Report on an inspection visit to police custody suites in Avon and Somerset

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by

HM Inspectorate of Prisons and

HM Inspectorate of Constabulary

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Ashley House
Monck Street
London SW1P 2BQ
England

Contents

1. Introduction

This report is part of a programme of inspections of police custody carried out jointly by our two inspectorates. These inspections form a key part of the joint work programme of the criminal justice inspectorates and contribute to the United Kingdom's response to its international obligation to ensure regular and independent inspection of all places of detention.[1] The inspections look at force-wide strategies, detainee treatment and conditions, respect for their individual rights and their health care provision.

Avon and Somerset Police had 10 designated custody suites working 24 hours a day and a further seven non-designated suites – providing a total capacity of 130 cells force-wide. During this announced inspection, all suites were visited with the main concentration on the designated facilities. The inspection was informed by a survey at HMP Bristol of prisoners who had previously been held in Avon and Somerset police cells.

We found good engagement between the force and partners, although relationships with the mental health trusts were challenging. Relations with the Police Authority were constructive and there was a very active independent custody visitor scheme.

Staff were respectful to detainees and the needs of juveniles were generally well met but there was limited acknowledgement of the differential needs of female detainees. Booking-in areas offered reasonable privacy and risk assessments on arrival were thorough, although many elements of day-to-day care were dependent on detainees making a request rather than being provided with basic services as a matter of routine. Pre-release risk assessments were often cursory or not completed at all.

The physical state of most suites was poor and environments were shabby and dirty. There were multiple safety issues and most cells had ligature points. Health and safety checks were inadequate and use of force was poorly monitored.

A large number of immigration detainees were held but interpreting services appeared adequate. Appropriate adults were provided for children but the service for vulnerable adults varied across the force, leading to long delays in custody for some detainees. Handling and management of DNA and forensic samples within custody appeared very good.

The provision of health services was generally good although contracted targets for response times were not met. The quality and cleanliness of medical rooms varied and some were poor. Medical facilities at the non-designated suites were poor. Arrangements for detainees with mental health problems were very mixed and there were still a relatively large number of people detained in police cells as a 'place of safety' under the Mental Health Act.

This inspection identified some positive aspects of custody provision in Avon and Somerset. However, this report sets out a number of recommendations that we believe will assist the Chief Constable and the Police Authority to improve the quality of custody provision. We

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

expect them to consider these in the wider context of force priorities and resourcing, and to provide us with an action plan in due course.

Sir Denis O'Connor
HM Chief Inspector of Constabulary

Nick Hardwick
HM Chief Inspector of Prisons

November 2010

2. Background and key findings

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

2.2 At the time of this announced inspection, Avon and Somerset Police had 10 primary custody suites designated under PACE for the reception of detainees across the county. These were located in Bristol at Southmead (10 cells), Broadbury Road (12) and Trinity Road (29), and Staple Hill (nine) covered the South Gloucestershire district. There were suites at Bath (nine), Weston-super-Mare (12), Bridgwater (eight), Taunton (nine), Minehead (seven) and Yeovil (13). The suites operated 24 hours a day and dealt with detainees arrested as a result of mainstream policing. There were also non-designated suites with a total of 12 functioning cells at Cribbs Causeway (The Mall), Radstock, Nailsea, Frome, Wells, Chard and Wincanton. All suites were visited during this inspection. A survey of prisoners at HMP Bristol who had formerly been detained at custody suites in the force area was conducted by an HM Inspectorate of Prisons researcher and inspector to obtain additional evidence (see appendix III).

2.3 The force cell capacity was 130. In the year from August 2009 to July 2010, 46,112 detainees had been dealt with across all custody suites. An average of 40 detainees a month had been detained for immigration matters.

2.4 Comments in this report refer to all suites unless specifically stated otherwise.

Strategy

2.5 There was good engagement between the force and partners at the strategic level, although relationships with mental health trusts were an ongoing challenge. The estate had suffered from chronic under-investment and, although there were longer-term plans for improvements, the force faced real challenges to make it safe. Relationships with the Police Authority were good and there was a very active independent custody visitor scheme. Day-to-day management of custody was devolved to districts and overseen by the central criminal justice unit. Management structures in districts were confusing. Most custody staff were permanent and training arrangements were adequate. Some staff had worked in custody for many years and therefore risked becoming desensitised and there were concerns regarding staffing ratios. Information about near misses and lessons learned were being disseminated but not all staff were aware of this. Dip sampling of custody records was taking place. There was limited oversight of use of force in custody and extremely limited data analysis.

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

Treatment and conditions

2.6 Staff demonstrated respectful relationships and interactions with detainees. The approach to dealing with juveniles was generally good but there was limited acknowledgement of the specific needs of female detainees. Facilities and access for detainees with physical disabilities were limited. Materials for the observance of most major faith groups were provided. Booking-in areas offered reasonable privacy and risk assessments on arrival were thorough. The quality of shift handovers varied. Staff generally had an appropriate focus on the safety of detainees but many cell call bells were routinely muted. Staff sought to use de-escalation techniques with difficult or violent detainees.

2.7 The physical environment of most suites was poor. There were multiple safety issues in cells. The estate as a whole was tired, shabby and dirty, although graffiti was reasonably well controlled. Arrangements for health and safety checks were inadequate but staff were generally clear about fire evacuation procedures. Detainees were routinely provided with a blanket and mattress, although some of the latter were dirty. Toilet paper was not routinely provided and showers were rarely offered. Where clothing was removed for forensic or other reasons, paper suits were usually the only alternative provided. Food and drink were readily available but the quality of meals was poor. Outside exercise and visits were rarely facilitated.

Individual rights

2.8 Custody sergeants critically reviewed the reasons for detention and encouraged detainees to take legal advice. Detainees were given a rights and entitlement leaflet available in a range of languages. A large number of detainees were held for immigration matters and delays were sometimes evident but interpreting services were used when needed. Staff did not routinely ask about any dependants when detainees arrived in custody. Pre-release risk assessments were often cursory or not completed. PACE was adhered to. Appropriate adults were provided for juveniles but provision for vulnerable adults needed to be developed. The management and storage of PACE DNA and forensic samples was very good. Court cut-off times were often too early. Detainees were not told how to make a complaint but any complaints made were referred to the duty inspector.

