of the detention officer handovers were very brief and unsystematic.

4.23 Pre-release risk planning was good. At all suites, detainees were given a leaflet of contact details for local agencies. Our custody records analysis showed that a good level of care was shown towards women with vulnerabilities – for example, in one case an officer took a woman to her home because of heavy rain. People arrested for domestic violence were given an excellent leaflet setting out the Staffordshire Police policy on domestic violence with information about where they could receive help to change their behaviour. Similarly, anyone who came into the suite under the influence of alcohol was given advice and information about local alcohol agencies. Custody sergeants knew the local arrangements for passing information about vulnerable detainees to social services.

Recommendations

4.24 Custody records should be sampled to ensure that where observations are not undertaken at the required intervals, action is taken to improve practice.

4.25 Suicide prevention kits should include anti-ligature shears and be readily accessible.

4.26 All custody staff should be involved in the same shift handover and, where possible, this should take place away from the booking-in area and be recorded.

Housekeeping point

4.27 CCTV images of toilet areas at Watling House should be obscured.

Good practice

4.28 *Those charged or arrested for a domestic violence-related offence were given information about where they could receive help to change their behaviour.*

Use of force

4.29 In our prisoner survey, 77% of respondents said that their handcuffs had been removed on arrival at the custody suite. We observed some detainees arriving at Stoke custody suite in handcuffs, which were removed promptly. Custody staff had good knowledge of de-escalation methods. However, at Burton a woman detainee was brought into the custody suite handcuffed because she was alleged to have assaulted the arresting officer. Although she quickly became compliant, she remained handcuffed throughout the 35 minutes it took to book her in. She told the custody sergeant she was in considerable discomfort, and in our view the cuffs could have been removed much sooner, and given her compliance there was little reason for her to remain handcuffed.

4.30 During the inspection, force was used on a detainee who refused to have his necklace removed and who became agitated. Staff carried him to a camera cell to calm him down and search him. The custody sergeant involved was clear about the process for completing the use of force form and recording the incident on the detainee's custody record, but told us that it was unlikely that they would receive any feedback. This potentially volatile situation was handled well by all the staff involved.

4.31 Use of force was recorded but with no apparent monitoring of trends. This meant that opportunities to review and develop tactics and procedures for the use of force could be missed. All staff had been trained in approved safety techniques and received annual refresher training.

4.32 Staff told us that the decision whether to strip search a detainee was part of the risk assessment and based on relevant intelligence. We saw no strip searching taking place. The force did not collect data about strip searching.

Recommendation

4.33 Detainees should only remain handcuffed while they are booked in when a risk assessment indicates this is necessary for the safety of staff, the public or the detainee.

Housekeeping point

4.34 Staffordshire Police should collate and analyse use of force data on strip searching and on use of force, in accordance with the Association of Chief Police Officers policy and National Policing Improvement Agency guidance.

Physical conditions

4.35 All custody suites, except Tamworth, were clean, well decorated and almost free of graffiti, with no evident ligature points. Some of the cells in Tamworth needed deep cleaning, particularly the toilet areas, which were badly stained. The communal toilet and washbasin near the detention room were dirty and unhygienic, and needed to be thoroughly cleaned. There was some graffiti in one of the holding rooms at Stoke. Staff told us that a zero tolerance policy featured instant removal of graffiti and prosecution of offenders. There was regular steam cleaning of cells. Cells were taken out of use between occupancy for cleaning. When the cleaners were off duty at Watling House and Burton, custody staff dealt with bodily fluid spillages themselves, using special kits. At Stoke, CDOs emptied vacated cells and cleared and cleaned any small spillages of drink or food. Toilets, washbasins and showers in the Stoke and Stafford suites were clean and tidy.

4.36 All cells had good natural light. Cells keys were generally well managed, although on the last day of inspection several sets of keys were left on the side of the custody desk, which anyone could have accessed. Custody detention officers and custody sergeants primarily unlocked detainees for access by arresting officers, and this was generally well managed.

4.37 Detainees we spoke to at Stoke told us that custody staff explained the use of the cell call bell when they were taken to the cell. A custody assistant at the suite was responsible for answering the bell through an intercom that enabled them to speak to detainees in their cell. Cell call bells were responded to promptly in all the suites. The custody assistants at Stoke were particularly responsive and caring towards vulnerable detainees located in CCTV cells. The cells in all suites, except Stoke, displayed messages pointing out the cell call bell and that it should be used for assistance, and signs to the toilet flush.

4.38 Watling House and Burton suites had fire evacuation boxes with ample supplies of plastic handcuffs. However, when we asked about fire evacuation procedures, one detention officer appeared unaware of their existence, showing us a bag with insufficient metal handcuffs instead. There had been no practice evacuations at the open suites, although staff told us they

had received a talk from their line manager about how to undertake an evacuation. We were told that the fire alarm system at Burton was subject to frequent faults (indeed, an engineer was attempting to repair it during the inspection). Stoke had had an evacuation walkthrough, and handcuffs and instructions for evacuation were available to staff, who were familiar with them. At Tamworth, the evacuation pack was prominently displayed behind the custody desk, but we were unable to locate the one at Stafford. Smoking was not allowed in the custody suites.

Recommendation

4.39 The fire alarm system at Burton should be made reliable or replaced.

Housekeeping points

4.40 The stained toilets and communal washbasin in Tamworth should be deep cleaned.

4.41 Fire evacuation procedures should be clarified, and regular fire evacuation drills should be carried out and recorded.

Good practice

4.42 *A zero tolerance policy ensured instant removal of graffiti from cells and prosecution of offenders.*

Detainee care

4.43 All cells contained a mattress and a pillow but at Stoke they were not routinely wiped down between uses. We found stocks of clean blankets but detainees told us that they had to ask for their blankets. All cells, except the detention rooms at Tamworth and Stafford, had toilets, and there was toilet paper in most of the cells. Custody staff told us that detainees in E wing at Stoke were supplied with toilet paper following a risk assessment. Hand basins and drinking water was available in the cells at Stoke. The Tamworth and Stafford suites had communal hand basins.

