Report on an inspection of police custody suites in West Yorkshire

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by

HM Inspectorate of Prisons and

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1. Introduction

This is the sixth in a series of reports in the first year of a programme of police custody inspections carried out jointly by our two inspectorates. These inspections are conducted as part of the joint work programme of the criminal justice chief inspectors, agreed by Ministers. They also contribute to the United Kingdom's compliance with its international obligations to ensure regular independent inspection of all places of custody[1]. In each inspection, we examine force-wide strategies, treatment and conditions and healthcare.

West Yorkshire has 13 suites designated under the Police and Criminal Evidence Act, 1984 (PACE) for the reception of detainees. These provide up to 250 cells and 52 interview rooms. Limited resources restricted our inspection to a sample of suites: Leeds Bridewell in the City and Holbeck Basic Command Unit (BCU), Stainbeck and Killingbeck in North East Leeds BCU and Bradford South BCU. Short visits were also undertaken to Pudsey, Weetwood and Pontefract.

Strategic leadership was sound and the Chief Constable had taken a personal interest in custodial matters, for which he was also the regional lead. A strategic review of the estate had led to plans, agreed with the Police Authority, to reduce the number of suites and to construct three new divisional facilities. However, this plan was some way from fruition and a range of improvements were required in the interim. The force's own themed supportive custody visits had identified various shortfalls, but these findings were not always acted on. We had a particular concern about the poor management of some forensic samples and DNA, which needed urgent attention to avoid undermining both individual prosecutions and public confidence.

The quality of custodial accommodation varied: Stainbeck was well maintained, Killingbeck was tired and grubby, while Pudsey was hardly fit for use. It has since been closed. Even in some newer suites, such as Bradford South, there was limited natural light and ventilation could be a problem. A number of other weaknesses were identified at a number of sites: toilets and showers were often inadequately screened and the provision of hygiene materials and food varied. Safety arrangements were generally adequate, although not all staff were issued with cell keys and ligature knives, and detainees were not always instructed in the use of the cell bell.

In general, PACE was properly adhered to. While risk assessments were usually thorough, as on other inspections we were disappointed to find insufficient attention paid to the particular needs of women, children and immigration detainees. There were often delays in obtaining appropriate adults, which could result in unnecessary overnight stays. Complaint systems were inadequate. Access to solicitors and to translation services was generally satisfactory.

Healthcare services were poor. They lacked sufficient oversight and a needs analysis to inform delivery. We were not assured of the veracity of call out response times claimed by the provider. The quality of healthcare accommodation varied and some was not fit for use. Infection control was weak and medicines management required improvement. Links between healthcare and drug referral workers were poor and healthcare record-keeping was inadequate. Drug misuse services were good.

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

This inspection of a sample of custody suites in West Yorkshire has illustrated a wide range of service quality. Senior managers need to assure themselves that their strategic aspirations are actually delivered on the ground, as this is clearly not always the case. Indeed, some shortfalls reflect a lack of action in response to the force's own internal monitoring processes. This report sets out a number of recommendations for improvement and it is hoped that this will assist the Chief Constable and the Police Authority to develop further the quality of custodial provision in their force.

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2. Background and key findings

Background

2.1 HM Inspectorates of Prisons and Constabulary have begun a programme of joint inspections of police custody suites as part of the UK's international obligation to ensure regular independent inspection of all places of detention. These inspections do not look only at the implementation of the Police and Criminal Evidence Act (PACE) codes. They are also informed by *Expectations* 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 The West Yorkshire Police Force has 13 custody suites designated under PACE 1984 for the reception of detainees. These provide up to 250 cells and 52 interview rooms. Lawcroft House in Bradford South is mothballed. The other suites operate 24 hours a day and deal with detainees arrested as a result of mainstream policing. Keighley Old Police Station is the designated Operation Safeguard facility, but this was stood down at the time of the inspection.

2.3 This inspection was conducted in Leeds Bridewell in the City and Holbeck Basic Command Unit (BCU), Stainbeck and Killingbeck in North East Leeds BCU and Bradford South BCU. Short visits were paid to Pudsey in North West Leeds and Wakefield. Healthcare inspectors also visited Pudsey and Weetwood in North West Leeds and Pontefract. Inspectors examined force-wide custody strategies, as well as treatment and conditions, individual rights and healthcare in each of the four suites inspected. A survey of prisoners at HMP Leeds who had formerly been detained in West Yorkshire custody suites was conducted by HM Inspectorate of Prisons researchers to obtain additional data (see Appendix 3).

2.4 The custody suites were open 24 hours a day. Leeds Bridewell was the busiest suite and had held 1,431 detainees in August 2008 alone. Bradford South was the second busiest with 1,252 detainees held in August. Detainees were a mixture of adults, juveniles and immigration detainees. Stainbeck had held 595 and Killingbeck 607 detainees in the same period.

Strategic overview

2.5 Yorkshire custody suites benefited from a good strategic lead. There was a distinction between the management of policies and procedures for the safer detention and handling of persons in police custody at a strategic level and the day-to-day delivery of these at divisional level. A review of the estate had resulted in plans to reduce the number of custody suites from 13 to eight with the construction of three new divisional cell areas, but this was not due to be completed until 2014. The Police Authority was supportive of future plans and engaged with the command team in the decision-making process. The excellent themed supportive custody visits were not always acted on. Approved custody training was delivered, although staff required refresher and first aid training. There was a good relationship with the Crown Prosecution Service.

Findings from the custody suites

Killingbeck

Treatment and conditions

2.6 This older custody suite was grubby. The cells were poorly lit and poorly ventilated, with graffiti dating back to 2005. No pillows or underwear were available. Toilets in the male and female designated cells were not screened and there was just one sanitary towel in stock. The showers were only half screened and only one shower was used due to privacy issues. Records did not record the offer of exercise or showers to detainees. The exercise yard was dirty and the doors leading to it covered in graffiti. Cell call bells were generally answered promptly. Staff had a good understanding of safety issues, but did not carry ligature knives and there were only two sets of keys for three members of staff on duty. Records showed that some detainees were held over 10 hours without being offered food. Tracksuits and paper suits were available when required. Visitors could hand clothes in at the front desk. Clothing was left outside cells. Visits were not facilitated.

Individual rights

2.7 A standard risk assessment was used for all detainees. Specific provision for juveniles was not in place and some were held longer than necessary due to difficulties obtaining the attendance of appropriate adults. Finding an appropriate adult for vulnerable adults was also difficult, leading to delays. Appropriate adults could not remain with detainees in their cells and parents were not allowed to visit juveniles in the night. Detainees were made aware of entitlements verbally and given a written sheet of rights available in 46 languages. A copy of PACE was available for detainees, but was extremely tatty and the first nine pages were missing. Detainees were not interviewed while unfit. A professional telephone interpreting service was routinely used for non-English speakers for all formal processes. A call out list of signers for the deaf was available. There was no written complaints procedure. We found examples of detainees being discouraged from asking for a solicitor, but access to solicitors was generally good.

Bradford South

Treatment and conditions

2.8 This large facility was purpose built, yet offered little natural light. The ventilation was reasonable, but cells could become very warm. Operational demands meant people were put in the most appropriate cell available. Six glass door cells held both male and female detainees and juveniles. Two faced each other and offered no privacy. The environment was reasonably clean. Detainees were given mattresses and blankets, but no pillows. Toilet facilities were basic, with no screening, toilet paper or sink. Women had to ask for sanitary items. The two showers available for all detainees were not private and appeared unused. There was no evidence that the three areas for fresh air were used. Cell call bells were responded to swiftly. People were booked in following the standard risk assessment procedure. All staff we spoke to were confident in safety matters and all had received fire safety training. Staff did not carry ligature knives. Cut down kits were available and everyone carried keys. Meals were offered at set times. Most detainees kept their own clothes or were

given tracksuits. There were no domestic visits. Detainees had to ask for things rather than being offered them and nothing was available to read or pass the time.

Individual rights

2.9 Custody reviews were conducted appropriately and on time. Detainees were made aware of entitlements verbally and given a sheet of rights available in 46 languages. The two holding cells and arrangements for receiving four people at once offered little privacy. Many juveniles were held overnight due to the unavailability of appropriate adults through Social Services after 10pm. Parents were not allowed to visit their children at night. The same difficulties occurred for vulnerable adults. There was no written complaints procedure and detainees were generally unaware of how to make a complaint. Solicitors expressed concern that staff dissuaded people from asking for a solicitor. They also complained about long waits to see clients and only being given the front cover of police custody records. They consulted in private and the periods of detention checked were appropriate. There was no evidence that detainees were interviewed while unfit.

Stainbeck

Treatment and conditions

2.10 The environment was appropriate and respectful. Cells had natural light and were reasonably clean. Graffiti was limited to the backs of doors and the base of beds. In-cell toilet arrangements were similar to Killingbeck and Bradford South. Cells were rarely shared and only following a risk assessment. There were no facilities for detainees with disabilities. One exercise yard was used on request. Not all detainees were told how to use cell call bells. Staff demonstrated good awareness of safety issues. Detainees were given useful information on diets and allergies and could have sealed food brought in. Alternative clothing was offered where necessary, apart from underwear. Most detainees wore their own clothes. Apart from some old magazines available on request, there was nothing for detainees to read. The visits room was used for storage.

Individual rights

2.11 Staff said they would bail juveniles if no appropriate adult could be found rather than keeping them overnight. Visits to juveniles were facilitated. Staff were not trained in child protection. Finding an appropriate adult for vulnerable adults was problematic. All detainees were informed of their legal rights and defence solicitors said their clients' requirements were responded to. The response from the UK Border Agency could be slow, with some detainees waiting three or four days before being collected. There were some issues about production to court. Applications after 1pm were not allowed the same day. Detainees were not told how to make a complaint. We were concerned about the lengthy restraint of one detainee. There was no official formal pre-release risk management, but custody logs demonstrated post-release care planning.

Leeds Bridewell

Treatment and conditions

2.12 The cells were reasonably clean, although there was a small amount of graffiti on the base of beds. There was no cleaning schedule. Detainees had to ask for toilet paper, soap, shaving equipment, sanitary towels and to wash and dry hands. They were given only one clean

blanket. There was no policy on when detainees should get exercise, showers or visits. The exercise yard was grubby. A female detention officer was available on all shifts. Most detainees said they were not told how to use of the cell call bell, but those used were responded to quickly. The intercom system was in the very busy main area. Staff understood safety issues, including the need to regularly monitor and rouse detainees. Plenty of alternative clothing was available, but no underwear. Detainees said they were generally well treated, but had nothing to do and they were not automatically given reading material.

Individual rights

2.13 Juveniles often stayed overnight awaiting an appropriate adult. There was no evidence that they were treated in an age-appropriate way and parents could not visit them overnight. All cases checked showed detainees had been detained appropriately and for a reasonable time. The booking in desk was poorly designed and did not allow any privacy. A professional telephone interpreting service was used freely and information about detainees' rights was available in many languages. There were delays going to court and some courts did not accept after 10am on a Saturday. Detainees were not clear about how to make a complaint.

Pudsey

Treatment and conditions

2.14 This older station was in an appalling state. Most cells were occupied by two people, despite the fact that one detainee was very distressed about not receiving his methadone and causing considerable disruption to his cellmate. The cells were covered in graffiti and dirty. Space was limited and detainees' clothes were stored on the floor outside cell doors. The environment was not conducive to staff dealing supportively with detainees.

Individual rights

2.15 Custodial staff dealt with detainees as well as they could in the cramped and unpleasant conditions. Detainees we spoke to were remarkably positive about their treatment at the suite. Detainees were given with verbal and written information about PACE.

Healthcare

2.16 Greater oversight of the medical contract was needed. We seriously questioned the responsiveness of the primary healthcare service. There were several examples of calls not being dealt with as quickly as the log implied and we were not assured that calls were actually responded to within the timescales as claimed. There was no independent monitoring of the figures produced by Serco Health. It was unclear whether a needs assessment had been carried out. Defibrillators were not yet in use. The 22 forensic medical examiners worked in isolation and there was no opportunity for lessons to be drawn from practice. No one assessed the continuous professional development of medical staff. Medical record keeping was poor and different staff used different proformas.