Health care

2.9 Medacs delivered the primary health care service. Clinical governance arrangements were adequate but some management arrangements were underdeveloped. Response times were monitored by the contractor and some contractual targets were not being met. Custody staff were particularly unhappy about this issue. The quality and cleanliness of medical rooms was mixed and some were poor. Arrangements for the management of medications were adequate but some staff were unclear about a new storage system. Resuscitation equipment was available at all the main suites but often poorly located and few custody staff had been trained in its use. Medical facilities in the non-designated suites were poor.

2.10 Police made efforts to collect prescribed medications from homes. Different systems for storing clinical records were used and not all forensic medical examiners could access the NSPIS (national strategy for police information systems) IT system. There was good support to detainees with substance use issues. Not all drug workers supported alcohol users but could signpost to community alcohol services. Methadone maintenance was supported once certain criteria were met.

2.11 Arrangements for detainees with mental health problems were extremely mixed. Some progress had been made in opening specific hospital beds for detainees held under Section 136 of the Mental Health Act (1983) to divert them from police custody but these were limited and a large number were still held. This was a particular problem in the Avon area. Many staff were unclear about the current arrangements and there was little in place to address the broader mental health issues of detainees.

Main recommendations

2.12 The force should address immediately the significant safety issues presented by the multiple ligature points in most cells.

2.13 The force should collate the use of force and monitor it locally and at force-wide level, for example by ethnicity, location and officer involved.

2.14 Cells and detainee areas should be kept clean.

2.15 Pre-release risk assessments should be of sufficient quality and depth to identify any areas of concern and outline the action taken to address them.

2.16 Police custody should be used as a place of safety for Section 136 assessments only in extreme cases.

3. Strategy

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

3.1 Avon and Somerset Police had a clear strategic structure for custody. An assistant chief constable (ACC) held overall responsibility, while actual provision of custodial services was overseen by a chief superintendent in charge of the criminal justice department. A force custody manager (FCM) was in turn responsible for ensuring the corporate delivery of custody at a district level, including the provision of custody policies, force protocols and central oversight of all custody suites. However, the day-to-day operation was devolved to six territorial districts that owned and operated the custody suites, including providing and managing all custody staff working in them. Each district had a police inspector who acted as custody manager, some of whom had other responsibilities not related to custody. This command structure meant that custody managers had to answer to both their districts and headquarters. The lines of command were also inconsistent in that custody staff at Bristol were line-managed by custody managers while those in outlying districts were line managed by section inspectors.

3.2 The FCM chaired a six-weekly heads of custody meeting attended by the district custody managers and representatives from the estates department and Medacs, which provided the health care professionals in custody suites. The Independent Custody Visitor Coordinator from the Police Authority also attended the meeting.

3.3 Most custody staff were permanent and trained to an approved standard, although refresher training had been introduced only recently. There was no limit on how long staff worked in the custody suites and some had been in post for many years, with the potential for them to become desensitised to conditions in the custody suites. There were sometimes not enough sergeants or detention officers for the number of cells and detainees, which exposed detainees, staff and the force to unnecessary risks at particularly busy times.

3.4 The chief constable chaired the local criminal justice board (LCJB) and the ACC sat on its criminal justice and custody sub-group. This level of involvement of chief police officers had encouraged greater engagement of most strategic partners, although some partner health organisations remained a challenge (see section on health care). The fact that the force was an offender management pathfinder area had also helped develop good relationships between the various partners.

3.5 Relationships with the Police Authority (PA) were described as good and supportive and were reflected in the PA's heavy investment in the proposed private finance initiative (PFI) builds (see below). A PA lead for custody held quarterly meetings with the chief superintendent of criminal justice to discuss performance, had regular contact with the ACC and linked into the LCJB. Performance and audits that presented risks, including those by external auditors, were kept in the force risk register. PA members had visited other forces to examine their custody provision. The PA operated an active independent custody visitors (ICV) scheme. This had 80 members, with plans to increase to 90. The ICVs were broadly supportive of the police but were not afraid to challenge them on behalf of detainees when necessary. The PA said it was proud of the progress made with the scheme.

3.6 Reductions in Home Office financial grants in recent years meant the force had faced tough challenges when allocating resources (termed 'damping down'). Even without such challenges, there had clearly been a sustained and chronic under-investment in the Avon and Somerset custody suites. Most cells contained multiple ligature points and were therefore inherently unsafe (see also section on treatment and conditions). In September 2007, the National Policing Improvement Agency (NPIA) had recorded that 'the force has recognised the need to develop its custody estate and new builds are to be introduced over the next three to five years'. However, this timetable had already slipped as the force had submitted plans for three large PFI custody suite builds to be completed between 2014 and 2018. It was therefore vital that a shorter-term strategy be produced to address the significant safety issues identified and manage the risks they presented.

3.7 Learning points from adverse incidents were circulated to staff through the force intranet but not all staff were aware of this or knew how to access the information. Dip samples of custody records were by themes, such as mental health issues, appropriate adults or individual rights, but there were discrepancies between custody managers in the numbers completed.

3.8 Avon and Somerset Police had made the decision that guidance on monitoring and collating the use of force was too bureaucratic and had therefore departed from it. This was not consistent with NPIA guidance or the Association of Chief Police Officers policy on the use of force. As a result, the force could not say how much force was being used by staff or against whom and relied instead on the professional standards department to identify any trends. This level of monitoring was inadequate as it was based solely on recorded complaints and not all detainees subject to the use of force were likely to complain.

Recommendation

3.9 The force should review the current model of delivering custody services, management structures and staffing levels to ensure the care and welfare of detainees.