4.44 In our survey, 20% of respondents, against the comparator of only 9%, said they had been offered a shower. Showers in the custody suites (except Tamworth) were clean but had little privacy for women. The communal shower area in Tamworth was dirty and required cleaning. Our custody record analysis showed that four detainees who were held longer than 24 hours – including one for 53 and one for 54 hours – were not offered showers. CDOs in Stoke told us that they offered showers when they were not busy, and expected CDOs on the night shift to facilitate showers for detainees going to court.

4.45 Toothpaste and brushes, razors and combs, and replacement underwear were available in the custody suites, but there were no razors at Watling House and Burton, which meant that male detainees could not shave before going to court. Female detainees were not routinely informed about or offered a hygiene pack.

4.46 There were stocks of replacement clothing in all the suites, including paper suits, tracksuits and plimsolls, which we observed detainees wearing. Detainees whose trousers were removed

were only given paper suits. Custody sergeants at Stoke said that family and friends could bring in clothing.

4.47 Our custody record analysis showed that detainees received meals when they requested them. Twenty-two detainees (73% of the sample) were offered at least one meal while in custody. All custody suites supplied microwave meals, including halal and vegetarian options. At Stafford, some of the meals had passed their expiry date and needed to be removed from the store cupboard, while at Watling House, the microwave was dirty. Stoke had an impressive kitchen area where CDOs prepared meals and drinks, and we observed detainees offered meals and drinks regularly. Staff told us they would provide meals to detainees outside regular mealtimes. All detainees were asked about dietary requirements when they were booked in.

4.48 In our survey, only 4% of respondents said they had been offered outside exercise, and in our custody record analysis no detainees had been offered time outside. At Stoke we observed a detainee in the exercise yard, supervised by the CDO. Custody staff told us that they offered time outside when they could facilitate it as it was difficult to provide a CDO for supervision. The exercise yards were covered by CCTV.

4.49 There was a good stock of books, newspapers and magazines at Watling House and Burton. However, only one of the detainees we spoke with said they had been offered something to read. Stoke custody suite had a limited range of books and newspapers, supplied by staff. There was no reading material in foreign languages or in easy-read format in any of the custody suites. In our custody record analysis, five detainees (17%) had been given reading materials. Visits by detainees' relatives were facilitated in the secure visits room in Stoke custody suite. Custody sergeants told us that they mainly authorised secure visits for immigration detainees who could potentially be there for a few days. In Watling House, staff told us that vulnerable young people could occasionally have a social visit. The secure visits room in Burton was used as a storeroom and visits were never allowed.

Recommendations

4.50 All detainees held overnight, or who require one, should be offered a shower.

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

4.52 All suites should hold and offer a range of reading materials, including books and magazines suitable for young people and non-English speakers.

4.53 Visits should be facilitated for vulnerable young people or detainees held for long periods.

Housekeeping points

4.54 Razors should be available for male detainees to have a shave before attending court.

4.55 Female detainees should routinely be offered hygiene packs.

5. Individual rights

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

Rights relating to detention

5.1 We observed custody sergeants checking the circumstances of the detainee's offence and arrest to determine if detention was appropriate. Most custody sergeants could recall only a few occasions when they had refused to detain, but we saw a sergeant advise a colleague that, on the basis of the information available about a particular person brought in by an arresting officer, he would refuse detention. Staff believed that alternatives to custody, such as street bail, fixed penalty notices and voluntary attendance, were being increasingly used. There was a lack of clarity on use of the voluntary interview at station procedure, which the force had advocated as an alternative to arrest for selected offences. Several custody officers said that even if they thought that the matter could have been dealt with by this procedure, they would still accept detention as the suspect was already at the custody suite. Solicitors were of the view that some of their clients could have been dealt with other than by arrest.

5.2 Many solicitors believed that their clients were generally detained for too long, and there was some evidence to support this view. We observed several cases where detention was unnecessarily prolonged, and in our custody record analysis, five detainees (17%) had been held for more than 24 hours and 17 (57%) were held overnight. However, custody sergeants were clear about their obligations to ensure that cases proceeded quickly, and we observed them regularly prompting investigating staff to ensure that there were no unnecessary delays. There was some evidence that, wherever possible, detainees arriving late were interviewed and processed before the following morning. Overall, there was no clear pattern of over-long detention.

5.3 We were told that some immigration detainees waited several days to be collected. Custody staff did not have a recognised liaison officer in the UK Border Agency (UKBA) to progress cases, although there was contact with the UKBA Stoke office. Data supplied by the force showed that in the year to March 2012, 155 immigration detainees had been held in custody.

5.4 Staff assured us the custody suites were never used as a place of safety for children under section 46 of the Children Act 1989. Staff said they contacted social services to confirm the availability of secure PACE beds for juveniles held overnight who could not be bailed, although none were aware that any such beds had ever been available in the county. However, they reported that non-secure accommodation requested had been made available.

5.5 The force adhered to the PACE, rather than Children Act 1989, definition of a child, which meant that those aged 17 were not provided with an appropriate adult (AA) unless they were otherwise deemed vulnerable. Relatives or family friends were usually contacted initially to act as an AA. When this was not possible, during office hours staff had to request AAs from the local youth offending team (YOT) or social services. Out of hours, AAs were requested through the social services emergency duty team (EDT), although there was no cover between midnight and 9am. We were told that lengthy delays waiting for AAs to arrive were common. All three young people under 17 in our custody record sample had been interviewed in the presence of a family member and released in less than six hours. In Watling House we found a

16 year old held in custody for two nights as he came from outside the county and there were problems in arranging suitable secure accommodation for him.