2.17 Links between Serco Health, drug referral workers and mental health trusts were poor and there were no information sharing protocols. Serco concentrated on physical health issues. There was no central log of how many detainees detained under section 136 of the Mental Health Act were referred to mental health facilities and staff were unclear about the protocols for doing this. There was limited mental health awareness training for custodial staff.

2.18 There were difficulties accessing the medical cupboards in custody suites. No one could explain the contents of the green metal boxes at Leeds Bridewell and Stainbeck or how to access them. There were problems dealing with clinical waste. There was no strategy for the destruction of DNA across the force and the storage and destruction of this and other samples was unacceptable. With the exception of Bradford South and Killingbeck, the treatment rooms we visited were unfit for use. There were no credible infection control procedures. The rooms were neither forensically clean nor suitable for treating patients. The management of medicines required significant attention.

2.19 Substance misuse services were good. Drug intervention programme provision covered all sites and the cover offered at Leeds and Bradford was as good as anywhere we have seen. The continuity into the community was good.

3. Strategy

3.1 The Chief Constable for West Yorkshire Police (WYP) had taken a personal interest in custodial matters and was the regional lead on custody. An Assistant Chief Constable was the portfolio holder for custody. Management of custody policies and procedures rested with a chief inspector located in the custody services department at headquarters. His role in implementing and overseeing the guidance on the safer detention and handling of persons in police custody (SDHP) was seen as critical to the force, although day-to-day delivery of SDHP occurred at divisional senior management team level. The force had undertaken a thorough review of its custody estate and the subsequent plan will eventually see the force migrating from 13 to eight designated custody suites, with new custody suites built and others refurbished. The Police Authority was supportive of future plans and engaged with the command team in the strategic decision-making process. WYP was aware of the risks presented by its old custody estate and had made the development of new custody suites a priority. However, these were not due for completion until 2014 and interim action to improve the state of the custody suites was necessary.

Expectation

3.2 There is a policy focus on custody issues at a chief officer level that is concerned with developing and maintaining the custody estate, staffing custody suites with trained staff, managing the risks of custody, meeting the health and wellbeing needs of detainees and working effectively with colleagues in the health service, immigration service, youth offending service, criminal justice teams, Crown Prosecution Service (CPS), courts and other law enforcement agencies.

Findings

3.3 The Assistant Chief Constable (ACC) was the senior portfolio holder for custody issues within WYP. He had taken an active interest in custodial matters and chaired the custody project board of senior managers. The ACC was supported by a chief inspector responsible for the implementation of SDHP and who provided force policies and standard operating procedures (SOPs) for custody suites in each division. These protocols related to healthcare provision, the role of independent custody visitors (ICVs) and guidance to custody staff on risk assessments. The SDHP policies had been fully updated, were comprehensive and clearly reflected the attention paid to the SDHP.

3.4 There were 13 designated custody suites spread across eight divisions. Each division was responsible for the management of custody suites within its command area and responsibility rested with each divisional commander who was a chief superintendent. Leeds Bridewell and Bradford South were the two biggest custody suites, with 68 and 34 cells respectively. Day-to-day management of custody was exercised by a chief inspector and inspector within the respective divisions. New custody suites were not anticipated to be on stream until 2014 at the earliest as part of the plan for future builds and refurbishments.

3.5 Force policies and SOPs were designed to help divisions deliver safe and consistent levels of service, although responsibility and accountability for delivery rested with the divisional senior management teams (SMTs). Command team oversight at force level was progressive, but we were not convinced that the strategic intent of the command team was being delivered at

divisional level. There was a lack of corporacy across divisions and among custody teams within the same custody suite. There appeared to be a lack of broad intrusive supervision into custodial matters at the divisional SMT level, with evidence that SMT visits were confined to the general area of the charge desk. This raised doubts about the depth and quality of divisional management of custody and its issues.

3.6 Divisional commanders were supported by the custody services department who carried out themed supportive custody visits, which led to action plans and follow-up visits to ensure compliance. These visits included representatives from estates, professional standards and the fingerprint departments. The aim was to ensure that SDHP, force policies and legislation were complied with and that the custody suites were suitable. The reports were detailed, thorough and good practice. Of particular note was the dip-sampling by the professional standards department of live and archived custody records, which reviewed associated closed-circuit television (CCTV) footage and was an important and effective tool for contributing to good governance. However, divisional SMTs were not consistent in picking up and pro-actively dealing with the issues highlighted in these reports, which was leading to a breakdown between the strategic intent of the force and the delivery of desired outcomes.

3.7 Policies and audit trails relating to the handling, storage and submission of DNA, blood and urine samples had not resulted in samples being stored correctly or dealt with expeditiously. Samples were incorrectly stored in fridges and freezers alongside ice cream, with some improperly bagged. This led to confusion among staff tasked with submitting samples so many were not submitted for analysis and had been allowed to remain in freezers for a number of years. Of particular concern was a blood sample labelled as related to a deceased victim of a road traffic collision that had either not been submitted for toxicology tests or properly disposed of if not required. We were unsure whether it really related to a road death investigation or whether there was an error on the label. We also noted a number of historic blood samples relating to ‘unconscious drivers’, which again appeared neither to have been analysed nor disposed of.

3.8 Security of samples was also an issue in that the majority were stored in fridges and freezers in insecure rooms and the fridges and freezers themselves were insecure. One freezer door was damaged and wide open, calling into question the integrity of the samples inside. Samples in another freezer had been defrosted and it was noted on the exhibits themselves that this had occurred, yet they had not been disposed of. The issue of how the continuity of forensic exhibits was ensured was also questionable. We found a forensic safe bag that had been torn open, not re-sealed and contained numerous forensic exhibits. The bag did not indicate when it had been torn open or by whom. One themed supportive custody visit had noted finding forensic/DNA exhibits/samples going back to 2001, but disappointingly this had not been addressed and appeared to be a force-wide problem. The force was potentially missing opportunities to bring offenders to justice and solve old cases. These practices were exposing the force to unacceptable levels of risk. The maintenance of public confidence in forensic evidence is crucial.

3.9 One custody sergeant said he was so exasperated in his attempts to rectify ongoing problems that he had taken numerous old samples and forensic exhibits, some relating to the most serious type of offences, to the divisional property office. The situation was very unsatisfactory. The opportunity to learn lessons from previous high profile cases involving forensic samples needed to be taken and addressed as a matter of urgency.

3.10 Approved custody training for custody officers and staff was delivered corporately. All custody sergeants and detention officers (DOs) had received nationally approved custody training before their deployment into custody suites and staff were organised, polite and professional in

their approach to detainees. Police constables were also used and we were told they could not be deployed in custody suites unless they had been custody trained. A number of custody officers and DOs needed refresher training, including first aid training. Defibrillators and oxygen were not provided in custody suites, although training on defibrillators was being rolled out and defibrillators were due to be deployed thereafter.

3.11 There were different working practices concerning staffing in custody suites and a lack of consistency among custody staff put additional pressures on some custody sergeants. Of particular concern was the ratio of sergeants to detainees in the Leeds Bridewell custody suite. A DO was used to oversee entry and exit of staff, solicitors and vehicles as well as monitoring CCTV, answering cell bells from detainees and answering the telephone. The DO was so busy that there was a significant risk of a cell bell or incident on the cell CCTVs being missed. This risk had also been noted on a themed supportive visit report.

3.12 Risk assessments on balance were reasonably thorough. However, a significant percentage of staff did not appear to be going onto the page containing details behind warning markers when interrogating the Police National Computer (PNC), relying instead on the front page warning markers and therefore not obtaining as full a picture of risk as possible. In some of the larger stations, risk assessments were carried out by DOs and a number of the themed custody visits reported that many risk assessments were completed without the custody sergeant. The DOs did not regularly form part of the handover briefing and were not specifically briefing sergeants coming on duty with regard to risk assessments. This process left opportunities for information gaps between sergeants and DOs on the same shift, and shifts going off duty risked failing to pass information to oncoming shifts thereby leaving vulnerable detainees at greater risk.

3.13 A new healthcare contract had been awarded to Serco Health in August 2006 after problems with the previous service provider. Service level agreements had been agreed outlining response times for healthcare providers. There were no corroborative data to check against information provided by Serco and there were inaccuracies in management information.

3.14 The force had a positive relationship with the Crown Prosecution Service (CPS), with ongoing partnership work being developed at Local Criminal Justice Board level. No criticisms were put forward about the quality of CPS cover. Defence solicitors were generally positive about their experience of attending custody suites, described relationships with the police as good and said custody staff were professional in their approach to detainees.

Expectation

3.15 There is an effective management structure for custody that ensures that policies and protocols are implemented and managed and that there are mechanisms for learning from adverse incidents, rubbing points or complaints.

Findings

3.16 Sergeants in the smaller custody suites highlighted the difficulty of getting some of the bigger custody suites to accept overflow detainees without providing a member of staff from their own team to accompany the detainees and therefore leaving the smaller custody suite with less resilience to meet its obligations.

3.17 There was no formal SOP covering cell bell usage and staff response. The current practice presented risks as a large percentage of detainees were unaware of the existence of a cell bell

and what it could be used for. This increased the risk to the force of suffering a serious adverse incident.

3.18 There was a need to interrogate the NICHE custody system to obtain a broader overview of the management information contained within it, to identify more readily the profile of detainees entering the custody suites. This should include how many detainees were held for more than 24 hours and how many were juveniles, women and UK Border Agency (UKBA) detainees. The lack of information about UKBA detainees suggested opportunities to expedite their cases with UKBA as well as recharging costs were being missed. There were no specific policies dealing with the needs of juveniles, women and UKBA detainees detained beyond 24 hours. Custody officers and managers did not sufficiently recognise the impact of custody on juveniles and women.

3.19 Detainees were not given any information about how to make a complaint while in custody. Those detained at the police stations did not raise any concerns about their treatment, but detainees in the local prison did, although custody records did not substantiate any of these. There was an opportunity for the force to take a more rounded view of complaints with a view to addressing underlying causes that could be exploited to the benefit of all.

Expectation

3.20 Maintenance of facilities only occurs when the suite is closed down.

Findings

3.21 The age and limited capacity of cell provision within WYP meant that maintenance was completed when facilities were open. The condition of some of the older cellular accommodation was unacceptable and required immediate remedial action.

Recommendations

3.22 West Yorkshire Police should examine whether the current model of devolving custody to divisions is one that is capable of delivering the outcomes required.

3.23 West Yorkshire Police should introduce an effective system of intrusive supervision with audit trails detailing findings and follow up actions.

3.24 Divisional senior management teams should pro-actively and consistently address the issues raised by the custody service department themed supportive visit reports.

3.25 The force should urgently improve the method for taking, storing, tracking and submitting all DNA and forensic samples.

3.26 The force should review individual cases where blood or other forensic samples have been taken from victims of road traffic collisions and ‘unconscious drivers’ and not submitted for analysis to ascertain if the failure to submit them may have resulted in adverse implications for individual cases or findings that require further action by the force.

3.27 There should be consistent working practices across all custody suites in the force that reflect the pressures faced by busier custody suites and treat custody suites as force-wide rather than divisional resources.

3.28 The responsibilities of the CCTV detention officer at Leeds Bridewell should be assessed to ensure that detainee safety or welfare is not compromised.

3.29 Risk assessments should be carried out in such a way that leaves no room for information gaps either between detention officers and sergeants on the same shift or which results in less than fully informed handovers occurring between off going and incoming shifts.

3.30 A formal standard operating procedure should be developed to cover use of cell bells and how staff react to them.

3.31 West Yorkshire Police should make greater efforts to utilise management information within the NICHE custody system to achieve a better understanding of the profile of detainees.

3.32 Specific policies on the treatment of juveniles, women and UKBA detainees who stay in custody for more than 24 hours should be introduced.

3.33 The force should take a more rounded view of complaints and monitor trends in order to address any underlying causes.