4. Treatment and conditions

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

Respect

4.1 Most detainees arrived at custody suites in police cars, although vans were used if a detainee was violent or disruptive. Those arriving at custody suites in the Bristol area had short journeys but others who went to the more remote suites had journeys of up to an hour. Detainees were usually escorted to court in cellular vans operated by the escorting contractor. The vans we inspected were clean and well maintained. Escorting and custody staff reported good working relationships. Detainee escort records were complete and detailed any risk factors. Custody staff were polite and respectful to detainees, usually using their first or preferred name. Most custody suites had a single custody sergeant. Detainees were booked in one at a time, allowing reasonable privacy, although the booking-in area at Southmead was crowded and noisy during the inspection because nine staff had congregated in the small office immediately behind the charge desk.

4.2 Many staff demonstrated an understanding of the distinct needs of children and young people, using age-appropriate language. Any female under the age of 17 was allocated a nominated female officer who was not usually present in the custody suite but was introduced to the detainee and called on to speak to her at her request or the request of the custody sergeant. There was little to occupy young people and staff did not have an understanding of the specific issues relating to strip searching of young people. Notices in some custody suites stated that female detainees could ask to see a female member of staff but little, if anything, else was done to meet their specific needs in custody.

4.3 Staff had recently been given an IT-based diversity training package and had an adequate appreciation of cultural and religious differences. Each suite contained a range of materials to support observance of the main religious groups detained. A telephone interpreting service and interpreters were used to communicate with non-English speakers. Telephone interpreting was usually used for booking in and face-to-face interpreters for interviews, charging and cautions. Custody sergeants used telephone interpreters effectively.

4.4 There were few adaptations for detainees with physical disabilities or mobility problems. Only Trinity Road was equipped with an adapted cell. Not all custody suites had a hearing loop but a DVD helping custody staff to explain the process was available in some suites and there was a list of staff trained in sign language.

Recommendations

4.5 There should be clear policies and procedures to ensure that the distinct needs of juveniles and females in custody are met.

4.6 All the main custody suites should provide better access and communication for detainees with disabilities.

Housekeeping point

4.7 Custody sergeants should ensure that only staff and visitors directly involved with a detainee being booked in are present around the booking in desk.

Safety

4.8 Detainees being booked in were risk assessed by the custody sergeant using all the information available, including that provided by arresting officers and their own observations. The risk assessments we observed, including in our custody record analysis, were thorough and detainees assessed as a risk to themselves were put on more frequent or constant observation. Most custody suites had at least one cell covered by closed-circuit television (CCTV) and used this for detainees who were drunk, deemed at risk of self-harm or suicide or had identified or suspected mental or physical health issues. Custody sergeants were aware of the risk of self-harm and suicide in custody and took an appropriately cautious approach, frequently using constant observation and/or rousing while assessing the detainee's behaviour over time. Staff carried safety knifes to use as ligature cutters on their belts or attached to cell keys. These were flimsy and one officer described how his had come apart exposing the blade when used. Not all shifts had built in time for a staff handover, although staff usually arrived early for their shift for this to take place. The quality of handovers varied, although those we saw were mostly good.

Housekeeping points

4.9 Staff should be issued with robust ligature cutters.

4.10 An overlap period should be built into all shifts to allow an effective handover between staff.

Use of force

4.11 All staff we spoke to said they had been trained in the use of force and had annual refresher training. We observed appropriate de-escalation of use of force, with handcuffs usually removed as soon as detainees arrived at the police station. When detainees remained handcuffed on arrival at the charge desk, custody sergeants asked officers why they had not been removed earlier.

Physical conditions

4.12 Most cells contained multiple ligature points (see section on strategy). These included issues with cell doors, viewing hatches, T-bar handles and toilets, all of which were pointed out to the force during the inspection. The physical environment of most suites was poor and particularly dirty, with some cells containing food, phlegm, blood and excrement stains. There was some graffiti scratched into wooden plinths and doors, although custody staff regularly checked cells and painted over it where possible. Health and safety walk-throughs were unsophisticated, inadequate and not compliant with SDHP in that they either did not adequately cover the issues needed or were not carried out at regular intervals.

4.13 The no smoking policy was rigorously enforced for staff and detainees. Nicotine replacement lozenges were available at some suites but staff were unsure about the correct procedures for issuing them to detainees.

4.14 Staff were aware of evacuation procedures. Most suites had a stock of evacuation handcuffs in a locked cabinet but there were not enough at Broadbury Road and staff there did not know where they were kept. Arrangements at Trinity Road were potentially unsatisfactory as they involved detainees being evacuated to a narrow caged area immediately adjacent to the rear of the custody suite.

4.15 All cells had a call button but staff did not always tell new arrivals how to use it. In our prison survey, only 10% of respondents said staff had explained the correct use of the cell bell. The systems at Bath and Yeovil were not audible and we observed those at Southmead, Trinity Road and Minehead being muted. The systems were checked weekly at most suites and daily at others but were not routinely checked whenever a detainee was located in a cell.

Recommendations

4.16 Health and safety walk-throughs should be more robust, thorough and capable of withstanding scrutiny.

4.17 Cell call bells should be audible and should be muted only in exceptional circumstances.

Housekeeping points

4.18 Custody suites should have enough handcuffs readily available to evacuate all detainees safely.

4.19 Custody staff and police officers locating detainees in cells should routinely check that the cell call button is working and explain its use.

Personal comfort and hygiene

4.20 All cells contained a plastic-covered mattress and some, but not all, detention officers used antiseptic wipes to clean these after use. We found some that were dirty. All detainees were offered a clean blanket and most were given an extra blanket to use as a pillow.

4.21 Shower areas were reasonably clean and most were adequately screened. However, in our custody record analysis, only one detainee had been given a shower, while six detainees had gone to court and two to police stations out of the area without being offered one. One detainee had been held for 32 hours without being offered a shower. In our prison survey, only 6% of respondents said they had been offered a shower. Toothbrushes, toothpaste, razors and shaving foam were available on request. Women and girls were not routinely offered a female hygiene pack on arrival, although notices in some booking-in areas indicated that sanitary supplies were available on request. Detainees in some suites were given a supply of toilet paper while others had to request it. Cells covered by CCTV at Trinity Road did not have the toilet obscured.