5.6 During booking in, staff gave all detainees a leaflet summarising their rights and entitlements, but this was out of date as a newer version had been introduced. The newer version could be downloaded and printed in foreign languages when needed, but was not available in a pictorial or easy-read format for detainees with learning difficulties or limited literacy. An audio version of the rights and entitlements was also available in 44 languages, although staff found this too difficult to access.

5.7 In the Watling House and Burton custody suites, a professional telephone interpreting service could be used at the booking-in desks, but through speaker phones, which affected privacy. The booking-in desk at Stoke had two-handset telephones for interpreting. Staff at Stoke said there was a good face-to-face interpreter service available to facilitate investigative interviews, although, under a new contract, there were sometimes delays in obtaining interpreters in person and on the telephone for a particular language.

Recommendations

5.8 Staffordshire police should work with the local authority to ensure the provision of appropriate overnight accommodation for juveniles who have been charged but cannot be bailed to appear in court.

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

5.10 There should be two-handset telephones in all suites to facilitate telephone interpreting.

Rights relating to PACE

5.11 Detainees' right to free legal representation was clearly explained to them. Those who refused the offer were asked the reasons why, which were recorded on the custody record, and were reminded that they could change their mind at any time. In our custody record analysis, seven detainees (23%) accepted the offer of legal advice, and three (10%) who had initially refused later changed their mind. Although 23 detainees had initially declined the offer of legal advice, the reason for this was noted on only four records. A duty solicitor scheme was in place and posters indicating this, in 23 different languages, were prominently displayed.

5.12 In Stoke, defence solicitors had a large room in which to work and be readily available for clients, which we have not seen provided in any other police force. Solicitors welcomed the facility, and said that it had improved legal provision to detainees by cutting out travelling times. The custody suite in Stoke had consultation rooms and clean, well-equipped interview rooms. Solicitors at all the suites told us that custody staff were helpful and provided a copy of the custody record on request. Some solicitors at Watling House and Burton believed that detention times had increased due to the reduction of custody suites, and said there was also a lack of facilities for them at these suites.

5.13 Detainees were told that they could consult copies of the PACE codes of practice, but at Watling House these were out of date (2004 version), and Burton had only one up-to-date copy and several out-of-date copies. We observed detainees being told they could inform someone of their arrest. In our custody record analysis, 11 detainees (37%) wanted someone informed of their arrest, and in 10 of these cases custody staff had contacted or attempted to

contact the nominated person. Detainees were not interviewed while they were under the influence of drugs or alcohol.

5.14 We were told that most detention reviews took place face-to-face and on time, but at Burton we observed a review over the telephone as the inspector was elsewhere. We found that on one night in Stoke, the duty inspector held 17 reviews, only one of which was face to face as the detainees were asleep. A random sample of six of the relevant custody records showed that none of the detainees were subsequently informed that a review had taken place or of their continued right to free legal advice.

5.15 The management of DNA in custody was generally sound, but some samples were not collected from the standby suites, and in the open suites some had been placed on the wrong shelves.

5.16 Detainees were transported to court promptly, but the court cut-off times were too early at Cannock (noon on weekdays, 10am weekends) and Burton (sometimes as early as 11am). The cut-off times at Stoke were better, at approximately 2pm on weekdays and 9.30am on weekends. There was some flexibility, and we observed Cannock magistrates court accepting a detainee who was booked in at Watling House at 11.55am if he could arrive at the court by 1pm. On this occasion, police officers transported the detainee rather than arrange to use the prisoner escort contractor. Staff told us they regularly transported detainees in such circumstances so that they were not in custody longer than necessary. There were no court video links.

Recommendation

5.17 Staffordshire Police should work with HM Court and Tribunal Service to ensure that early court cut-off times do not result in unnecessarily long detentions in custody.

Housekeeping points

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

5.19 Detainees should be informed of any reviews carried out while they were asleep, and this should be recorded in the custody record.

5.20 There should be effective oversight of the management and collection of DNA samples, especially at the standby suites.

Good practice

5.21 *Defence solicitors had the benefit of a large room in which to work and be readily available for clients.*

Rights relating to treatment

5.22 The force expected that complaints from detainees would be taken while they were still in custody, but staff varied in their practice. Although some sergeants said they might note a complaint if they had the time, most staff we spoke to said they would simply give the detainee

the Independent Police Complaints Commission (IPCC) leaflet about how to make a complaint, and direct them to attend their local police station on release. When detainees arrived in custody, they were not routinely told how to make a complaint about their treatment, but the information was contained in support material given to vulnerable detainees on their release. No notices about the complaints procedure were displayed in any custody suite. There was some limited analysis of complaints, with learning points notified to staff through the team room internet facility.

Recommendation

5.23 Detainees should be able to make a complaint before they leave custody, and data on complaints should be monitored.

6. Health care

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

Governance

6.1 The force recognised that it needed to improve the health service for detainees. There was engagement with NHS partners and others, supported by sharing information protocols and a range of meetings.

6.2 The current health system was led by forensic medical examiners (FMEs) and the arrangements were outdated. Each doctor had an individual contract with the force, which included clear instructions about how records should be stored and response times. However, the contracts were not monitored or enforced. The force's own audits had recognised major problems with the FME contract. Provision of health services was due to be put to tender as part of the move towards the NHS commissioning of offender health services.