Good practice

3.34 *Themed supportive visits by the custody services department with representatives from estates, professional standards and the fingerprint departments involved all the necessary parties to identify and address issues on behalf of the force. The model used was thorough, searching and could easily be replicated in other forces.*

4. Treatment and conditions

4.1 Physical conditions in the older suites required urgent and immediate attention. The planned new estate in 2014 was too distant for some suites. Otherwise, the cells were reasonably clean and relatively graffiti-free. In several areas, such as showers, sanitary products, exercise and reading materials, detainees were not routinely informed of what was available. The use of cell call bells was not routinely explained, although staff response to calls was good and they were aware of basic safety issues. Staff interaction with detainees was limited by the time available and the priority placed on processes and procedures. Staff were generally not as sensitive to individual need as we would expect, although some offered excellent quality of care. Most detainees wore their own clothes. Tracksuits rather than paper suits were offered to those whose clothes were taken for forensic reasons.

Expectation

4.2 Custody staff are aware of the risk of self-harm from:

- attempted suicide
- drugs ingestion
- medical conditions
- alcohol

and these risks are assessed, monitored and managed appropriately.

Findings

4.3 The booking in areas offered little privacy, which could have discouraged detainees from disclosing important or personal information. A generic risk assessment was used for all detainees, irrespective of sex, age or risks posed. This covered the risk of suicide, drugs and alcohol use, medical conditions and medication. Information was gathered from the detainee and escorting staff. However, questions were not always asked in such a way as to encourage detailed responses and some assumptions were made about risks posed when a detainee was known to staff.

4.4 All detainees were monitored regularly and this was recorded. Those considered at risk could be placed in a cell covered by closed-circuit television (CCTV) cameras or put under constant observation in a cell with a glass door or with the cell door open and an officer sitting outside. We saw one detainee at Stainbeck on constant observation and there was good interaction between him and the officer designated to observe him. Bradford South contained six observation cells with glass doors, but two were opposite each other. This offered no privacy or dignity and risked putting a vulnerable detainee at risk from another if both cells were occupied without constant observation by staff. A 14 year-old girl who declared that she had self-harmed in the previous two weeks was left alone and unoccupied in a cell for several hours while waiting for an appropriate adult to attend.

4.5 Cells were checked before use, but the metal end of a zip was found in the bowl of one toilet at Stainbeck. This was removed by the custody sergeant.

4.6 Self-harm was included in the initial training course for custody staff, but they had not received specialist training. However, they had a reasonable understanding of the systems and processes available to manage those at risk. Apart from at Killingbeck, where there were two sets of keys for three staff on duty, all staff carried keys. They did not carry ligature knives. Cut down kits were available. Staff we asked were aware that the need to rouse detainees meant they had to receive a verbal or physical response.

4.7 At Killingbeck, a doctor was not called out to see two detainees prescribed methadone who arrived during the night. They were eventually seen several hours after their initial detention when staff asked a doctor seeing a third detainee to see them as well.

4.8 Verbal handovers took place at every shift change. Those we observed were thorough and covered risk issues, but the detail was not recorded.

Expectation

4.9 Custody staff are aware of any risk of harm to others and this is managed appropriately. Detainees are not placed in cells together unless a risk assessment indicates that it is safe to do so. Risk assessments include whether the detainee has previous convictions for racially aggravated offences.

Findings

4.10 Detainees did not routinely share cells other than at Pudsey and were supervised in holding or waiting areas. The risk assessment was reasonably thorough, but did not cover any homophobic or racial offences, although the police national computer (PNC) recorded those known to present a risk to others. Staff placed too much reliance on the front page warning markers on the PNC. In the larger suites, detention officers carried out risk assessments without always being overseen by the custody sergeant.

Expectation

4.11 Holding cells are equipped with call bell systems and their purpose is explained to detainees. They are responded to within a reasonable time.

Findings

4.12 Cells had call bells and these were mostly answered promptly. However, at Leeds Bridewell, they were answered by a busy detention officer who also monitored CCTV screens and operated the opening and closing of doors, so requests were passed to another officer for action. Requests made by detainees were not recorded and, apart from at Bradford South, the cell call system had not been explained to detainees. In our survey, 86% of detainees said they had not been told how to use the call bell.

Expectation

4.13 Holding areas, cells, interview rooms and detention rooms are:

- clean
- free from graffiti

- in good decorative order
- of a suitable temperature
- well ventilated
- well lit
- equipped with somewhere to sit
- free of ligature points.

Findings

4.14 Killingbeck had two women's cells and nine men's cells. There were three juvenile cells, one with CCTV, some distance from the main office. All cells were dark, dirty and poorly ventilated, and the juvenile cells had graffiti on the walls and benches. There were no spillage kits for dealing with bodily fluids. The booking-in area was dark and not particularly clean, mostly due to the age of the building, and the four interview rooms were austere and poorly ventilated.

4.15 The custody suite at Bradford South was purpose built, clean and in a good state of repair. It contained nine women's cells, 21 men's cells and four cells for juveniles. Of these, six were glass cells for constant observation, six were dry cells without sanitation and six had CCTV. All cells were clean, but quite gloomy, poorly ventilated and there was some graffiti. Some had only a low plinth to sit on. The eight interview rooms were soundproofed and dark, but adequately ventilated. There were two holding rooms, which were clean but lacked natural light. Four draughting booths for detainees who had been subjected to CS gas were mostly used for storage and detainees needing fresh air were put out in exercise yards. Violent detainees were occasionally held in the booths to separate them from other detainees in the holding areas.

4.16 Stainbeck had two women's cells, 12 men's cells and two cells for juveniles in separate areas, although the different groups could be located next to each other when the suite was busy. No female detainees were held during the inspection, but there was not always a female member of staff on duty. One of the women's cells had a low bed. All other bed plinths were high enough for detainees to sit down. CCTV was often used to monitor intoxicated detainees of either sex.

4.17 Of the 61 cells at Leeds Bridewell, four were used for juveniles and 10 for women. Sixteen cells, including four for women, were used for detainees appearing in court during the day, but could be used for police detainees in the evening and overnight. There was always a female detention officer on duty. Some cells contained low beds and were used for intoxicated detainees. All other bed plinths were high enough for detainees to sit down. Two cells had transparent doors and two had CCTV.

4.18 In both Stainbeck and Leeds Bridewell, there was a lot of graffiti on the back of cell doors and wooden bed plinths. Much of it was carved in and some had clearly been there for several years. What appeared to be food, but could have been human waste, had been flicked high up on some walls. Detention officers were responsible for clearing up vomit and urine, but had not received specific training for this. There was a blood spillage kit and a specialised deep cleaning company could be used when necessary. There were no published cleaning schedules or a policy on the cleaning-up of spillages. Cells had natural lighting supplemented by electric lights and were free of obvious ligature points. There were no facilities for detainees with disabilities.

Expectation

4.19 A smoking policy for staff and detainees is enforced that respects the right of individuals to breathe clean air in the custody suite.

Findings

4.20 The custody suites were no smoking areas. Nicotine replacement support was not routinely offered, although nicotine gum had been provided for one detainee at Killingbeck. In our survey, 70% of detainees said they had not been offered anything to help them cope with not smoking.

Expectation

4.21 Detainees are provided with suitable meals that cater for special dietary requirements, and drinks at appropriate intervals.

Findings

4.22 Meals catering for a wide range of dietary requirements were offered at specific meal times and drinks were given on request. In our survey, 84% of detainees said they had been offered something to eat and 86% something to drink. However, custody records indicated that some detainees were held for prolonged periods with no food or drink, and that those being interviewed at meal times missed that meal. Detention officers had not had food hygiene training and two staff at Stainbeck incorrectly told us that all meat was halal.

Expectation

4.23 Detainees are provided with a mattress, pillow and clean blankets if held overnight.

Findings

4.24 Mattresses and clean blankets were provided, but pillows were not.

Expectation

4.25 Detainees are able to use a toilet in privacy, and toilet paper and washing facilities are provided.

Findings

4.26 Not all cells, including all juvenile cells at Killingbeck, Bradford South and Stainbeck, had in-cell toilets and none had washbasins. Toilets could not be used in private, but those in camera cells were concealed on the CCTV monitors. Toilet paper had to be requested. Soap and feminine hygiene packs were not offered routinely.

4.27 The showers at Killingbeck and Bradford South were all half-screened and there were issues about decency, particularly for female detainees.

4.28 In Stainbeck, only the separate toilet in the men's area contained paper, soap and a towel. Separate toilets and sinks outside cells were available at Leeds Bridewell and contained paper, soap and hand drying facilities. Showers were also available, although the one by the three dry cells was used for storage.

Expectation

4.29 Detainees whose clothing is taken for forensic examination are provided with suitable alternative clothing before being released or transferred to court.

Findings

4.30 Detainees whose clothing was removed or who required clean clothing were offered tracksuits and plimsolls or foam slippers, but underwear was not provided. Paper forensic suits were also available.

Expectation

4.31 Detainees who are held for more than 24 hours are able to take a shower and a period of outdoor exercise.

Findings

4.32 Detainees were not routinely offered showers or exercise, even when held for more than 24 hours. In our survey, 95% of detainees said they had not been offered a shower and 98% said they had not been offered exercise.

4.33 During the inspection, one female detainee at Killingbeck requested and was given exercise, but was left unsupervised and observed only by camera. The yard was an adequate size, but dirty and austere. The exercise yards at Stainbeck and Leeds Bridewell were open to the elements and Stainbeck offered no shelter. The exercise areas at Bradford South were small, narrow and netted in.

Expectation

4.34 Detainees who are held in custody for several days are provided with suitable reading material. Visits are also allowed, and changes of clothing, especially underwear, are facilitated.

Findings

4.35 Reading material was not routinely provided. Visits were not facilitated, but clothes for detainees could be left at the front desk.

Expectation

4.36 Custody suite staff have received fire safety training and evacuation procedures are practised frequently.

Findings

4.37 Not all staff had received fire safety training. There had been no recent fire evacuation exercises at Killingbeck or Stainbeck and only a table-top exercise at Leeds Bridewell.

Other findings

4.38 Detention staff said Killingbeck was due to close in 12 months, but the facilities were due to be refurbished before that, including installing a second booking in terminal. Some detainees had been told to leave their clothes on the floor outside their cell door, and lockers in the main booking area used to store detainees' property were not lockable. The whiteboard used to record detainee particulars was on the wall in the booking in area and visible to everyone passing through.

4.39 Cells at Bradford South were designated as for men, women or juveniles, but detention staff said they tended to locate detainees in one area to make observations less time consuming. They did not believe this put vulnerable detainees at risk. There were no clear policies for the use of cells with CCTV or glass doors and we observed them being used for different purposes.

4.40 One defence solicitor said officers were receptive at Stainbeck and that his clients were properly and appropriately responded to there.

Recommendations

4.41 Custody staff should receive specialist self-harm training.

4.42 Juvenile detention rooms should have integral sanitation.

4.43 Cells should be provided with more natural light, and ventilation in interview rooms improved.

4.44 The use of the cell call bell should be explained to all detainees.

4.45 Cells should be thoroughly searched for unauthorised items before use.

4.46 Cells and other areas should be cleaned to a high standard and a cleaning schedule published and monitored.

4.47 Toilets in all cells and showers should be adequately screened and deep cleaned.

4.48 All detainees should have access to hand washing facilities.

4.49 The booking in areas should be made more private.

4.50 All staff on duty should carry keys and ligature knives.

4.51 Risk assessments should include whether the detainee has previous convictions for racially aggravated or homophobic offences.