4.22 All suites had a supply of plimsolls, tracksuit bottoms and T-shirts in a range of sizes. Underwear was not a standard stock item but detention officers at Bath had bought a small stock of women's underwear. Custody sergeants usually allowed replacement clothing to be issued only to detainees going to court or being released. Detainees whose clothing had been seized for evidential purposes or removed due to soiling were given a white paper suit and

foam slippers and encouraged to arrange for family or friends to bring in replacement clothing where possible.

Recommendations

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

4.24 Unless there is good reason to do otherwise, adequate replacement clothing rather than paper clothing should be provided to detainees when their own clothes have been taken from them.

Housekeeping points

4.25 Mattresses should routinely be wiped down after use.

4.26 All female detainees should be offered a hygiene pack on arrival.

4.27 All detainees should be given a supply of toilet paper.

4.28 Replacement underwear should be available if required.

Catering

4.29 Staff routinely offered detainees a meal on arrival, at mealtimes and on request at any time of the day or night. Only microwave meals were available. Vegetarian and halal diets were catered for but most meals were unappetising, with low nutritional value and calorific content. Detention officers we spoke to gave detainees who were hungry two or more meals. The kitchen areas where food was prepared were clean and well maintained and staff checked food temperatures before serving. Hot and cold drinks were provided on request.

Recommendation

4.30 Food should be of sufficient quality and calorific value to sustain detainees for the duration of their stay.

Activities

4.31 With the exceptions of Bath and Staple Hill, suites had an outside exercise area, although these were generally small and without seating. Custody staff said detainees using the yards had to be supervised at all times, which was difficult to arrange so yards were rarely used. All custody suites had a limited stock of books and other reading materials. These were regularly offered to detainees but most were worn and did not meet the needs of the diverse range of detainees held. Visits were available only in exceptional circumstances and at the discretion of the custody sergeant.

Recommendation

4.32 Detainees held for longer periods should be offered outdoor exercise.

Housekeeping point

4.33 There should be a reasonable selection of reading material covering a range of interests and reading abilities, including children's literature.

5. Individual rights

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

Rights relating to detention

5.1 When detainees were brought into the custody suite, custody sergeants checked the circumstances of the arrest with the arresting officer and confirmed that detention was appropriate. A number of custody sergeants described themselves as gatekeepers and gave examples of instances when they had refused to authorise custody. Custody suites were not used as a place of safety for children under Section 46 of the Children Act 1989.

5.2 All detainees were offered a leaflet detailing their rights and entitlements. Copies were available in a wide range of languages and there were posters on walls to help identify a detainee's first language. Interpreting services were used when required (see section on treatment and conditions). Detainees were asked if they wanted someone informed of their whereabouts and were often allowed to speak to family or friends on the telephone provided this would not interfere with the investigation. Staff also allowed more than one telephone call if detainees had legitimate family or employment issues to manage. Detainees were not routinely asked if they had dependency obligations, although any issues raised were dealt with appropriately. We saw staff reassure one female detainee that she would be bailed in time to collect her children from school.

5.3 The pre-release risk assessments we saw were at best perfunctory, appearing to be little more than a template that custody sergeants were obliged to complete without any qualitative assessment of needs. Staff said these assessments were completed only when detainees were deemed particularly vulnerable but there was no common definition of what this meant. Our custody record analysis included examples of pre-release risk assessments that reported no risks even though risks had been identified at the booking-in stage or during custody. Leaflets for useful contacts, such as Samaritans, were available but staff said they had little if anything to offer even the most vulnerable detainees.

Recommendation

5.4 Custody staff should ensure that dependency obligations are routinely identified and, where possible, addressed.

Rights relating to PACE

5.5 The procedural requirements of PACE were applied efficiently and detainees were given the opportunity to consult a copy of PACE. Detainees were not interviewed while under the influence of drugs or alcohol or if medically unfit. All were asked if they wanted to consult a solicitor. If they declined, custody sergeants routinely asked their reasons and noted their response on the custody record. Detainees could speak to their legal adviser in a private room and defence solicitors were positive about their relationships with staff and the treatment of detainees. Their main concern was that the single telephone line into the custody suites at Southmead and Staple Hill made it difficult for them to get through. Detainees we interviewed

in custody suites did not complain about undue delays in contacting a solicitor but 85% compared with 65% in our prison survey said this was an issue. Custody sergeants routinely provided solicitors with a copy of the custody records.

5.6 The force adhered to the PACE definition of a child, so appropriate adults were arranged only for those under the age of 17 or vulnerable adults. There was no evidence that juveniles were interviewed without an appropriate adult present. When necessary, appropriate adults were provided by the local youth offending team during office hours, which appeared to work effectively. Arrangements out of hours and for vulnerable adults varied across the region, with some long delays, particularly for adults, resulting in some unnecessarily long periods in custody. It was positive that the force had tried to identify a pool of volunteers to act as appropriate adults but this did not cover the whole area and had the drawback of lacking independence from the force. Managers were aware of these deficiencies and were seeking alternative solutions.

5.7 Court cut-off times varied across the area. We were told by staff that courts at Taunton and Yeovil sometimes refused to take cases after 11am, which was too early and led to some detainees unnecessarily being held overnight.

5.8 The taking and storing of DNA and forensic samples was well organised, with only very small amounts of DNA stored in freezers. An equally good situation existed with forensic samples. All samples we saw were properly bagged and labelled and continuity of evidence was on a very strong footing. There was clear ownership of the issue and intrusive supervision by property clerks.

Recommendations

5.9 Appropriate adults should be available to support juveniles aged 17 and under and vulnerable adults in custody, including out of hours.

5.10 Court cut-off times should be extended to avoid detainees being held overnight in police custody.

Rights relating to treatment

5.11 Detainees were not routinely told how to make a complaint but posters displayed at Bath and Staple Hill explained the complaint procedures and gave information about the Independent Police Complaints Commission. Staff said the duty inspector would take the details for any detainee who wanted to make a complaint before they left.