6.3 The FMEs had a range of skills. In the north of the county they were all GPs, some of whom also ran GP surgeries while on call for the police. In the south, doctors had a range of backgrounds, including psychiatry, accident and emergency, and gynaecology. We found some evidence of doctors working for 24 hours on call without a break. Most of the doctors had worked for the police force for a considerable time and had acquired skills and experience. In the north, there was little evidence of clinical governance arrangements, and there were no minuted meetings, organised training or continuous professional development (CPD). The lead FME relied on the fact that as all his colleagues were GPs, they would have CPD, including resuscitation and defibrillation training. By contrast, the lead GP in the south told us that he undertook appraisals, one-to-one supervision, dip sampling of clinical records and training events. He did not have on-call FME duties, but was available at all times for advice and mental health assessments.

6.4 Most of the clinical rooms were not fit for purpose and did not meet infection control standards. Only the custody facility in Stoke had a couch, but it was broken and there was no paper couch roll. At Watling House, the handwashing facilities were inadequate and most items in the cupboards were out of date. The room at Tamworth also held the breathalyser, and there was thick dust on the wall that cordoned off the toilet. We found out-of-date, patient-issue medications in drawers in the room at Stafford. Not all the rooms had sharps bins, and in those that did they were not signed or dated by the person who had assembled them. There was no clinical apparatus such as blood glucose or blood pressure monitoring equipment. The three main suites each had a separate forensic examination room, which was thoroughly cleaned and sealed after use.

6.5 Each suite had basic resuscitation kits, including automated external defibrillators (AEDs), but no oxygen. The kits were checked during suite maintenance checks, but we found out-of-date defibrillator pads at every suite. The kits at Watling House were in a locked cupboard, which was difficult to open and could delay attendance to a detainee. Not all staff were appropriately trained in first aid and defibrillation.

Recommendations

6.6 Clinical governance arrangements for health professionals, including the management, training and accountability of staff, should be robustly implemented and monitored.

6.7 All clinical rooms should be fit for purpose and meet infection control guidelines.

Housekeeping points

6.8 All resuscitation equipment should be checked regularly, and checks should be documented.

6.9 There should be annual first aid training, including use of automated external defibrillators.

Patient care

6.10 In our prisoner survey, 65% of respondents said they had seen a doctor when they were detained, against the comparator of only 44%, but in our analysis of custody records only 30% (10 out of 30) said they were seen by the FME, with an average wait of about an hour and the longest wait of 165 minutes. Staff also told us of long waits for an FME, and data collated by the force confirmed this. FMEs defended the delays by telling us that there was little that needed to be dealt with immediately, and if it were urgent, the detainee should be in A&E. Custody staff appeared to accept the delays by FMEs, and did not report them as adverse events. Staff were not aware of the response times stated in the FME contracts, and there were no penalties for failure to comply.

6.11 Detainees did not have a choice of gender of the attending FME but had to see whoever was on call. Police said they would organise a chaperone if required or, failing that, would take the detainee to A&E.

6.12 We saw one clinical interaction, which took place in a cell. It was perfunctory and did not include any clinical observations, such as blood sugar monitoring.

6.13 FMEs used the NSPIS to record clinical findings, as well as their own notebooks for contemporaneous records. Some entries on NSPIS used medical abbreviations that were difficult for custody staff to understand. There was no evidence that written consent was sought from the detainee for treatment. FMEs stored their own contemporaneous records; we were not assured that all complied with the Caldicott guidelines on the use and confidentiality of personal health information.

6.14 There was a force policy that no medications were held in suites, and doctors were required to bring medications with them. We saw medications that were carried in small plastic carrier bags and unlocked briefcases. We found nicotine replacement therapy in most suites, gin and laxatives in Stoke, and shared-use asthma inhalers in Watling House and Burton. Not all detainees had received their medications at the right time, and because some prescribing was not clear, CDOs had to contact the doctor for further instructions. Police went to a detainee's home address to collect medications if needed. Doctors left medications to be given to detainees in labelled bags clipped to the front of custody record sheets. They were often loose tablets and bagged according to the time to be given, rather than by type of medication. There were arrangements to enable the police to collect methadone, but it was not always used. In our analysis of custody records, only two people on methadone were provided with it in custody; the rest were offered alternatives.

6.15 In our sample, eight detainees (27%) said they were on medication on arrival in custody. Five (17%) were seen by a health care professional; the others either had their medication (asthma puffer) on them, had taken their daily dose before arrival in detention and left before they required a further dose or were in custody for less than an hour.

6.16 Medications were left by the FMEs and administered by custody staff, but they made an entry in the detention log rather than the NSPIS medical form to indicate administration. Staff were unclear about the policy for the disposal of unused medications. We found some locked boxes for the purpose, but we were able to reach in and take bags of medications out, and one CDO told us that they put unused medications in a clinical waste bin or a drawer in the clinical room.

Recommendations

6.17 All clinical records should be stored in line with the Data Protection Act and Caldicott guidelines on the use and confidentiality of personal health information.

6.18 All medications should be stored safely and securely at all times.

Housekeeping point

6.19 Clinical entries on NSPIS and instructions for the administration of medications should be clear, unambiguous and understood by non-clinical staff.

Substance use

6.20 AD Solutions provided a substance misuse service across the force area. A worker visited the three main suites at least daily on weekdays. At other times, the police obtained the detainee's consent to refer them on to services. The service did not see juveniles or illegal immigrants, but did refer juveniles to appropriate services. A worker from the service saw detainees for both drugs and alcohol issues, undertook an initial assessment and carried out brief intervention work in the custody suite. They then saw the detainee again in the community, if appropriate within 48 hours. They also referred detainees to prison drug services when needed. In our custody record analysis, drugs and/or alcohol worker services were offered to all but one of the detainees, and all declined this service. Needle exchange was not available in custody.

Housekeeping points

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

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

Mental health

6.23 Two NHS mental health trusts covered the county – North Staffordshire Combined NHS Trust (NCST), and South Staffordshire and Shropshire Foundation Trust (SSFT). As a result, arrangements for the care of detainees with mental health needs differed across the force area. There was a range of meetings, such as the criminal justice mental health steering group, attended by several agencies, including the police, health services, social services,

probation, youth justice and voluntary groups. There was engagement and willingness to ensure services worked well.