4.52 A child/gender-appropriate risk assessment should be developed and implemented.

4.53 Requests made by detainees should be recorded in their custody records.

4.54 Nicotine replacement support should be available.

4.55 Graffiti should be removed.

4.56 Staff should receive food hygiene training.

4.57 Detainees being interviewed at meal times should be offered food when the interview has finished.

4.58 Spillage kits should be provided to deal with bodily fluids.

4.59 Appropriate facilities for detainees with disabilities should be provided.

4.60 Staff should be aware of which meals are suitable for Muslim diets.

4.61 Pillows should be provided.

4.62 Toilet paper, soap and feminine hygiene packs should be provided automatically.

4.63 Underwear should be supplied when required.

4.64 Property and clothing removed from detainees should be stored in locked lockers.

4.65 Detainees held in custody for more than 24 hours should be offered showers and exercise.

4.66 Detainees should be offered reading material and those held more than 24 hours allowed to have visits.

4.67 Custody suite staff should receive fire safety training and evacuation exercises should be practiced frequently.

5. Individual rights

5.1 Individual legal rights took priority and were met. Detention was authorised appropriately and detainees were informed of their rights. This information was available in a range of languages and translation services were used when needed. There was no separate policy for managing young people in detention, but the appropriate adult service was used and there was no evidence that young people were interviewed without an appropriate adult. This proved problematic out of hours and resulted in juveniles spending longer in custody. The problem with obtaining an appropriate adult was even more severe for vulnerable adults. Women were not treated with regard to their particular vulnerability. Early cut off times from the courts for cases to be heard sometimes led to delays and people being detained longer than necessary. Detainees were not routinely told how to complain.

Expectation

5.2 Detention is appropriate, authorised and lasts no longer than is necessary. In the case of immigration detainees alternative disposals are expedited.

Findings

5.3 Detention was appropriate and authorised. Reviews were generally held on time and were flagged up on a computer system as due or overdue. Problems with getting an appropriate adult in the evenings meant juveniles arriving after 7pm usually stayed overnight. Frequent disagreements between social services and mental health services over who was responsible for providing an appropriate adult for vulnerable adults also led to people spending longer than necessary in custody. The task usually fell to the emergency social services duty team, but this could take up to six hours to arrange.

5.4 The custody sergeant at Bradford South estimated that penalty notices for disorder were used instead of custody about four times a week. Under a pilot scheme driven by the Crown Prosecution Service, three women in the previous fortnight had received a conditional caution in return for attending a Together Women Programme Project centre.

5.5 In almost all records examined at Leeds Bridewell and Stainbeck, individuals had been detained for longer than six hours. Problems at Leeds Bridewell were exacerbated by the facility acting as a central 'lock-up' with no easily accessible staff. Typically, staff in charge of individual detainee cases were carrying out enquiries elsewhere in the city, which led to some delays and extended detention.

Expectation

5.6 Detainees, including immigration detainees, are told that they are entitled to have someone concerned for their welfare informed of their whereabouts. Any delay in being able to exercise this entitlement, such as phoning a person concerned for their welfare, is authorised at the level of Inspector or above. They are asked if they wish to see a doctor.

Findings

5.7 Detainees were told that someone could be informed of their whereabouts, although the call was not always made in the presence of detainees, which led to some anxiety about whether it had been made. Staff reported some problems with moving immigration detainees to the appropriate immigration holding facility. This could mean detainees waiting several days, particularly if they were brought in just before the weekend. In our survey, a third of detainees said they had concerns about needing to contact someone.

5.8 Detainees we saw being booked in were asked if they needed to see a doctor, but a nurse was sometimes sent if the detainee could or would not say what the problem was. Doctors were automatically called if there were any concerns.

Expectation

5.9 Detainees who have difficulty communicating are adequately provided for with staff who can communicate with them or interpreters.

Findings

5.10 Interpreters and telephone interpreting services were used to communicate with detainees who did not speak English. However, detainees were sometimes delayed due to difficulties finding an interpreter. We understood that a pilot project running at Bradford was seeking to identify speakers of less common languages in the local community, but this had not yet filtered down to the operational staff on duty. Details of detainees' rights and entitlements were provided in a range of languages. A list of signers for the deaf was available.

Expectation

5.11 There are special arrangements for detained young people that cover:

- the limited use of restraints
- the conduct of any strip search
- location in unlocked detention rooms close to the custody desk where possible for observation purposes
- separation from adults at all times including in showers and the exercise yard
- specially trained officers allocated until the appropriate adult arrives
- whether appropriate adults are indeed appropriate for the task
- the capacity for the relative, guardian or appropriate adult to remain with the detained young person during waiting periods, in the detention room if necessary.

Findings

5.12 There were no special arrangements for detained young people, other than the legal requirements laid out in PACE, and children aged 17 or over were considered and treated as adults. Staff had not had any specific training in working with juveniles or child protection, although they showed some awareness of issues such as non-accidental injuries. Staff at Stainbeck had also become aware of some child protection issues relating to a 13 year-old girl, who was eventually discharged into the care of social services rather than to her home address.

5.13 Although there were four cells for juveniles at Bradford South, none contained toilets and juveniles held for several hours or overnight were often put in an adult cell so they had in-cell sanitation. Juveniles held for longer periods at Killingbeck could be moved to the women's cell area for the same reason. Juveniles in both suites were on half-hourly observations.

Expectation

5.14 Female detainees are able to be dealt with by female staff, or where this is not possible, hygiene packs for women are routinely provided. Staff are aware that the impact of detention on women is different to the impact on men, and adopt their level of observation and support appropriately.

Findings

5.15 Not all custody suites always had a female member of staff on duty, but a female officer would be called from the station when necessary. Hygiene packs for women were not routinely provided and women were expected to ask for sanitary products. Some staff showed no real appreciation of how custody had a different impact on women. One officer at Killingbeck said the only difference in how he would treat women would be not to tell them dirty jokes. The store room in the same suite contained just one sanitary towel.

Expectation

5.16 Persons detained who have dependency obligations are catered for.

Findings

5.17 Detainees were not routinely asked about dependents, but were expected to raise any issues themselves. Arrangements could be made for children to be looked after until another carer could be found. Detainees with dependents whose offence was minor were bailed; otherwise, social services were called. There were no links with Age Concern or other community groups who might be able to offer support.

Expectation

5.18 Detainees are able to have a solicitor present when interviewed by police officers. Those under the age of 17 or vulnerable adults or those with learning disabilities are not interviewed without a relative, guardian or appropriate adult present. Solicitors and advocates arrive promptly so as not to unnecessarily prolong the period in custody. Detainees are able to consult with legal representatives in privacy.

Findings

5.19 Detainees were routinely asked if they wanted a solicitor present. However, at Killingbeck and Bradford South, some staff we saw did not encourage this and one solicitor said his clients were told that asking for a solicitor would only mean they were detained for much longer than necessary. In our survey, 56% of detainees said they had not requested a solicitor. Detainees could see their solicitor in private and any delays in solicitors seeing their clients were not unreasonable, although solicitors at Bradford South said it was not unusual for them to have to wait up to two hours to see detainees.

5.20 There was a protocol between the force and local social services departments about the provision of appropriate adults, although there were often delays in finding one in the late evenings and at weekends. One adult detainee at Leeds Bridewell was being held under the mental health act. His custody record indicated that he had been in and out of custody several times due to non-availability of an appropriate adult. He was finally being interviewed after a delay of over a week.

Expectation

5.21 Detainees are not interviewed by police officers while under the influence of alcohol or drugs, or if medically unfit unless in circumstances provided for under PACE.

Findings

5.22 Detainees were not interviewed or charged until deemed capable and medically fit. Juveniles and vulnerable adults were not interviewed or charged without an appropriate adult present.

Expectation

5.23 Suitable legal advice is available for both police detainees and immigration detainees.

Findings

5.24 Access to a solicitor was through a call centre that routed the request to an immigration or criminal lawyer as appropriate. Detainees were informed of their rights and were given an information sheet available in a range of languages.

Expectation

5.25 Detainees are not subject to inhuman or degrading treatment in the context of being interviewed, or in the denial of any services they need. They are allowed a period of eight hours continuous break from interviewing in a 24-hour period.

Findings

5.26 There were no complaints about inhuman or degrading treatment. Detainees were given a period of eight hours continuous break and where possible this was during the night.

Expectation

5.27 Detainees are not handcuffed in secure areas unless there is a risk of violence to other detainees or staff.

Findings

5.28 Detainees were not unnecessarily handcuffed in secure areas. However, we were concerned about one man who arrived at Stainbeck at 5.45am and threatened to harm staff if his handcuffs were removed. The time when handcuffs were removed was not recorded, but it

appeared to be when he was seen by the doctor at 11.20am, even though the custody record indicated that he had been compliant when he went to the toilet at 9.32am.

Expectation

5.29 Those charged are produced at court promptly either in person or via video link.

Findings

5.30 Getting detainees to court was not a problem in the mornings, but court availability reduced in the afternoons and on Saturday mornings. Limitations on the availability of court sessions meant that some detainees spent additional time in custody or were released on police bail without being dealt with.

Expectation

5.31 Detainees know how to complain about their care and treatment. They are not discouraged from doing so but are supported in doing so where necessary.

Findings

5.32 There was no formal written complaints procedure and detainees were not told or given information in writing about how to make a complaint.

Expectation

5.33 There is an effective system in place for reporting and dealing with racist incidents.

Findings

5.34 There was no formal system for dealing with racist incidents and no local register of such incidents.

Expectation

5.35 All custody suites hold a copy of the PACE Code of Practice C, and detainees, including immigration detainees, know they are able to consult it. Detainees or their legal representatives are able to obtain a copy of their custody record on release, or at any time within 12 months following their detention.

Findings

5.36 All detainees at Killingbeck and Bradford South were made aware of PACE Code C, told they could borrow it and given a two-page summary, but the copy at Killingbeck was water damaged and missing the first nine pages. At Leeds Bridewell and Stainbeck, there was only one copy behind the desk and it was not on display.

5.37 Solicitors at Killingbeck said they could get a copy of their client's custody record, but that staff would not give them details of what had happened to the detainee, such as whether they were

charged, cautioned or bailed. One firm of solicitors at Bradford South said they were given only the front sheet of custody records. There was no effective forum through which such issues could be resolved (see also section on strategy).

Expectation

5.38 Pre-release risk management is conducted and vulnerable detainees are released safely.

Findings

5.39 There was no formal pre-release risk management procedure. However, at Killingbeck and Bradford South, arrangements were made to ensure that juveniles and vulnerable adults were escorted home and women released at night were taken by taxi or given a lift by staff. Men could use the telephone to make necessary arrangements or were taken to a station if they had a long way to travel. At Leeds Bridewell and Stainbeck, juveniles were usually released to a named carer or occasionally into the care of social services. Arrangements for vulnerable adults were less robust.

Recommendations

5.40 Appropriate adults should be promptly available for juveniles and vulnerable adults and should be able to wait with the detainee.

5.41 Relationships with the UK Border Agency should be developed to ensure immigration detainees are held in police custody for as short a time as possible.

5.42 The telephone call made to inform concerned others about the whereabouts of detainees should be made either by the detainee or in the presence of the detainee where possible to alleviate anxiety that others might be worrying about them.

5.43 All young people under the age of 18 should be treated as children.

5.44 Custody staff should receive specialist training in the management of juveniles and policy and staff guidelines should be produced.

5.45 Detainees should not have to disclose why they need to see a doctor to non-medical staff.

5.46 Detainees should not be unnecessarily delayed while an interpreter is found.

5.47 Staff should be familiar with the 'hard to reach' language pilot at Bradford.

5.48 A children and young person's policy should be developed so that it goes beyond procedural compliance and actually addresses more fully the distinctive needs of young people in custody.

5.49 Custody staff should receive training on the differential impact of custody on different groups of detainees, particularly women.

5.50 Female detainees should routinely be offered a choice of sanitary products and sufficient stocks should be available.

5.51 On arrival, all detainees should be asked if they have any dependency obligations.

5.52 Detainees should be told that can see a solicitor free of charge and should not be discouraged from doing so.

5.53 Primary carers should be able to visit juveniles held overnight.

5.54 Detainees who are charged should be produced at court promptly.

5.55 Detainees should be given clear and simple instructions about how they can make a complaint both during and after detention.

5.56 When restraints are used, the custody record should detail all decisions and the reasons and timings.

5.57 All copies of PACE code C should be legible and in good condition.

5.58 Solicitors should always be able to obtain a copy of their client's custody record and given information about what has happened to detainees relating to bail, charges or cautions.

5.59 The force should consider setting up a forum with defence solicitors for dealing with issues pertinent to the effective administration of legal advice and rights.

5.60 A pre-release risk management policy should formalise measures taken to ensure that detainees are returned home safely.