Recommendation

5.12 Detainees should routinely be told how to make a complaint in line with the Independent Police Complaints Commission statutory guidance.[3]

[3] IPCC statutory guidance (2010)

6. Health care

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

Clinical governance

6.1 General health services were provided by Medacs, who had held the contract since September 2008 and on an interim arrangement prior to that. Mental health services were provided by Avon and Wiltshire Partnership Trust (AWP) in the north and Somerset Partnership Trust (SPT) in the south. There were no diversion or liaison schemes based in the custody suites but AWP ran a court assessment and referral service. Arrangements differed depending on area but both mental health trusts had governance arrangements in place. Substance use services were provided by a range of providers depending on location.

6.2 Detainees were routinely asked on arrival if they wanted to see a health care professional (HCP). One custody suite had a notice stating that detainees could see a HCP of their own gender but this was not displayed at other suites. HCPs had access to interpreting services, which they used as required. There was no health information in languages other than English.

6.3 Nursing staff said they had received induction training and some mentioned other regular update training, such as forensic sampling. A range of training events was planned for later in the year. Some but not all staff had clinical supervision. Agency doctors were used frequently but the mechanisms to ensure their competency were unclear.

6.4 The force monitored the contract with Medacs through monthly reports and contract monitoring meetings. The contract included the provision of doctors for the care of victims of sexual assaults. It also included a range of key performance indicators (KPIs) but the judgement about level of achievement was sometimes made only by Medacs staff. The contract stated that, depending on the nature of the call, Medacs staff would respond to 90% of calls within an hour. This target had not been achieved and the force had therefore initiated financial penalties. The latest performance reporting stated that 83% of all calls (both to custody and for the victims of sexual assaults) were met within the relevant response times but did not distinguish between nurses and doctors. The response time was measured from when the HCP arrived at the custody suite to see the first detainee for whom they been requested. Subsequent calls about other detainees at the same suite were not recorded, even though these detainees might have faced a considerable additional wait to be seen.

6.5 The clinical rooms varied greatly throughout the area. Most were a reasonable size but the room at Staple Hill was too small and in an inappropriate location. No infection control audits had been carried out and cleaning schedules were limited and in some areas ineffective. None of the rooms were sufficiently clean and the room at Broadbury Road was particularly grubby. All sharps bins had recently been replaced and all were correctly signed and dated when first used.

6.6 Drugs cupboards in clinical rooms were tidy and there were no discrepancies in the recording of medications. Only Medacs staff had access to them through a combination locking system. However, these medicines were used only by nursing staff as doctors carried their own medications in unlocked bags. Each suite had recently been supplied with a medicine

cupboard to store detainees' own medications, including those prescribed in custody, but the system for their use was confusing and not uniform across the force. Staff at Bath said the cupboard had 'just appeared' and had no idea what it was for, while those at Taunton had a written protocol to follow. Medications in the cupboard at Trinity Road were not entered in the medicines record book and included medications belonging to a detainee who had been released. There were also discrepancies in the number of tablets listed as in the cupboard. There was a store of asthma inhalers, GTN spray (for angina) and nicotine replacement lozenges in a cupboard at Southmead and most items were at least a year out of date. Each medical room had a newly installed fridge for medications needing to be stored in a refrigerator but no documented checks were made on these and at least one recorded a previous temperature of well above 8 degrees Celsius.

6.7 Medications prescribed by the forensic medical examiner (FME) were administered by officers who then signed the relevant prescription on NSPIS. Any nurse administering medications had to get a verbal order by telephone from an FME for a single dose because they were not using patient group directions due to a lack of training.

6.8 Defibrillators had been installed in all designated custody suites but we could not find one at Minehead. Oxygen and suction were also available. Few custody staff had been trained to use defibrillators, although this was planned and all were up to date with basic first aid training. The defibrillator at Yeovil was conveniently situated in the corridor outside the booking-in area and its whereabouts was clearly signed. Defibrillators at other suites were locked in the medical room, which could delay staff access to it. The policy was that custody staff were responsible for day-to-day checks of the equipment but the documented checks varied. Some staff said that as the equipment was in a medical room and they had not been trained, they did not feel able to check it. Medacs staff had been instructed to check the equipment if it was in their room but these checks had not been completed either.

6.9 The undesignated custody suites contained few first aid kits or resuscitation equipment and what was there was often out of date. Staff said they avoided taking anyone with health problems or who might require an HCP into an undesignated custody suite but this did not take account of the fact that someone could become unwell while at the suite.

Recommendations

6.10 There should be robust infection control procedures for all clinical rooms, which should be clean and capable of being used for taking forensic samples.

6.11 All resuscitation equipment should be regularly checked and all staff able to access and use it effectively. The location of defibrillators should be agreed by Medacs and the force so that staff working at stations other than their normal station can locate it quickly.

6.12 The introduction of patient group directions should be expedited to ensure that patients receive appropriate medication as quickly as possible.

Housekeeping points

6.13 The procedure for the storage of detainees' personal medication should be standard across the force and custody staff should have clear instructions on the management of such medicines.

6.14 The doctors' medical bags should be lockable.

6.15 Medications that need to be kept in a refrigerator should be stored between 2 and 8 degrees Celsius and refrigerator temperatures checked daily.

6.16 All custody suites should have basic first aid equipment that is regularly checked and ready to use.

6.17 Out-of-date medications should be removed from custody suites.

Patient care

6.18 HCPs worked 12-hour shifts and provided 24-hour cover. No handover time was built into the shift pattern. A nurse based at Trinity Road also covered Southmead and a nurse at Staple Hill also served Broadbury Road and Bath. Another nurse based at Taunton covered Minehead, Yeovil, Bridgwater and Weston-super-Mare, although a second nurse came on shift to cover Weston and Bridgwater between 4pm and 3am. Nurses had to report to log in with Medacs at their 'base station' at the start of duty regardless of where they lived and where they needed to be. Time spent travelling to see a patient could therefore be extended because nurses had to log in at their base unit before attending the custody suite. The FMEs were not custody based and not all were permanent staff. Two were on duty at any one time, one for the north and one for the south of the force area. If one FME was called to attend a victim of sexual assault, it left one doctor covering the whole force. Cover for any nurse off sick was provided by those who remained on duty, resulting in reduced cover across the force area.