6.24 NSCT was due to start a mental health diversion scheme in Stoke, with staff based at the suite every day. But at the time of the inspection they attended custody when requested by an FME, most of whom were Mental Health Act section 12 approved.

6.25 In the south of the county, a section 12 approved FME was always available, and a criminal justice mental health team visited Watling House daily. The team also attended the local magistrates court, but there was no service provided to Burton (except by the FMEs), which resulted in inequity of service across the force area.

6.26 We were told that it was difficult to get a team to attend a suite out of hours for a mental health assessment. The FMEs said they would wait until office hours before requesting an assessment, although we found evidence of one night-time assessment at Watling House. We understood that there were no agreed timescales for the mental health team's attendance.

6.27 There were four section 136 suites (see footnote [3]) across the force area, one in the north and three in the south, although one was due to close later in 2012. The force had recently collected statistics about the number of section 136 arrests as part of a wider project. Between 2010/11 and 2011/12, there had been a 22% increase in people arrested under section 136 who were taken directly to a custody suite. The majority of the arrests – 94 out of 131 in 2011/12 – were in the north of the county. There was no agreement between the two NHS trusts for inter-county transfers if any of the suites were busy.

6.28 Well-attended section136 strategy meetings considered any incidents where learning could be shared. NHS staff told us that the number of unannounced police arrivals in the section 136 suites had dropped as a result of the meetings. Joint protocols had been developed, including one giving the ward manager authority to determine when police should leave the suite.

Recommendations

6.29 All detainees should have equal access to mental health services across the force area.

6.30 Police custody should not be used as a place of safety for those arrested under section 136 of the Mental Health Act 1983.

7. Summary of recommendations

Main recommendations — To Staffordshire Police

7.1 Staffordshire Police should ensure clear lines of accountability, and systematic monitoring and control at inspector level and above. (2.19)

7.2 The new health care arrangements should ensure sound clinical governance, prompt attendance by health care professionals, and secure handling of records and medicines. (2.20)

National issues — To the Home Secretary

7.3 Appropriate adults should be available to support without undue delay juveniles aged 17 and under in custody, including out of hours. (2.21)

Recommendations — To Staffordshire Police

Strategy

7.4 The format of the 'team room' computer page should be made more accessible, and staff should be given the necessary training to use it effectively. (3.16)

7.5 All staff working in custody should receive regular refresher training, with effective management oversight of this process. (3.17)

Treatment and conditions

7.6 Booking-in areas should provide sufficient privacy. (4.12)

7.7 Managers should ensure that the reasonable requirements of detained children, women and people with disabilities are met. (4.13)

7.8 There should be hearing loops in the booking-in areas, and all custody staff should know how to operate them. (4.14)

7.9 Staff should be given up-to-date guidance on the treatment of transgender detainees. (4.15)

7.10 Custody records should be sampled to ensure that where observations are not undertaken at the required intervals, action is taken to improve practice. (4.24)

7.11 Suicide prevention kits should include anti-ligature shears and be readily accessible. (4.25)

7.12 All custody staff should be involved in the same shift handover and, where possible, this should take place away from the booking-in area and be recorded. (4.26)

7.13 Detainees should only remain handcuffed while they are booked in when a risk assessment indicates this is necessary for the safety of staff, the public or the detainee. (4.33)

7.14 The fire alarm system at Burton should be made reliable or replaced. (4.39)

7.15 All detainees held overnight, or who require one, should be offered a shower. (4.50)

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

7.17 All suites should hold and offer a range of reading materials, including books and magazines suitable for young people and non-English speakers. (4.52)

7.18 Visits should be facilitated for vulnerable young people or detainees held for long periods. (4.53)

Individual rights

7.19 Staffordshire police should work with the local authority to ensure the provision of appropriate overnight accommodation for juveniles who have been charged but cannot be bailed to appear in court. (5.8)

7.20 Information about detainees' rights and entitlements should always be available in a range of formats that meet specific needs. (5.9)

7.21 There should be two-handset telephones in all suites to facilitate telephone interpreting. (5.10)

7.22 Staffordshire Police should work with HM Court and Tribunal Service to ensure that early court cut-off times do not result in unnecessarily long detentions in custody. (5.17)

7.23 Detainees should be able to make a complaint before they leave custody, and data on complaints should be monitored. (5.23)

Health care

7.24 Clinical governance arrangements for health professionals, including the management, training and accountability of staff, should be robustly implemented and monitored. (6.6)

7.25 All clinical rooms should be fit for purpose and meet infection control guidelines. (6.7)

7.26 All clinical records should be stored in line with the Data Protection Act and Caldicott guidelines on the use and confidentiality of personal health information. (6.17)

7.27 All medications should be stored safely and securely at all times. (6.18)

7.28 All detainees should have equal access to mental health services across the force area. (6.29)

7.29 Police custody should not be used as a place of safety for those arrested under section 136 of the Mental Health Act 1983. (6.30)

Housekeeping points

Strategy

7.30 Regular health and safety checks should be carried out to a consistent standard and with greater involvement by the custody managers. (3.18)

Treatment and conditions

7.31 CCTV images of toilet areas at Watling House should be obscured. (4.27)

7.32 Staffordshire Police should collate and analyse use of force data on strip searching and on use of force, in accordance with the Association of Chief Police Officers policy and National Policing Improvement Agency guidance. (4.34)

7.33 Fire evacuation procedures should be clarified, and regular fire evacuation drills should be carried out and recorded. (4.41)