Housekeeping point

5.61 Solicitors should not have to wait unreasonable amounts of time to see detainees.

Good practice

5.62 *A pilot scheme offering conditional cautions for women was a good way to ensure that women received help and support while also diverting them from custody.*

6. Healthcare

6.1 In our survey, 75% of detainees had been seen by a health professional in custody and 59% of these rated the quality of health services provided as bad or very bad. The police contracted Serco Health to provide health professionals to each custody suite. While the company had specific target times in which to respond to calls, the recording of data was inaccurate and some detainees waited several hours to be seen. Clinical governance arrangements were limited. Many of the treatment rooms were not suitable and there were no infection control measures. The storage of medication was poor. Protocols for the care of detainees with mental health problems did not appear to be well known or well used.

Expectation

6.2 The decency, privacy and dignity of detainees are respected.

Findings

6.3 Detainees being booked in were asked about any physical or mental health issues and whether they wanted to see 'health care'. This was at the main desk alongside other detainees and with no confidentiality. Most staff booking in detainees appeared sensitive to their needs (see also paragraph 5.8).

Expectation

6.4 Detainees are treated by health care professionals and drug treatment workers in a professional and caring manner that is sensitive to their situation and their diverse needs, including language needs.

Findings

6.5 Serco Health provided forensic medical examiners (FMEs) and nurses. Serco Health managers said detainees could ask to see a health care professional of their own gender, but it was unclear how detainees were made aware of this. Serco Health was contracted to provide three FMEs and two nurses at any time for the whole of West Yorkshire, with additional FMEs over a weekend. However, there were occasions during the inspection when only one nurse was available and the number of FMEs was also reduced. The nurses tended to base themselves at the two busiest stations, Leeds Bridewell and Bradford South, and worked 13-hour shifts. The FMEs were mobile and some had drivers. They staggered their shift start and finish times, with 12-hour shifts starting at 6am, 7am and 8am.

6.6 Serco Health was obliged to respond to calls within 60 or 90 minutes depending on the nature of the call. Calls were made to a call centre where they were managed by staff who used flow charts to assist in their decision making. Information provided by Serco Health to the police indicated that between June and August 2008, 97.3% of calls had been dealt with within the time limits, with 99% of category 2 calls (which included suicide risk, detention to interview or detain, symptoms of alcohol addiction or drug addiction and any other cases discussed and agreed with the officer in charge) being met in August 2008. We were not assured of the

accuracy of the data. In one case at Leeds Bridewell, for example, a call to Serco Health had been placed at 4pm. A nurse was dispatched from Bradford and attended at 5pm, but did not examine the detainee and stated that it would be more suitable for an FME to attend. A pre-arranged appointment was made and the FME was asked to see the detainee when he came on duty at 7pm. Serco Health records showed the call was completed at 9.20pm. However, the pre-arranged appointment status was not subject to any service level agreement. There were other cases where detainees had waited several hours to be seen.

6.7 The clinical custody record included a section to be completed by custody staff and health professionals to indicate the time the call was placed and the time the detainee was seen. However, in many cases this information was not recorded or was incomplete, so any audit of the records would have been impossible.

6.8 Staff could use a telephone interpreting service for detainees who did not speak English.

Expectation

6.9 Clinical governance arrangements include the management, training and supervision and accountability of staff.

Findings

6.10 Clinical governance arrangements were limited. While there was a management structure within Serco Health, it was unclear to whom the nurses reported professionally, as neither of the senior managers was a health services professional. The FMEs were employed as individuals, although the company had appointed a medical director in an attempt to provide some clinical leadership. Nurses we spoke to did not receive clinical supervision.

Expectation

6.11 Patients are treated by health care staff who receive ongoing training, supervision and support to maintain their professional registration and development. Staff have the appropriate knowledge and skills to meet the particular health care needs of detainees in police custody.

Findings

6.12 Health services staff had previously been employed by another provider, but had transferred to Serco Health in August 2006 when WYP changed contractors. The medical director had recently introduced monthly training for FMEs and managers said all staff had up-to-date resuscitation training. It was unclear what other professional development was available to them.

6.13 Not all FMEs were Section 12 approved. It was unclear how Serco Health monitored the professional registration of its staff.

Expectation

6.14 All equipment (including resuscitation kit) is regularly checked and maintained and all staff (healthcare and custody staff) understand how to access and use it effectively.

Findings

6.15 None of the custody suites visited had a defibrillator, although we understood that police staff were being trained in their use in the coming months, after which defibrillators would be installed in each custody suite. There were ambubags at each station and first aid kits. The kits were in various states of tidiness and there was no standard list of what they should contain or documented checks of the equipment.

Expectation

6.16 Detainees are able to request the services of a health care professional in and out of hours, and to continue to receive any prescribed medication for current health conditions or for drug maintenance.

Findings

6.17 Detainees were not prescribed medication for their drug dependency unless they had been in custody for six hours or more. If a detainee usually collected methadone daily from a pharmacist, custody sergeants could organise for the medication to be collected and brought to the station, so that an FME could prescribe and administer it. This happened once during the inspection, but the clinical custody record did not make clear that the detainee had actually received the methadone, although he assured us he had been given his relevant medications.

6.18 Nursing staff could administer symptomatic relief for drug withdrawal using specific patient group directions (PGDs), but could not provide relief for alcohol withdrawal.

Expectation

6.19 Clinical examinations are conducted out of the sight and preferably out of the hearing of police officers. Treatment rooms provide conditions that maintain decency, privacy and dignity. Infection control facilities are implemented. There is at least one room that is forensically clean.

Findings

6.20 Treatment rooms were unsuitable. Most were not clean, many were untidy and some were cluttered. All had a panic alarm system.

6.21 The room used by health professionals in Bradford South was clean, but the couch did not have a paper roll on it, the examination light did not work and the storage cupboard was untidy, with empty boxes and other rubbish littering the shelves.

6.22 In Pudsey, there were empty boxes littering the small room, graffiti on the desk, thick dust on some surfaces and a domestic dustbin with a yellow bag in it rather than a pedal-operated bin. Again there was no paper roll for the examination couch.

6.23 The treatment room at Killingbeck was clean, but sharps boxes and clinical waste bins had not been emptied and both contained clinical and general waste. The domestic cleaner suggested that contaminated clinical waste was often found in the general waste bin. There was no evidence of soap or alcohol handwash in the room.

6.24 The tiny treatment room at Weetwood station was shared by health services staff and drug workers as well as being used to store frozen exhibits, DNA and a variety of items. It was also the route to the only staff toilet. The room was the width of the examination couch, which could not be used as items were stored on top of it.

6.25 The surgical room at Pontefract was shared with the drug intervention programme (DIP) team and the intoxiliser machine. Access to storage cupboards was inhibited by this additional equipment and there was no access to the examination bed due to DIP sampling kits. The toilet facilities in the room were also used for storage. There was no soap, and alcohol handwash could not be used as it could contaminate the intoxiliser machine.

6.26 At Leeds Bridewell, the examination couch did not have a paper roll. There was a roll at Stainbeck, but it was on the floor under the couch and there was no yellow bin.

6.27 Most treatment rooms had full sharps bins that had not been annotated to determine their location. There were no infection control procedures.

6.28 Police staff we spoke to said they would accompany a health professional during a clinical consultation if the detainee was refractory or if requested to do so by the clinician.

Expectation

6.29 Detainees are offered the services of a drugs or alcohol arrest referral worker where appropriate and referred on to community drugs/alcohol teams or prisons' drugs workers as appropriate.

Findings

6.30 Drug support workers were provided by a voluntary sector organisation, Crime Reduction Initiative (CRI). They were available between 7am and 11pm each weekday and 10am until 6pm at weekends and bank holidays. There were different teams for different areas of the county, with three workers on duty at any one time in the Leeds area: one for Leeds Bridewell, one for Pudsey and Weetwood and one for Killingbeck and Stainbeck.

6.31 In the three months to September 2008, there had been 777 positive drugs tests in Leeds. In Bradford over the same period, 494 adults had tested positive and had an initial required assessment imposed. Of these, 450 (91%) had been seen by a DIP worker.

6.32 Custody staff referred adult detainees to a drugs worker if they were to be tested for drugs, either as a result of a trigger offence or if a drugs test was authorised by an inspector. When possible, the workers accompanied the detainee during the test, which was carried out by police staff. If positive, the detainee was offered the services of the drug worker and, if they accepted, assessed. The drugs workers offered harm minimisation advice and referred detainees on to treatment in the community if requested. The drugs workers made appointments for detainees either with the worker the detainee had originally met or with a worker with a specific themed responsibility, such as alcohol addiction. Two workers on the Leeds team took specific responsibility for 'working women'.

6.33 However, at Killingbeck police station, a detainee who openly admitted to excessive cannabis use was attended to by an FME. Discussion with the chaperone who attended the consultation suggested that cannabis use was referred to. The detainee confirmed that they had details of an appropriate drugs team, but later said they had not initiated contact with it and openly

requested some assistance regarding cannabis use. It was not noted that a record was made of this nor did custody staff offer any assistance to the detainee, who was subsequently released.

6.34 If detainees were remanded in custody, drugs workers referred them to prison drug workers.

Expectation

6.35 A liaison and/or diversion scheme enables mentally disordered detainees to be identified and diverted into appropriate mental health services, or referred on to prison health care services.

Findings

6.36 All three mental health trusts in the West Yorkshire area had protocols with the police for detainees with mental health problems. However, custody staff we spoke to described difficulties in ensuring that detainees requiring a mental health assessment were dealt with in a timely way and some health professionals stated that they would expect the custody sergeant to organise mental health services when required rather than referring the detainee directly.

6.37 Custody sergeants received two hours of training on mental health in their custody officer initial course and an hour in their refresher training. Detention officers received a 1.5-hour lecture on mental health in their training.

Expectation

6.38 Police custody is not used as a place of safety for section 136 assessments[2] except where the detainee needs to be controlled for his or her own safety or the safety of others.

Findings

6.39 According to statistics provided, the force had dealt with 71 detainees under section 136 of the Mental Health Act in custody suites in the previous six months. This represented 0.78% of the total number of arrests in the period. Individual custody suites did not keep records of detainees detained under section 136. Within the West Yorkshire area, five alternative places of safety were provided by the three mental health trusts, but the police did not keep statistics on how many detainees were taken to each of them. There were protocols for their use, but it was not possible to ascertain whether arresting police officers knew about the protocols and how they could be implemented.

Expectation

6.40 Each detainee seen by health care staff has a clinical record containing an up-to-date assessment and any care plan conforms to professional guidance from the regulatory bodies. Ethnicity of the detainee is also recorded.

[2] 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 e.g. 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.

Findings

6.41 The clinical records of detainees differed depending on whether they had been seen by a nurse or an FME, although the clinical custody record (information provided to custody staff) was provided on the same pro-forma by all.

6.42 If a nurse saw the detainee, he or she completed a pro-forma (there were several different versions in use). The form included a section for the detainee to indicate that he or she agreed to clinical information being shared with the police. At the end of the nurses' shift, the records of all the detainees seen by them were sealed in an envelope and left in a plastic box in one of the treatment rooms for collection by Serco Health staff.

6.43 FMEs made their clinical notes either free hand or using a pro-forma. After the consultation, they kept the clinical records themselves. Neither pro-forma recorded the ethnicity of the detainee. There was no clear policy for the storage and retention of clinical records and FMEs we spoke to said they would keep clinical records indefinitely.

Expectation

6.44 Any contact with a doctor or other health care professional is also recorded in the custody record, and a record made of any medication provided. The results of any clinical examination are made available to the detainee and, with detainee consent, his/her lawyer.

Findings

6.45 Health professionals provided custody staff with a handwritten account of their consultation with a detainee, but there was no facility on the custody computer system for them. Records varied in quality. It was not always clear that the detainee had been seen by a nurse because the form stated 'doctor's signature' and some nurses crossed this out and added their own qualification, but others did not. There was evidence of medications being administered, but not recorded as being prescribed or administered. Staff we spoke to were unclear whether a detainee would be provided with a copy of their clinical records on request. One staff member categorically said he would not provide copies of his notes, but would provide a letter summarising the treatment given.