6.19 In our custody record analysis, 27% of detainees had been seen by a HCP. The longest wait, which had been to see a nurse, was approximately three hours, although the average wait was much less. However, staff at all designated suites described long delays for a HCP once called. During the inspection, staff at Yeovil requested a doctor at 8.01am to take forensic samples from a detainee later in the day when he had sobered up. A second call was made at 10.42am stating that the detainee was now in a fit state but the doctor did not arrive until over two hours later.

6.20 In our prison survey, 59% of respondents, compared with the comparator of 49%, said they had been on prescribed medication on arrival in custody and 39% of these were allowed to continue it while in custody. Custody staff made impressive efforts to obtain medication for detainees, either going to their home address or collecting it from a local pharmacy.

6.21 HCPs used paper records to record their contemporaneous notes about a consultation. The nurses used a pro forma but the doctors kept their own notes in a variety of forms. The nurses' records were sent to a central store but the doctors kept their own notes and it was not clear that all were aware of how clinical records should be stored to comply with Caldicott guidelines.[4] Not all nurses' records recorded the detainees' verbal or written consent and not all were signed. HCPs we spoke to were unclear whether they would give detainees a copy of their clinical notes and one FME said he would do so only if 'a court ordered him to'.

6.22 Following an assessment, the HCP entered a summary of the consultation on NSPIS but not all the doctors used NSPIS so their summary documentation was paper-based. It was not clear how these records were ever referred to or collated with the main NSPIS record, which risked custody staff not having information from the doctor about a detainee in their care.

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

Recommendation

6.23 All detainees should be able to see a health care professional within a reasonable time.

Housekeeping points

6.24 All clinical records should be stored in line with Caldicott guidelines and the Data Protection Act.

6.25 Any contact with a health care professional should be recorded on NSPIS.

6.26 The requirement for nurses to log in on reporting for duty at their base station should be reviewed to ensure that detainees are seen as soon as possible and there should be appropriate handovers at the end of shifts.

6.27 Detainees' consent should be recorded on clinical records and they should be able to obtain a copy of their clinical records.

Substance use

6.28 In our prison survey, 67% of respondents said they had had drug or alcohol problems on arrival in custody, 48% of these had been offered the chance to see or had seen a substance use worker and 34% had been offered relief medication. However, we saw little evidence of substitution medication being prescribed or administered.

6.29 Good substance use services were provided by different suppliers according to location. Drugs workers visited custody suites regularly and offered advice and ongoing support to detainees. Out-of-hours referral systems were used when necessary. Not all drug workers supported alcohol users but could signpost to community services as required. Methadone maintenance was supported once certain criteria were met. Bristol was a drug intervention programme 'intensive' area, so detainees who had committed a trigger offence were automatically drug tested and refusal of a test constituted a further offence. Needle exchange was available at most suites. Any juvenile declaring a drug issue was immediately referred to the appropriate young people's substance misuse service.

Mental health

6.30 The force reported that 282 persons had been detained under Section 136 of the Mental Health Act in the three months from April to June 2010 and 80% were in the Avon area. In the same period, 34 people had been arrested for another reason that subsequently resulted in a mental health disposal and 85% of these were in the Avon area. The force reported long delays for an assessment by an approved mental health practitioner (AMPH) both for those requiring a mental health assessment (up to 11 hours in the previous three months) and for those held under a Section 136 (between five and seven hours in the previous three months).

6.31 In Avon, progress had been made in identifying gaps in services and joint protocols had been agreed. An Avon mental health, social care and criminal justice group was attended by representatives from the police, Avon and Wiltshire Mental Health Partnership NHS Trust (AWP), emergency duty team (EDT), Nacro and the relevant primary care trusts but not from Medacs. The subject of detainees held under Section 136 was regularly discussed. A 24-hour Section 136 suite had been opened in Bristol two weeks before the inspection, which also

served South Gloucestershire, but there was no similar arrangement for Bath or Weston-super-Mare. Custody staff were unclear about how admission to the suite was organised, despite clear flowcharts being available. They also did not know whether staff from the mental health trust would attend a custody suite to undertake a mental health assessment. Medacs staff were similarly unclear and most did not even understand which mental health trust they were contacting.

6.32 In Somerset, there was a joint agency policy and procedure for Section 135/136 and two designated Section 136 suites at Taunton and Yeovil, although the former was temporarily closed. The policy stated that if a detainee was taken to a police station, the custody sergeant must alert the duty AMPH as soon as they arrived and inform a HCP so that the detainee could be assessed. However, custody staff were under the impression that Medacs staff contacted the AMPH, which caused unnecessary delays. The closure of the Section 136 suite at Taunton meant officers had to provide constant watches for detainees awaiting mental health assessment by a Medacs doctor or psychiatrist. At Taunton, the local Samaritans provided telephone support to detainees willing to talk to them and this was arranged by custody staff. Detainees at Taunton displaying mental health concerns were also given a mental health guide for emotional well-being booklet published by the NHS Trust to provide additional support.

Recommendation

6.33 Custody staff should receive mental health awareness training and guidance about local mental health protocols as part of their custody refresher training.