7.34 Razors should be available for male detainees to have a shave before attending court. (4.54)

7.35 Female detainees should routinely be offered hygiene packs. (4.55)

Individual rights

7.36 There should be sufficient up-to-date copies of the PACE codes of practice in all the custody suites. (5.18)

7.37 Detainees should be informed of any reviews carried out while they were asleep, and this should be recorded in the custody record. (5.19)

7.38 There should be effective oversight of the management and collection of DNA samples, especially at the standby suites. (5.20)

Health care

7.39 All resuscitation equipment should be checked regularly, and checks should be documented. (6.8)

7.40 There should be annual first aid training, including use of automated external defibrillators. (6.9)

7.41 Clinical entries on NSPIS and instructions for the administration of medications should be clear, unambiguous and understood by non-clinical staff. (6.19)

7.42 All detainees should be offered the services of a drugs/alcohol worker. (6.21)

7.43 Needle exchange should be available to detainees leaving custody if required. (6.22)

Good practice

7.44 Those charged or arrested for a domestic violence-related offence were given information about where they could receive help to change their behaviour. (4.28)

7.45 A zero tolerance policy ensured instant removal of graffiti from cells and prosecution of offenders. (4.42)

7.46 Defence solicitors had the benefit of a large room in which to work and be readily available for clients. (5.21)

Appendix I: Inspection team

Martin Kettle	HMIP team leader
Peter Dunn	HMIP inspector
Vinnett Pearcy	HMIP inspector
Fiona Shearlaw	HMIP inspector
Paul Davies	HMIC inspector
Mark Ewan	HMIC inspector
Elizabeth Tysoe	HMIP health care inspector
Andy Brand	Care Quality Commission inspector
Rachel Murray	HMIP researcher
Alice Reid	HMIP researcher

Appendix II: Summary of detainee questionnaires and interviews

Survey methodology

A voluntary, confidential and anonymous survey of the prisoner population who had been through a police station in the borough of Staffordshire 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 23 May 2012. A list of potential respondents to have passed through the northern area custody facility or Watling House, Burton, Stafford or Tamworth police stations was created, listing all those who had arrived from Fenton or Stafford magistrates' courts or Stafford crown court within the past three months.[5]

Selecting the sample

In total, 55 respondents were approached; 27 respondents said they had been held in police stations outside Staffordshire. On the day, the questionnaire was offered to 28 respondents; there was one refusal and one questionnaire was returned blank. All of those sampled had been in custody within the last three months.

Completion of the questionnaire was voluntary. Interviews were carried out with any respondents with literacy difficulties. No respondents required an interview on this occasion.

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.

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

Response rates

In total, 26 (93%) respondents completed and returned their questionnaires.

Comparisons

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

Some questions have been filtered according to the response to a previous question. Filtered questions are clearly indented and preceded by an explanation as to which respondents are included in the filtered questions. Otherwise, percentages 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 55 police areas since April 2008.

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

Summary

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

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

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

Survey results

Section 1: About you

Q2 Which police station were you last held at?

Burton Police Station – 11; Watling House Custody Facility – 8;
Northern Area Custody Facility – 4; Stafford Police Station – 2; Tamworth Police Station - 1

Q3 How old are you?

16 years or younger	0 (0%)	*40-49 years*	3 (12%)
17-21 years	2 (8%)	*50-59 years*	0 (0%)
22-29 years	12 (46%)	*60 years or older*	0 (0%)
30-39 years	9 (35%)		

Q4 Are you:

Male	26 (100%)
Female	0 (0%)
Transgender/transsexual	0 (0%)

Q5 What is your ethnic origin?

White - British	21 (81%)
White - Irish	0 (0%)
White - other	1 (4%)
Black or black British - Caribbean	1 (4%)
Black or black British - African	0 (0%)
Black or black British - other	0 (0%)
Asian or Asian British - Indian	0 (0%)
Asian or Asian British - Pakistani	2 (8%)
Asian or Asian British - Bangladeshi	0 (0%)
Asian or Asian British - other	0 (0%)
Mixed heritage - white and black Caribbean	1 (4%)
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	4 (16%)
No	21 (84%)

Q7 What, if any, is your religion?

None	7 (27%)
Church of England	12 (46%)
Catholic	4 (15%)
Protestant	0 (0%)
Other Christian denomination	1 (4%)
Buddhist	0 (0%)

Hindu 0 (0%)
Jewish 0 (0%)
Muslim 2 (8%)
Sikh 0 (0%)

Q8 How would you describe your sexual orientation?
Straight/heterosexual 26 (100%)
Gay/lesbian/homosexual 0 (0%)
Bisexual 0 (0%)

Q9 Do you consider yourself to have a disability?
Yes 5 (20%)
No 20 (80%)

Q10 Have you ever been held in police custody before?
Yes 26 (100%)
No 0 (0%)

Section 2: Your experience of the police custody suite

Q11 How long were you held at the police station?
Less than 24 hours 9 (35%)
More than 24 hours, but less than 48 hours (2 days) 11 (42%)
More than 48 hours (2 days), but less than 72 hours (3 days) 4 (15%)
72 hours (3 days) or more 2 (8%)

Q12 Were you told your rights when you first arrived there?
Yes 21 (81%)
No 2 (8%)
Don't know/can't remember 3 (12%)

Q13 Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')?
Yes 13 (50%)
No 7 (27%)
I don't know what this is/I don't remember 6 (23%)

Q14 If your clothes were taken away, what were you offered instead?
My clothes were not taken 12 (48%)
I was offered a tracksuit to wear 3 (12%)
I was offered an evidence/paper suit to wear 9 (36%)
*I was **only** offered a blanket* 0 (0%)
Nothing 1 (4%)

Q15 Could you use a toilet when you needed to?
Yes 22 (85%)
No 4 (15%)
Don't know 0 (0%)

Q16 If you used the toilet there, was toilet paper provided?
Yes 16 (64%)

No..... 9 (36%)