Expectation

6.46 Information sharing protocols exist with all appropriate agencies to ensure efficient sharing of relevant health and social care information.

Findings

6.47 There was no evidence of information sharing protocols between relevant agencies to ensure efficient sharing of relevant health and social care information. Anecdotally, health services staff said they would expect the custody sergeant to make the necessary arrangements if a detainee needed to be referred to another agency such as the mental health team or drugs worker.

Expectation

6.48 All medications on site are stored safely and securely, and disposed of safely if not consumed. There is safe pharmaceutical stock management and use.

Findings

6.49 Serco Health staff carried their own supplies of medication, which were supplied from the Serco Health call centre. Each treatment room had a drugs disposal safe where unused or discarded medications should have been placed, but not all staff appeared to be aware of them or how they should be used. One detention officer said any unused medications were discarded in a yellow clinical waste bin, while one FME admitted that he carried discarded medications in a single container in his case for disposal at a pharmacy when the container was full. In Pontefract, custody staff secured all unused medication in a box for which they held the key and disposed of the medication monthly. Neither of the FMEs we met had bags that were locked at the time of the inspection. Staff at Pontefract said there had been an occasion during a consultation when a detainee had stolen medication from an FME's bag.

6.50 There were out-of-date medications in cupboards at Weetwood and paracetamol tablets loose in a cupboard in Stainbeck. At Leeds Bridewell, there was a bag with a combination lock that apparently contained medications, but none of the staff knew the combination number.

6.51 Each treatment room contained green metal cupboards that had apparently been used by the previous health services provider to store medications, but we could not find anyone with a key. However, conversations with individual staff members suggested that some staff still used the cupboards, unbeknown to Serco Health management.

6.52 Prescribed medication (non-controlled drugs) was left by FMEs with custody staff to administer when required. In most suites, staff recorded the times the medications were due to be administered on their white board and detention officers signed the clinical custody record when the medication had been given.

Recommendations

6.53 The information supplied by Serco Health to West Yorkshire Police should be accurate and auditable and reflect the actual time that detainees wait to be seen by a healthcare professional.

6.54 There should be clinical governance arrangements that include the management, training, supervision and accountability of staff.

6.55 Treatment rooms should provide conditions that maintain decency, privacy and dignity.

6.56 Infection control guidelines should be implemented and adhered to.

6.57 There should be a full resuscitation kit, including an automated external defibrillator, in each suite, which should be regularly checked and maintained. All staff (custody and health services) should know how to access and use it effectively.

6.58 Nurses should be able to administer symptomatic relief for alcohol withdrawal.

6.59 West Yorkshire Police should ensure that the protocols with the local mental health trusts are known by all staff and implemented appropriately to ensure that detainees with mental health problems are cared for appropriately.

6.60 All clinical records should conform to professional guidance from health professionals' regulatory bodies.

6.61 All clinical records should be held in accordance with Caldicott guidelines.

6.62 Any contact with a health professional should be recorded in the custody record.

6.63 The results of any clinical examination should be made available to the detainee or his/her lawyer (with consent) on request.

6.64 There should be information sharing protocols with all appropriate agencies to ensure efficient sharing of relevant health and social care information.

6.65 All medication should be stored safely and securely and disposed of safely if not consumed.

6.66 There should be safe pharmaceutical stock management.

Housekeeping point

6.67 Health professionals completing the clinical custody record should record their professional qualifications.

Good practice

6.68 *The amount of time drug workers were available within each 24-hour period offered extensive cover to detainees.*

7. Summary of recommendations

Recommendations

Strategy

7.1 West Yorkshire Police should examine whether the current model of devolving custody to divisions is one that is capable of delivering the outcomes required. (3.22)

7.2 West Yorkshire Police should introduce an effective system of intrusive supervision with audit trails detailing findings and follow up actions. (3.23)

7.3 Divisional senior management teams should pro-actively and consistently address the issues raised by the custody service department themed supportive visit reports. (3.24)

7.4 The force should urgently improve the method for taking, storing, tracking and submitting all DNA and forensic samples. (3.25)

7.5 The force should review individual cases where blood or other forensic samples have been taken from victims of road traffic collisions and 'unconscious drivers' and not submitted for analysis to ascertain if the failure to submit them may have resulted in adverse implications for individual cases or findings that require further action by the force. (3.26)

7.6 There should be consistent working practices across all custody suites in the force that reflect the pressures faced by busier custody suites and treat custody suites as force-wide rather than divisional resources. (3.27)

7.7 The responsibilities of the CCTV detention officer at Leeds Bridewell should be assessed to ensure that detainee safety or welfare is not compromised. (3.28)

7.8 Risk assessments should be carried out in such a way that leaves no room for information gaps either between detention officers and sergeants on the same shift or which results in less than fully informed handovers occurring between off going and incoming shifts. (3.29)

7.9 A formal standard operating procedure should be developed to cover use of cell bells and how staff react to them. (3.30)

7.10 West Yorkshire Police should make greater efforts to utilise management information within the NICHE custody system to achieve a better understanding of the profile of detainees. (3.31)

7.11 Specific policies on the treatment of juveniles, women and UKBA detainees who stay in custody for more than 24 hours should be introduced. (3.32)

7.12 The force should take a more rounded view of complaints and monitor trends in order to address any underlying causes. (3.33)

Treatment and conditions

7.13 Custody staff should receive specialist self-harm training. (4.41)

7.14 Juvenile detention rooms should have integral sanitation. (4.42)

7.15 Cells should be provided with more natural light, and ventilation in interview rooms improved. (4.43)

7.16 The use of the cell call bell should be explained to all detainees. (4.44)

7.17 Cells should be thoroughly searched for unauthorised items before use. (4.45)

7.18 Cells and other areas should be cleaned to a high standard and a cleaning schedule published and monitored. (4.46)

7.19 Toilets in all cells and showers should be adequately screened and deep cleaned. (4.47)

7.20 All detainees should have access to hand washing facilities. (4.48)

7.21 The booking in areas should be made more private. (4.49)

7.22 All staff on duty should carry keys and ligature knives. (4.50)

7.23 Risk assessments should include whether the detainee has previous convictions for racially aggravated or homophobic offences. (4.51)

7.24 A child/gender-appropriate risk assessment should be developed and implemented. (4.52)

7.25 Requests made by detainees should be recorded in their custody records. (4.53)

7.26 Nicotine replacement support should be available. (4.54)

7.27 Graffiti should be removed. (4.55)

7.28 Staff should receive food hygiene training. (4.56)

7.29 Detainees being interviewed at meal times should be offered food when the interview has finished. (4.57)

7.30 Spillage kits should be provided to deal with bodily fluids. (4.58)

7.31 Appropriate facilities for detainees with disabilities should be provided. (4.59)

7.32 Staff should be aware of which meals are suitable for Muslim diets. (4.60)

7.33 Pillows should be provided. (4.61)

7.34 Toilet paper, soap and feminine hygiene packs should be provided automatically. (4.62)

7.35 Underwear should be supplied when required. (4.63)

7.36 Property and clothing removed from detainees should be stored in locked lockers. (4.64)

7.37 Detainees held in custody for more than 24 hours should be offered showers and exercise. (4.65)

7.38 Detainees should be offered reading material and those held more than 24 hours allowed to have visits. (4.66)

7.39 Custody suite staff should receive fire safety training and evacuation exercises should be practiced frequently. (4.67)

Individual rights

7.40 Appropriate adults should be promptly available for juveniles and vulnerable adults and should be able to wait with the detainee. (5.40)

7.41 Relationships with the UK Border Agency should be developed to ensure immigration detainees are held in police custody for as short a time as possible. (5.41)

7.42 The telephone call made to inform concerned others about the whereabouts of detainees should be made either by the detainee or in the presence of the detainee where possible to alleviate anxiety that others might be worrying about them. (5.42)

7.43 All young people under the age of 18 should be treated as children. (5.43)

7.44 Custody staff should receive specialist training in the management of juveniles and policy and staff guidelines should be produced. (5.44)

7.45 Detainees should not have to disclose why they need to see a doctor to non-medical staff. (5.45)

7.46 Detainees should not be unnecessarily delayed while an interpreter is found. (5.46)

7.47 Staff should be familiar with the 'hard to reach' language pilot at Bradford. (5.47)

7.48 A children and young person's policy should be developed so that it goes beyond procedural compliance and actually addresses more fully the distinctive needs of young people in custody. (5.48)

7.49 Custody staff should receive training on the differential impact of custody on different groups of detainees, particularly women. (5.49)

7.50 Female detainees should routinely be offered a choice of sanitary products and sufficient stocks should be available. (5.50)

7.51 On arrival, all detainees should be asked if they have any dependency obligations. (5.51)

7.52 Detainees should be told that can see a solicitor free of charge and should not be discouraged from doing so. (5.52)

7.53 Primary carers should be able to visit juveniles held overnight. (5.53)

7.54 Detainees who are charged should be produced at court promptly. (5.54)

7.55 Detainees should be given clear and simple instructions about how they can make a complaint both during and after detention. (5.55)

7.56 When restraints are used, the custody record should detail all decisions and the reasons and timings. (5.56)

7.57 All copies of PACE code C should be legible and in good condition. (5.57)

7.58 Solicitors should always be able to obtain a copy of their client's custody record and given information about what has happened to detainees relating to bail, charges or cautions. (5.58)

7.59 The force should consider setting up a forum with defence solicitors for dealing with issues pertinent to the effective administration of legal advice and rights. (5.59)

7.60 A pre-release risk management policy should formalise measures taken to ensure that detainees are returned home safely. (5.60)

Healthcare

7.61 The information supplied by Serco Health to West Yorkshire Police should be accurate and auditable and reflect the actual time that detainees wait to be seen by a healthcare professional. (6.53)

7.62 There should be clinical governance arrangements that include the management, training, supervision and accountability of staff. (6.54)

7.63 Treatment rooms should provide conditions that maintain decency, privacy and dignity. (6.55)

7.64 Infection control guidelines should be implemented and adhered to. (6.56)

7.65 There should be a full resuscitation kit, including an automated external defibrillator, in each suite, which should be regularly checked and maintained. All staff (custody and health services) should know how to access and use it effectively. (6.57)

7.66 Nurses should be able to administer symptomatic relief for alcohol withdrawal. (6.58)

7.67 West Yorkshire Police should ensure that the protocols with the local mental health trusts are known by all staff and implemented appropriately to ensure that detainees with mental health problems are cared for appropriately. (6.59)

7.68 All clinical records should conform to professional guidance from health professionals' regulatory bodies. (6.60)

7.69 All clinical records should be held in accordance with Caldicott guidelines. (6.61)

7.70 Any contact with a health professional should be recorded in the custody record. (6.62)

7.71 The results of any clinical examination should be made available to the detainee or his/her lawyer (with consent) on request. (6.63)

7.72 There should be information sharing protocols with all appropriate agencies to ensure efficient sharing of relevant health and social care information. (6.64)

7.73 All medication should be stored safely and securely and disposed of safely if not consumed. (6.65)

7.74 There should be safe pharmaceutical stock management. (6.66)

Housekeeping points

Individual rights

7.75 Solicitors should not have to wait unreasonable amounts of time to see detainees. (5.61)

Healthcare

7.76 Health professionals completing the clinical custody record should record their professional qualifications. (6.67)

Good practice

Strategy

7.77 Themed supportive visits by the custody services department with representatives from estates, professional standards and the fingerprint departments involved all the necessary parties to identify and address issues on behalf of the force. The model used was thorough, searching and could easily be replicated in other forces. (3.34)

Individual rights

7.78 A pilot scheme offering conditional cautions for women was a good way to ensure that women received help and support while also diverting them from custody. (5.62)

Healthcare

7.79 The amount of time drug workers were available within each 24-hour period offered extensive cover to detainees. (6.68)

Appendix 1 - Inspection team

Sara Snell	HMIP Team leader
Paddy Craig	HMIC Inspector
Susan Fenwick	HMIP Inspector
Karen Dillon	HMIP Inspector
Hayley Folland	HMIP Inspector
Joss Crosbie	HMIP Inspector
Elizabeth Tysoe	Healthcare inspector
Steve Quinn	Healthcare Commission inspector
Michael Skidmore	Researcher

Appendix 2 – On-site police custody survey

Detainee survey methodology

A voluntary, confidential and anonymous survey of the detainee population, who were present in a police station in West Yorkshire, was carried out during this inspection.