7. Summary of recommendations

Main recommendations

7.1 The force should address immediately the significant safety issues presented by the multiple ligature points in most cells. (2.12)

7.2 The force should collate the use of force and monitor it locally and at force-wide level, for example by ethnicity, location and officer involved. (2.13)

7.3 Cells and detainee areas should be kept clean. (2.14)

7.4 Pre-release risk assessments should be of sufficient quality and depth to identify any areas of concern and outline the action taken to address them. (2.15)

7.5 Police custody should be used as a place of safety for Section 136 assessments only in extreme cases. (2.16)

Recommendations

Strategy

7.6 The force should review the current model of delivering custody services, management structures and staffing levels to ensure the care and welfare of detainees. (3.9)

Treatment and conditions

7.7 There should be clear policies and procedures to ensure that the distinct needs of juveniles and females in custody are met. (4.5)

7.8 All the main custody suites should provide better access and communication for detainees with disabilities. (4.6)

7.9 Health and safety walk-throughs should be more robust, thorough and capable of withstanding scrutiny. (4.16)

7.10 Cell call bells should be audible and should be muted only in exceptional circumstances. (4.17)

7.11 All detainees held overnight or who require one should be offered a shower. (4.23)

7.12 Unless there is good reason to do otherwise, adequate replacement clothing rather than paper clothing should be provided to detainees when their own clothes have been taken from them. (4.24)

7.13 Food should be of sufficient quality and calorific value to sustain detainees for the duration of their stay. (4.30)

7.14 Detainees held for longer periods should be offered outdoor exercise. (4.32)

Individual rights

7.15 Custody staff should ensure that dependency obligations are routinely identified and, where possible, addressed. (5.4)

7.16 Appropriate adults should be available to support juveniles aged 17 and under and vulnerable adults in custody, including out of hours. (5.9)

7.17 Court cut-off times should be extended to avoid detainees being held overnight in police custody. (5.10)

7.18 Detainees should routinely be told how to make a complaint in line with the Independent Police Complaints Commission statutory guidance[5]. (5.12)

Health care

7.19 There should be robust infection control procedures for all clinical rooms, which should be clean and capable of being used for taking forensic samples. (6.10)

7.20 All resuscitation equipment should be regularly checked and all staff able to access and use it effectively. The location of defibrillators should be agreed by Medacs and the force so that staff working at stations other than their normal station can locate it quickly. (6.11)

7.21 The introduction of patient group directions should be expedited to ensure that patients receive appropriate medication as quickly as possible. (6.12)

7.22 All detainees should be able to see a health care professional within a reasonable time. (6.23)

7.23 Custody staff should receive mental health awareness training and guidance about local mental health protocols as part of their custody refresher training. (6.33)

Housekeeping points

Treatment and conditions

7.24 Custody sergeants should ensure that only staff and visitors directly involved with a detainee being booked in are present around the booking in desk. (4.7)

7.25 Staff should be issued with robust ligature cutters. (4.9)

7.26 An overlap period should be built into all shifts to allow an effective handover between staff. (4.10)

7.27 Custody suites should have enough handcuffs readily available to evacuate all detainees safely. (4.18)

7.28 Custody staff and police officers locating detainees in cells should routinely check that the cell call button is working and explain its use. (4.19)

[5] IPCC statutory guidance (2010)

7.29 Mattresses should routinely be wiped down after use. (4.25)

7.30 All female detainees should be offered a hygiene pack on arrival. (4.26)

7.31 All detainees should be given a supply of toilet paper. (4.27)

7.32 Replacement underwear should be available if required. (4.28)

7.33 There should be a reasonable selection of reading material covering a range of interests and reading abilities, including children's literature. (4.33)

Health care

7.34 The procedure for the storage of detainees' personal medication should be standard across the force and custody staff should have clear instructions on the management of such medicines. (6.13)

7.35 The doctors' medical bags should be lockable. (6.14)

7.36 Medications that need to be kept in a refrigerator should be stored between 2 and 8 degrees Celsius and refrigerator temperatures checked daily. (6.15)

7.37 All custody suites should have basic first aid equipment that is regularly checked and ready to use. (6.16)

7.38 Out-of-date medications should be removed from custody suites. (6.17)

7.39 All clinical records should be stored in line with Caldicott guidelines and the Data Protection Act. (6.24)

7.40 Any contact with a health care professional should be recorded on NSPIS. (6.25)

7.41 The requirement for nurses to log in on reporting for duty at their base station should be reviewed to ensure that detainees are seen as soon as possible and there should be appropriate handovers at the end of shifts. (6.26)

7.42 Detainees' consent should be recorded on clinical records and they should be able to obtain a copy of their clinical records. (6.27)

Appendix I: Inspection team

Sean Sullivan	HMIP team leader
Angela Johnson	HMIP inspector
Lucy Young	HMIP inspector
Martin Owens	HMIP inspector
Fiona Shearlaw	HMIC inspector
Paddy Craig	HMIC inspector
David Thompson	HMIC inspector
Mark Ewen	HMIC inspector
Elizabeth Tysoe	HMIP health care inspector
Bridget McEvilly	HMIP health care inspector
Andy Brand	Care Quality Commission inspector
Catherine Nichol	HMIP researcher

Appendix II: Custody record analysis

Background

As part of the inspection of Avon and Somerset police custody, a sample of the custody records of detainees held at Trinity Road, Broadbury Road, Yeovil, Bath and Taunton police custody suites in June 2010 were analysed. Custody records were held electronically on NSPIS (national strategy for police information systems). A total sample of 30 records was analysed:

Custody suite	Number of records analysed
Trinity Road	6
Broadbury Road	6
Yeovil	6
Bath	6
Taunton	6
Total	30

The analysis looked at the level of care and access to services such as showers, exercise and telephone calls detainees received. Any additional information of note was also recorded.

Demographic information

- Four (13%) of the detainees were female and 26 were male.
- Three (10%) detainees under the age of 17 were included in the sample.
- There were 28 (93%) detainees in our sample with a white British/other ethnic background and two with a black or ethnic minority background.
- Two (7%) detainees had been held for more than 24 hours. Twelve (40%) had been in custody overnight, including those who had arrived during the night and were not released until the morning (between midnight and 3am). Fourteen (47%) detainees had been held for less than six hours.

Risk assessments

Initial risk assessment statements were largely clear and contained helpful information.