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

	Good	*Neither*	*Bad*
Cleanliness	14 (54%)	3 (12%)	9 (35%)
Ventilation/air quality	5 (21%)	4 (17%)	15 (63%)
Temperature	5 (22%)	5 (22%)	13 (57%)
Lighting	15 (65%)	3 (13%)	5 (22%)

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

Yes..... 16 (62%)
No..... 10 (38%)

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

Yes..... 5 (20%)
No..... 20 (80%)

Q20 **Were you held overnight?**

Yes..... 24 (92%)
No..... 2 (8%)

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

Not held overnight..... 2 (8%)
Pillow..... 7 (27%)
Blanket..... 20 (77%)
Nothing..... 4 (15%)

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

Not held overnight/did not get any bedding 6 (25%)
Yes..... 12 (50%)
No..... 6 (25%)

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

Yes..... 5 (19%)
No..... 21 (81%)

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

Yes..... 1 (4%)
No..... 25 (96%)

Q25 **Were you offered anything to:**

	Yes	*No*
Eat?	20 (80%)	5 (20%)
Drink?	21 (95%)	1 (5%)

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

Very good	*Good*	*Neither*	*Bad*	*Very bad*	*N/A*
0 (0%)	4 (15%)	7 (27%)	9 (35%)	6 (23%)	0 (0%)

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

I did not have any food or drink	0 (0%)
Yes	13 (54%)
No	11 (46%)

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

I do not smoke	2 (8%)
I was allowed to smoke	0 (0%)
I was offered a nicotine substitute	1 (4%)
I was not offered anything to cope with not smoking	23 (88%)

Q29 Were you offered anything to read?

Yes	7 (27%)
No	19 (73%)

Q30 Was someone informed of your arrest?

Yes	10 (38%)
No	9 (35%)
I don't know	4 (15%)
I didn't want to inform anyone	3 (12%)

Q31 Were you offered a free telephone call?

Yes	15 (60%)
No	10 (40%)

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

My telephone call was not denied	15 (63%)
Yes	1 (4%)
No	8 (33%)

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

	Yes	*No*
Who was taking care of your children	2 (9%)	21 (91%)
Contacting your partner, relative or friend	8 (36%)	14 (64%)
Contacting your employer	5 (22%)	18 (78%)
Where you were going once released	3 (14%)	18 (86%)

Q34 Were you offered free legal advice?

Yes	24 (92%)
No	2 (8%)

Q35 Did you accept the offer of free legal advice?

Was not offered free legal advice	2 (8%)
Yes	15 (60%)
No	8 (32%)

Q36 Were you interviewed by police about your case?

Yes	21 (81%)

No..... 5 (19%)

Q37 Was a solicitor present when you were interviewed?

Did not ask for a solicitor/was not interviewed 5 (19%)
Yes..... 19 (73%)
No..... 2 (8%)

Q38 Was an appropriate adult present when you were interviewed?

Did not need an appropriate adult/was not interviewed..... 11 (44%)
Yes..... 4 (16%)
No..... 10 (40%)

Q39 Was an interpreter present when you were interviewed?

Did not need an interpreter/was not interviewed 12 (46%)
Yes..... 0 (0%)
No..... 14 (54%)

Section 3: Safety

Q41 Did you feel safe there?

Yes..... 19 (73%)
No..... 7 (27%)

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

Yes..... 9 (35%)
No..... 17 (65%)

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

I have not been victimised.....	17 (68%)	*Because of your crime*	5 (20%)
Insulting remarks (about you, your family or friends)	7 (28%)	*Because of your sexuality*.....	0 (0%)
Physical abuse (being hit, kicked or assaulted)	3 (12%)	*Because you have a disability*	0 (0%)
Sexual abuse	0 (0%)	*Because of your religion/religious beliefs*	0 (0%)
Your race or ethnic origin	1 (4%)	*Because you are from a different part of the country than others*.....	0 (0%)
Drugs	2 (8%)		

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

Yes..... 17 (68%)
No..... 5 (20%)
I wasn't handcuffed..... 3 (12%)

Q45 Were you restrained while in the police custody suite?

Yes..... 4 (15%)
No..... 22 (85%)

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

Yes..... 7 (27%)

No 19 (73%)

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

Yes 2 (8%)
No 24 (92%)

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

Very well	*Well*	*Neither*	*Badly*	*Very badly*	*Don't remember*
1 (4%)	9 (35%)	7 (27%)	7 (27%)	1 (4%)	1 (4%)

Section 4: Health care

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

Yes 12 (46%)
No 12 (46%)
Don't know 2 (8%)

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

	Yes	*No*
Doctor	16 (64%)	9 (36%)
Nurse	1 (7%)	14 (93%)
Paramedic	0 (0%)	15 (100%)

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

Yes 7 (28%)
No 12 (48%)
Don't know 6 (24%)

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

Yes 13 (50%)
No 13 (50%)

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

Not taking medication 13 (52%)
Yes 3 (12%)
No 9 (36%)

Q55 Did you have any drug or alcohol problems?