The survey was conducted on the 27th and 28th of October 2008 on all available detainees; those willing, available and fit for interview. Police stations where surveying took place were Stainbeck, Pudsey, Bradford, Wakefield Wood Street and Leeds Bridewell. In total, 18 interviews were conducted.

Completion of the questionnaire was voluntary and was completed via an interview with either an Inspectorate researcher or inspector.

Methodology

Every interview was conducted with each detainee individually. This gave an opportunity to explain the independence of the Inspectorate and the purpose of the questionnaire, as well as to answer questions confidentially. All completed questionnaires remained confidential – only members of the Inspectorate saw them.

Respondents were not asked to put their names on the survey, but as their names were obvious and known on selection there was an opportunity for verification and follow-up of issues at the police station via inspection of their custody record.

Police Custody Survey

Section 1: About You

Q1 **What police station are you currently being held at?**

Q2 **What type of detainee are you?**

Police detainee	18
Prison lock-out (i.e. you were in custody in a prison before coming here)	0
Immigration detainee	0
I don't know	0

Q3 **How old are you?**

16 years or younger	3	*40-49 years*	2
17-21 years	4	*50-59 years*	1
22-29 years	4	*60 years or older*	0
30-39 years	4		

Q4 **Are you:**

Male	15
Female	3
Transgender/Transsexual	0

Q5 **What is your ethnic origin?**

White - British	16
White - Irish	1
White - Other	0
Black or Black British - Caribbean	1
Black or Black British - African	0
Black or Black British - Other	0
Asian or Asian British - Indian	0
Asian or Asian British - Pakistani	0
Asian or Asian British - Bangladeshi	0
Asian or Asian British - Other	0
Mixed Race - White and Black Caribbean	0
Mixed Race - White and Black African	0
Mixed Race - White and Asian	0
Mixed Race - Other	0
Chinese	0
Other ethnic group	0

Please specify:

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

Yes	2
No	15

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

None	11
Church of England	5
Catholic	0
Protestant	0
Other Christian denomination	1
Buddhist	0
Hindu	0
Jewish	0
Muslim	0
Sikh	0

Any other religion, please specify

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

Straight / Heterosexual	14
Gay / Lesbian / Homosexual	0
Bisexual	0
Other (please specify):	

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

Yes	3
No	15
Don't know	0

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

Yes	17
No	1

Section 2: Your experience of this custody suite

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

Q11 **How long have you been held at this police station?**

1 hour or less	0
More than 1 hour, but less than 6 hours	9
More than 6 hours, but less than 12 hours	3
More than 12 hours, but less than 24 hours	5
More than 24 hours, but less than 48 hours (2 days)	1
More than 48 hours (2 days), but less than 72 hours (3 days)	0
72 hours (3 days) or more	0

Q12 **Were you given information about your arrest and your entitlements when you arrived here?**

Yes	14
No	2
Don't know/Can't remember	2

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

Yes	14
No	3
I don't know what this is/I don't remember	1

Q14 **If your clothes have been taken away, have you been offered different clothing to wear?**

My clothes were not taken	15
I was offered a tracksuit to wear	3
I was offered an evidence suit to wear	0
I was offered a blanket	0

Q15 **Can you use a toilet when you need to?**

Yes	16
No	0
Don't Know	0

Q16 **If you have used the toilet here, were these things provided?**

	Yes	*No*
Toilet paper	7	10
Sanitary protection	*0*	*1*
Other (please specify):		

Q17 Have you shared a cell at this police station?

Yes	2
No	16

Q18 How would you rate the condition of your cell:

	Good	*Neither*	*Bad*
Cleanliness	4	6	8
Ventilation / Air Quality	9	6	3
Temperature	8	2	8
Lighting	11	6	1

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

Yes	14
No	4

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

Yes	5
No	12

Q21 Have you been held overnight?

Yes	9
No	9

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

Not held overnight	9
Pillow	0
Blanket	7
Nothing	2

Q23 Have you been offered a shower at this police station since being here?

Yes	1
No	17

Q24 Have you been offered any period of outside exercise whilst here?

Yes	0
No	18

Q25 Have you been offered anything to:

	Yes	*No*
Eat?	13	5
Drink?	16	2

Q26 Was the food/drink you received suitable for your dietary requirements?

I have not had any food or drink	1
Yes	8
No	0

Q27 If you smoke, have you been offered anything to help you cope with the smoking ban here?

I do not smoke	2
I have been allowed to smoke	0
I have not been offered anything to cope with not smoking	11
I have been offered nicotine gum	0
I have been offered nicotine patches	0
I have been offered nicotine lozenges	0

Q28 Have you been offered anything to read?

Yes	2
No	15

Q29 Has someone been informed of your arrest?

Yes 6
No 6
I don't know 2
I didn't want to inform anyone 4

Q30 Were you offered a free telephone call?

Yes 6
No 12

Q31 If you were denied a free phone call, was a reason for this offered?

My phone call was not denied 6
Yes 0
No 4

Q32 Do you have any concerns about the following, whilst you are in police custody:

	Yes	*No*
Who is taking care of your children	0	18
Contacting your partner, relative or friend	6	12
Contacting your employer	1	17
Where you are going once released	4	14

Q33 Have you been interviewed by police officials about your case yet?

Yes 6
No ..... 12 If No, go to Q35

Q34 Were any of the following people present when you were interviewed?

	Yes	*No*	*Not needed*
Solicitor	3	1	2
Appropriate Adult	1	0	5
Interpreter	0	0	6

Q35 How long did you have to wait (or how long have you been waiting) for your solicitor?

I have not requested a solicitor 10
2 hours or less 1
Over 2 hours but less than 4 hours 2
4 hours or more 5

Q36 Have you been officially charged?

Yes 1
No 13
Don't Know 4

Q37 How long have you been in custody *after* being charged?

I have not been charged yet 13
1 hour or less 0
More than 1 hour, but less than 6 hours 2
More than 6 hours, but less than 12 hours 0
12 hours or more 0

Q38 Do you have any other comments about your time in custody here?

Section 3: Safety

Q39 Do you feel safe here?

Yes 14
No 3

Q40 **Has another detainee or a member of staff victimised (insulted or assaulted) you here?**

Yes	1
No	16

Q41 **If you have felt victimised, what did the incident involve? (Please tick all that apply)**

I have not been victimised	16	*Because of your crime*	0
Insulting remarks (about you, your family or friends)	0	*Because of your sexuality*	0
Physical abuse (being hit, kicked or assaulted)	0	*Because you have a disability*	0
Sexual abuse	0	*Because of your religion/religious beliefs*	0
Your race or ethnic origin	0	*Because you are from a different part of the country than others*	0
Drugs	1		

Please describe:

Q42 **Have you been handcuffed or restrained whilst in this police custody suite?**

Yes	5
No	11

Q43 **Have you been injured whilst in police custody, in a way that you feel was not your fault?**

Yes	1
No	16

Q44 **Have you been told how to make a complaint about your treatment here, if you need to?**

Yes	2
No	14

Q45 **Do you have any other comments about safety in this police custody suite?**

Section 4: Healthcare

Q46 **Are you currently on any medication?**

Yes	4
No	13

Q47 **Have you been able to continue taking your medication whilst here?**

Not currently taking medication	13
Yes	1
No	3

Q48 **Did someone explain your entitlements to see a healthcare professional, if you need to?**

Yes	4
No	10
Don't know	3

Q49 **Have you been seen by the following healthcare professionals during your time here?**

	Yes	*No*
Doctor	7	11
Nurse	0	16
Paramedic	0	16
Psychiatrist	0	16

Q50 **Are you able to see a healthcare professional of your own gender?**

Yes	2
No	0
Don't know	10

Q51 **Do you have any drug or alcohol problems?**

Yes 5
No 12

Q52 **Have you seen, or been offered the chance to see a drug or alcohol support worker?**

I don't have any drug/alcohol problems 12
Yes 0
No 5

Q53 **Have you been offered relief or medication for your immediate symptoms?**

I don't have any drug/alcohol problems 12
Yes 3
No 2

Q54 **Please rate the quality of your healthcare whilst in police custody:**

	I have not been seen by health -care	*Very Good*	*Good*	*Neither*	*Bad*	*Very Bad*
Quality of Healthcare	11	1	2	1	0	1

Q55 **Do you have any specific <u>physical</u> healthcare needs?**

No 11
Yes 5
Please specify:

Q56 **Do you have any specific <u>mental</u> healthcare needs?**

No 12
Yes 4
Please specify:

Appendix 3 – Prisoner police custody survey

Prisoner survey methodology

A voluntary, confidential and anonymous survey of the prisoner population, who had been through a police station in West Yorkshire, was carried out for this inspection. The results of this survey formed part of the evidence-base for the inspection write-up.

Choosing the sample size

The survey was conducted on the 22nd of October 2008. A list of potential prisoners, who had been through West Yorkshire police stations, were created listing those who have come from the Magistrates courts of Huddersfield, Dewsbury, Pudsey, Wakefield, Bradford, Pontefract or Leeds, which receive those charged at West Yorkshire stations.

Selecting the sample

Hundreds of prisoners were identified and due to time constraints only 82 were approached from the list which indicated contact with West Yorkshire police. 20 could not be found, as they had either been released or relocated. From those approached 11 prisoners reported being held in police stations outside of West Yorkshire, or outside of our one month time period.

On the day, the questionnaire was given to 50 detainees and one prisoner refused to take a survey.

Completion of the questionnaire was voluntary. If a prisoner had literacy problems they were offered a joint interview by the research team and HMIC. No prisoners required an interview.

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.

Respondents were not asked to put their names on their questionnaire, but were told that if they put their names on the questionnaire it may aid inspection as their responses can be verified.

Response rates

In total, 45 (90%) respondents completed and returned their questionnaires.
However, 2 (4%) of those who returned a survey, returned them blank or spoiled.

One prisoner (2%) refused to accept a survey.

Police Custody Survey

Section 1: About You

Q1 **What police station were you last held at?**
See methodology

Q2 **What type of detainee were you?**

Police detainee	86%
Prison lock-out (i.e. you were in custody in a prison before coming here)	2%
Immigration detainee	0%
I don't know	7%

Q3 **How old are you?**

16 years or younger	0%	*40-49 years*	16%
17-21 years	2%	*50-59 years*	5%
22-29 years	51%	*60 years or older*	0%
30-39 years	26%		

Q4 **Are you:**

Male	100%
Female	0%
Transgender/Transsexual	0%

Q5 **What is your ethnic origin?**

White - British	77%
White - Irish	0%
White - Other	0%
Black or Black British - Caribbean	9%
Black or Black British - African	5%
Black or Black British - Other	0%
Asian or Asian British - Indian	0%
Asian or Asian British - Pakistani	5%
Asian or Asian British - Bangladeshi	2%
Asian or Asian British - Other	0%
Mixed Race - White and Black Caribbean	0%
Mixed Race - White and Black African	0%
Mixed Race - White and Asian	2%
Mixed Race - Other	0%
Chinese	0%
Other ethnic group	0%

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

Yes	7%
No	86%

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

None	23%
Church of England	44%
Catholic	14%
Protestant	0%
Other Christian denomination	2%
Buddhist	2%
Hindu	0%
Jewish	0%
Muslim	7%
Sikh	0%

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

Straight / Heterosexual	93%
Gay / Lesbian / Homosexual	0%
Bisexual	2%

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

Yes	21%
No	74%
Don't know	2%

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

Yes	93%
No	5%

Section 2: Your experience of this custody suite

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

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

1 hour or less	0%
More than 1 hour, but less than 6 hours	7%
More than 6 hours, but less than 12 hours	0%
More than 12 hours, but less than 24 hours	28%
More than 24 hours, but less than 48 hours (2 days)	19%
More than 48 hours (2 days), but less than 72 hours (3 days)	33%
72 hours (3 days) or more	14%

Q12 **Were you given information about your arrest and your entitlements when you arrived there?**

Yes	74%
No	16%
Don't know/Can't remember	7%

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

Yes	47%
No	37%
I don't know what this is/I don't remember	14%

Q14 **If your clothes were taken away, were you offered different clothing to wear?**

My clothes were not taken	44%
I was offered a tracksuit to wear	33%
I was offered an evidence suit to wear	9%
I was offered a blanket	9%

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

Yes	81%
No	16%
Don't Know	0%

Q16 **If you have used the toilet there, were these things provided?**

	Yes	*No*
Toilet paper	35%	60%
Sanitary protection	*5%*	*28%*

Q17 Did you share a cell at the police station?