Yes 12 (46%)
No 14 (54%)

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 14 (54%)
Yes 5 (19%)
No 7 (27%)

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

I didn't have any drug/alcohol problems 14 (56%)
Yes 4 (16%)

No..... 7 (28%)

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*
9 (36%)	0 (0%)	2 (8%)	6 (24%)	3 (12%)	5 (20%)

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

Yes..... 8 (31%)
No..... 18 (69%)

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

Yes..... 6 (23%)
No..... 20 (77%)

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..... 20 (77%)
Yes..... 0 (0%)
No..... 6 (23%)

Prisoner survey responses for Staffordshire Police 2012

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

Key to tables

		2012 Staffordshire	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		26	2033
SECTION 1: General information			
3	Are you under 21 years of age?	**8%**	**10%**
4	Are you transgender/transsexual?	**0%**	**0%**
5	Are you from a minority ethnic group (including all those who did not tick white British, white Irish or white other categories)?	**16%**	**29%**
6	Are you a foreign national?	**17%**	**15%**
7	Are you Muslim?	**8%**	**10%**
8	Are you homosexual/gay or bisexual?	**0%**	**2%**
9	Do you consider yourself to have a disability?	**21%**	**20%**
10	Have you been in police custody before?	**100%**	**92%**
SECTION 2: Your experience of this custody suite			
11	Were you held at the police station for over 24 hours?	**66%**	**68%**
12	Were you told your rights when you first arrived?	**80%**	**81%**
13	Were you told about PACE?	**50%**	**52%**
For those who had their clothing taken away:			
14	Were you given a tracksuit to wear?	**24%**	**40%**
15	Could you use a toilet when you needed to?	**84%**	**91%**
16	If you used the toilet, was toilet paper provided?	**65%**	**47%**
17	Would you rate the condition of your cell, as 'good' for:		
17a	Cleanliness?	**54%**	**33%**
17b	Ventilation/air quality?	**22%**	**23%**
17c	Temperature?	**22%**	**16%**
17d	Lighting?	**66%**	**45%**
18	Was there any graffiti in your cell when you arrived?	**62%**	**54%**
19	Did staff explain the correct use of the cell bell?	**21%**	**23%**
20	Were you held overnight?	**92%**	**92%**
For those who were held overnight:			
21	Were you given any items of bedding?	**83%**	**84%**
For those who were held overnight and were given items of bedding:			
22	Were these clean?	**66%**	**62%**
23	Were you offered a shower?	**20%**	**9%**
24	Were you offered a period of outside exercise?	**4%**	**6%**
25a	Were you offered anything to eat?	**79%**	**81%**
25b	Were you offered anything to drink?	**95%**	**84%**
For those who had food/drink:			
26	Was the quality of the food and drink you received good/very good?	**16%**	**11%**
27	Was the food/drink you received suitable for your dietary requirements?	**54%**	**44%**

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		
For those who smoke:			
28	Were you offered anything to help you cope with not being able to smoke?	**4%**	**7%**
29	Were you offered anything to read?	**27%**	**13%**
30	Was someone informed of your arrest?	**38%**	**43%**
31	Were you offered a free telephone call?	**60%**	**49%**
If you were denied a free telephone call:			
32	Was a reason given?	**12%**	**15%**
33	Did you have any concerns about:		
33a	Who was taking care of your children?	**9%**	**14%**
33b	Contacting your partner, relative or friend?	**36%**	**52%**
33c	Contacting your employer?	**22%**	**19%**
33d	Where you were going once released?	**15%**	**31%**
34	Were you offered free legal advice?	**92%**	**88%**
For those who were offered free legal advice:			
35	Did you accept the offer of free legal advice?	**66%**	**70%**
For those who were were interviewed and needed them:			
37	Was a solicitor present when you were interviewed?	**90%**	**79%**
38	Was an appropriate adult present when you were interviewed?	**30%**	**28%**
39	Was an interpreter present when you were interviewed?	**0%**	**14%**
SECTION 3: Safety			
41	Did you feel unsafe?	**27%**	**38%**
42	Has another detainee or a member of staff victimised you?	**34%**	**33%**
43	If you have felt victimised, what did the incident involve?		
43a	Insulting remarks (about you, your family or friends)	**27%**	**15%**
43b	Physical abuse (being hit, kicked or assaulted)	**13%**	**10%**
43c	Sexual abuse	**0%**	**3%**
43d	Your race or ethnic origin	**4%**	**2%**
43e	Drugs	**8%**	**9%**
43f	Because of your crime	**21%**	**11%**
43g	Because of your sexuality	**0%**	**1%**
43h	Because you have a disability	**0%**	**2%**
43i	Because of your religion/religious beliefs	**0%**	**2%**
43j	Because you are from a different part of the country than others	**0%**	**4%**
44	Were your handcuffs removed on arrival at the police station?	**77%**	**73%**
45	Were you restrained whilst in the police custody suite?	**16%**	**19%**
46	Were you injured whilst in police custody, in a way that was not your fault?	**27%**	**23%**
47	Were you told how to make a complaint about your treatment?	**8%**	**13%**
48	Were you treated well/very well by staff in the police custody suite?	**38%**	**34%**

Key to tables

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	Any percentage highlighted in blue is significantly worse		
	Any percentage highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
SECTION 4: Health care			
50	Did someone explain your entitlements to see a health care professional, if you needed to?	**46%**	**35%**
51	Were you seen by the following health care professionals during your time in police custody:		
51a	Doctor	**65%**	**44%**
51b	Nurse	**7%**	**21%**
	Percentage seen by either a doctor or a nurse	**65%**	**51%**
51c	Paramedic	**0%**	**4%**
52	Were you able to see a health care professional of your own gender?	**27%**	**26%**
53	Did you need to take any prescribed medication when you were in police custody?	**50%**	**41%**
For those who were on medication:			
54	Were you able to continue taking your medication while in police custody?	**26%**	**35%**
55	Did you have any drug or alcohol problems?	**46%**	**53%**
For those who had drug or alcohol problems:			
56	Did you see, or were offered the chance to see a drug or alcohol support worker?	**44%**	**43%**
57	Were you offered relief or medication for your immediate withdrawal symptoms?	**38%**	**24%**
For those who were seen by health care:			
58	Would you rate the quality as good/very good?	**13%**	**30%**
59	Did you have any specific physical health care needs?	**30%**	**32%**
60	Did you have any specific mental health care needs?	**24%**	**24%**
For those who had any mental health care needs:			
61	Were you seen by a mental health nurse/psychiatrist?	**0%**	**17%**