Yes	9%
No	84%

Q18 How would you rate the condition of your cell:

	Good	*Neither*	*Bad*
Cleanliness	26%	19%	56%
Ventilation / Air Quality	23%	9%	53%
Temperature	12%	14%	63%
Lighting	40%	16%	30%

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

Yes	60%
No	37%

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

Yes	14%
No	86%

Q21 Were you held overnight?

Yes	91%
No	9%

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

Not held overnight	9%
Pillow	7%
Blanket	60%
Nothing	23%

Q23 Were you offered a shower at the police station?

Yes	5%
No	95%

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

Yes	2%
No	98%

Q25 Were you offered anything to:

	Yes	*No*
Eat?	84%	12%
Drink?	86%	9%

Q26 Was the food/drink you received suitable for your dietary requirements?

I did not have any food or drink	12%
Yes	40%
No	49%

Q27 If you smoke, were you offered anything to help you cope with the smoking ban there?

I do not smoke	12%
I was allowed to smoke	4%
I was not offered anything to cope with not smoking	70%
I was offered nicotine gum	4%
I was offered nicotine patches	4%
I was offered nicotine lozenges	4%

Q28 Were you offered anything to read?

Yes	7%
No	93%

Q29 Was someone informed of your arrest?

Yes	35%
No	37%
I don't know	12%
I didn't want to inform anyone	16%

Q30 Were you offered a free telephone call?

Yes	37%
No	63%

Q31 If you were denied a free phone call, was a reason for this offered?

My phone call was not denied	37%
Yes	0%
No	47%

Q32 Did you have any concerns about the following, whilst you were in police custody:

	Yes	*No*
Who was taking care of your children	16%	44%
Contacting your partner, relative or friend	56%	33%
Contacting your employer	9%	47%
Where you were going once released	16%	49%

Q33 Were you interviewed by police officials about your case?

Yes	74%
No	23%

Q34 Were any of the following people present when you were interviewed?

	Yes	*No*	*Not needed*
Solicitor	63%	9%	5%
Appropriate Adult	0%	12%	21%
Interpreter	5%	12%	19%

Q35 How long did you have to wait for your solicitor?

I did not requested a solicitor	26%
2 hours or less	16%
Over 2 hours but less than 4 hours	9%
4 hours or more	47%

Q36 Were you officially charged?

Yes	74%
No	26%
Don't Know	0%

Q37 How long were you in police custody *after* being charged?

I have not been charged yet	26%
1 hour or less	9%
More than 1 hour, but less than 6 hours	0%
More than 6 hours, but less than 12 hours	12%
12 hours or more	53%

Section 3: Safety

Q39 Did you feel safe there?

Yes	60%
No	37%

Q40 Had another detainee or a member of staff victimised (insulted or assaulted) you there?

Yes	47%
No	51%

Q41 **If you have felt victimised, what did the incident involve? (Please tick all that apply)**

I have not been victimised	51%	*Because of your crime*	18%
Insulting remarks (about you, your family or friends)	20%	*Because of your sexuality*	0%
Physical abuse (being hit, kicked or assaulted)	10%	*Because you have a disability*	3%
Sexual abuse	3%	*Because of your religion/religious beliefs*	0%
Your race or ethnic origin	4%	*Because you are from a different part of the country than others*	0%
Drugs	10%		

Q42 **Were you handcuffed or restrained whilst in the police custody suite?**

Yes	51%
No	47%

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

Yes	23%
No	77%

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

Yes	14%
No	81%

Section 4: Healthcare

Q46 **When you were in police custody were you on any medication?**

Yes	56%
No	44%

Q47 **Were you able to continue taking your medication whilst there?**

Not taking medication	44%
Yes	23%
No	30%

Q48 **Did someone explain your entitlements to see a healthcare professional, if you needed to?**

Yes	28%
No	65%
Don't know	2%

Q49 **Were you seen by the following healthcare professionals during your time there?**

	Yes	*No*
Doctor	56%	35%
Nurse	19%	49%
Paramedic	0%	53%
Psychiatrist	0%	53%

Q50 **Were you able to see a healthcare professional of your own gender?**

Yes	30%
No	47%
Don't know	23%

Q51 **Did you have any drug or alcohol problems?**

Yes	72%
No	28%

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

I didn't have any drug/alcohol problems	28%

Yes 26%
No 47%

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

I didn't have any drug/alcohol problems 28%
Yes 26%
No 47%

Q54 **Please rate the quality of your healthcare whilst in police custody:**

	I was not seen by health -care	*Very Good*	*Good*	*Neither*	*Bad*	*Very Bad*
Quality of Healthcare	14%	5%	7%	12%	19%	40%

Q55 **Did you have any specific <u>physical</u> healthcare needs?**

No 58%
Yes 40%

Q56 **Did you have any specific <u>mental</u> healthcare needs?**

No 60%
Yes 33%

<u>Section 5: Prison Lock-Out Information</u>

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

Q58 **Were you told that you would be held in a police station, rather than a prison, before you arrived there?**

Yes 26%
No 37%

Q59 **How long did you spend in the escort van before arriving there?**

Less than 1 hour 33%
More than 1 hour, but less than 2 hours 7%
More than 2 hours, but less than 3 hours 7%
More than 3 hours, but less than 4 hours 0%
More than 4 hours 7%

Q60 **Were you offered the chance to let family/friends know where you were?**

Yes 19%
No 35%

Q61 **Did your property come with you to the police station?**

Yes 35%
No 16%
I don't know 5%

Q62 **On average, how much time were you able to spend out of your police cell each day?**

I was not able to spend any time out of my police cell 40%
Less than 1 hour 16%
More than 1 hour, but less than 2 hours 0%
More than 2 hours, but less than 3 hours 0%
More than 3 hours, but less than 4 hours 0%
More than 4 hours 0%

Prisoner Survey Responses for West Yorkshire Police 2008

Prisoner Survey Responses (Missing data has 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

		West Yorkshire	Police custody comparator
	Any percent highlighted in green is significantly better		
	Any percent highlighted in blue is significantly worse		
	Any percent highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
Number of completed questionnaires returned		43	135
SECTION 1: General Information			
2	Are you a Police detainee?	**90%**	**84%**
3	Are you under 21 years of age?	**2%**	**5%**
4	Are you Transgender/Transsexual?	**0%**	**2%**
5	Are you from a minority ethnic group? (including all those who did not tick White British, White Irish or White other categories)	**23%**	**41%**
6	Are you a foreign national?	**8%**	**17%**
7	Are you Muslim?	**8%**	**9%**
8	Are you homosexual/gay or bisexual?	**2%**	**3%**
9	Do you consider yourself to have a disability?	**21%**	**18%**
10	Have you been held in police custody before?	**95%**	**87%**
SECTION 2: Your experience of this custody suite			
For the most recent journey you have made either to or from court or between prisons:			
11	Were you held at the police station for over 24hours?	**65%**	**65%**
12	Were you given information about your arrest and entitlements when you arrived?	**76%**	**71%**
13	Were you told about PACE?	**48%**	**57%**
14	If your clothes were taken away, were you given a tracksuit to wear?	**64%**	**33%**
15	Could you use a toilet when you needed to?	**83%**	**84%**
16	If you did use the toilet, was toilet paper provided?	**37%**	**56%**
17	Did you share a cell at the station?	**10%**	**4%**
18	Would you rate the condition of your cell, as 'good' for:		
18a	Cleanliness?	**26%**	**28%**
18b	Ventilation/air quality?	**27%**	**15%**
18c	Temperature?	**13%**	**12%**
18d	Lighting?	**46%**	**42%**
19	Was there any graffiti in your cell when you arrived?	**62%**	**54%**
20	Did staff explain the correct use of the cell bell?	**14%**	**24%**
21	Were you held overnight?	**91%**	**87%**
22	If you were held overnight, were you given no clean items of bedding?	**23%**	**41%**
23	Were you offered a shower?	**5%**	**9%**
24	Were you offered a period of outside exercise?	**2%**	**9%**

Key to tables

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	Percentages which are not highlighted show there is no significant difference		
25a	Were you offered anything to eat?	**88%**	**74%**
25b	Were you offered anything to drink?	**90%**	**78%**
26	If you received food/drink, was it suitable for your dietary requirements?	**45%**	**36%**
27	For those who smoke: were you offered nothing to help you cope with the ban there?	**83%**	**79%**
28	Were you offered anything to read?	**7%**	**15%**
29	Was someone informed of your arrest?	**35%**	**44%**
30	Were you offered a free telephone call?	**37%**	**55%**
31	If you were denied a free call, was no reason given?	**100%**	**72%**
32	Did you have ay concerns about:		
32a	Who was taking care of your children?	**27%**	**27%**
32b	Contacting your partner, relative or friend?	**63%**	**60%**
32c	Contacting your employer?	**17%**	**29%**
32d	Where you were going once released?	**25%**	**39%**
34	If you were interviewed were the following people present:		
34a	Solicitor	**82%**	**73%**
34b	Appropriate adult	**0%**	**10%**
34c	Interpreter	**13%**	**7%**
35	If you requested your solicitor, did you wait over 4 hours for them?	**65%**	**67%**
37	If you were charged, were you held over an hour in custody after being charged?	**88%**	**96%**

Key to tables

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	Any percent highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
SECTION 3: Safety			
39	Did you feel unsafe?	**38%**	**44%**
40	Has another detainee or a member of staff victimised you?	**48%**	**39%**
41	If you have felt victimised, what did the incident involve?		
41a	Insulting remarks (about you, your family or friends)	**33%**	**27%**
41b	Physical abuse (being hit, kicked or assaulted)	**17%**	**20%**
41c	Sexual abuse	**5%**	**3%**
41d	Your race or ethnic origin	**7%**	**8%**
41e	Drugs	**17%**	**15%**
41f	Because of your crime	**31%**	**19%**
41g	Because of your sexuality	**0%**	**1%**
41h	Because you have a disability	**5%**	**3%**
41i	Because of your religion/religious beliefs	**0%**	**5%**
41j	Because you are from a different part of the country than others	**0%**	**3%**
42	Were you handcuffed or restrained whilst in the police custody suite?	**52%**	**49%**
43	Were you injured whilst in police custody, in a way that you feel is not your fault?	**23%**	**32%**
44	Were you told how to make a complaint about your treatment?	**15%**	**15%**

Key to tables

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	Any percent highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
SECTION 4: Healthcare			
46	Were you on any medication?	**56%**	**47%**
47	For those who were on medication: were you able to continue taking your medication?	**44%**	**33%**
48	Did someone explain your entitlement to see a healthcare professional, if you needed to?	**29%**	**37%**
49	Were you seen by the following healthcare professionals during your time in police custody:		
49a	Doctor	**62%**	**52%**
49b	Nurse	**28%**	**17%**
49c	Paramedic	**0%**	**3%**
49d	Psychiatrist	**0%**	**5%**
50	Were you able to see a healthcare professional of your own gender?	**30%**	**28%**
51	Did you have any drug or alcohol problems?	**72%**	**61%**
For those who had drug or alcohol problems:			
52	Did you see, or were offered the chance to see a drug or alcohol support worker?	**36%**	**42%**
53	Were you offered relief medication for your immediate symptoms?	**36%**	**26%**
54	For those who had been seen by healthcare, would you rate the quality as good/very good?	**14%**	**24%**
55	Do you have any specific physical healthcare needs?	**41%**	**36%**
56	Do you have any specific mental healthcare needs?	**35%**	**24%**