- Eleven detainees (37%) were brought into custody intoxicated and five of these detainees were seen by a doctor. Two detainees were seen by a drugs and/or alcohol worker and another detainee had an appointment made for them with the criminal justice interventions team.
- Seven (23%) detainees had current or previous self-harm or suicide issues.
- Three (10%) detainees in our sample had reported mental health problems. One of these was brought in under Section 136 for the purpose of assessment for sectioning.
- Six (20%) detainees in our sample reported being on medication on arrival in custody. Five of these detainees were seen by a health care professional.
- Five (17%) detainees entered custody injured and three of these were seen by a health care professional.
- In four (13%) risk assessments, it was noted to be a detainee's first time in custody.
- There were four (13%) detainees who were foreign nationals and all received their foreign national rights.

Young people

There were three young people in our sample aged under 17.

- They were all brought into the station in the afternoon and released within four hours.
- All of the young people had an appropriate adult present from the start of their detention, so they were present during the rights procedure and interview.
- One young woman was given a responsible female officer who was responsible for her welfare, conducted the interview and drove her home.
- One young person had a history of self-harm and was placed in a CCTV cell, with hourly visits by staff.

Women

- There were no gender-specific questions on NSPIS.
- Strip searches that occurred were carried out by female officers.

Interpreters

Two detainees had difficulties with English.

- One detainee, who could not read or write English, was booked into custody and given rights without an interpreter.
- For one detainee, whose level of English was unclear from the record, it was not stated when or what form of interpreter was used when booking him in and none was recorded on his main rights. He was later charged with an interpreter at the desk and rights were given again.

Inspector reviews

Inspector reviews were held in line with requirements, usually at the required times. However, in a few cases, the reviews were delayed due to operational reasons. One of the operational reasons given was competing custody demands. Some were also conducted over the telephone, due to operational necessity. Detainees were made aware of reviews that had been conducted while they were asleep once they were awake.

Services

- All detainees were offered the opportunity of having someone informed of their arrest. In addition, three (10%) detainees had made a telephone call during their time in custody.
- All detainees were routinely offered legal advice and nine (30%) detainees accepted.
- Eight (27%) detainees were seen by a health care professional.
  - ❖ The longest wait was approximately three hours. All three waiting times that were longer than an hour were to see a nurse.
  - ❖ The average wait for a health care professional was approximately 16 minutes.
- Eight (27%) detainees in our sample received at least one meal while in custody. Fourteen (47%) detainees were not offered a meal while in custody. All these detainees were in custody for less than seven hours. In two cases, detainees had been in custody over 12 hours - almost 15 hours in one case and over 30 hours in the other - and neither had received more than one meal.

- One detainee in the sample had been given outside exercise.
- One detainee was granted a supervised shower while in custody and one detainee was allowed access to washing facilities. All bar one of the six detainees released to court were not offered a shower or access to washing facilities. This included one person who had been held for over 30 hours.
- Two detainees had been provided with reading materials.
- No evidence of cell sharing was found.

Pre-release risk assessments

All stations had a pre-release risk assessment as an add-on at the end of every record. This, however, was very rarely changed from the pro forma. In many cases it reported no risks identified when risks had been identified when being booked in or throughout the detainee's time in custody.

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Appendix III: Summary of detainee questionnaires and interviews

Prisoner survey methodology

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

Choosing the sample size

The survey was conducted on 13 August 2010. A list of potential respondents to have passed through Trinity Road, Broadbury Road, Southmead Road, Staple Hill, Bath, Yeovil, Taunton, Minehead, Bridgwater and Weston-super-Mare police stations was created, listing all those who had arrived from Bath, Bridgwater, Bristol, North Somerset, South Somerset and Mendips, West Somerset, North Avon or Frome magistrates' courts within the past two months.

Selecting the sample

In total, 73 respondents were approached. Ten respondents reported being held in police stations outside Avon and Somerset, four could not speak English so it was impossible to determine the police station they had been in and one could not be located as he was attending court. On the day, the questionnaire was offered to 58 respondents. There were five refusals and seven non-returns. All those sampled had been in custody within the last two months.

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

Methodology

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

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

- 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
- seal the questionnaire in the envelope provided and leave it in their room for collection.

Response rates

In total, 46 (79%) respondents completed and returned their questionnaires.

Comparisons

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

Some questions have been filtered according to the response to a previous question. Filtered questions are clearly indented and preceded by an explanation as to which respondents are included in the filtered questions. Otherwise, percentages provided refer to the entire sample. All missing responses are excluded from the analysis.

The current survey responses were analysed against comparator figures for all prisoners surveyed in other police areas. This comparator is based on all responses from prisoner surveys carried out in 32 police areas since April 2008.

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

Summary

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

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

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

Survey results

Section 1: About you

Q2 What police station were you last held at?

Trinity Road	16	Staple Hill	2	Taunton	0
Broadbury Road	7	Bath	9	Minehead	0
South Mead Road	3	Yeovil	0	Bridgwater	0
				Weston-super-Mare	7

(2 unknown)

Q3 What type of detainee were you?

Police detainee	44 (96%)
Prison lock-out (i.e. you were in custody in a prison before coming here)	0 (0%)
Immigration detainee	0 (0%)
I don't know	2 (4%)

Q4 How old are you?

16 years or younger	0 (0%)	*40-49 years*	8 (18%)
17-21 years	5 (11%)	*50-59 years*	0 (0%)
22-29 years	18 (40%)	*60 years or older*	1 (2%)
30-39 years	13 (29%)		

Q5 Are you:

Male	46 (100%)
Female	0 (0%)
Transgender/transsexual	0 (0%)

Q6 What is your ethnic origin?

White - British	36 (78%)
White - Irish	1 (2%)
White - other	0 (0%)
Black or black British - Caribbean	2 (4%)
Black or black British - African	1 (2%)
Black or black British - other	1 (2%)
Asian or Asian British - Indian	1 (2%)
Asian or Asian British - Pakistani	1 (2%)
Asian or Asian British - Bangladeshi	0 (0%)
Asian or Asian British - other	0 (0%)
Mixed heritage - white and black Caribbean	2 (4%)
Mixed heritage - white and black African	1 (2%)
Mixed heritage- white and Asian	0 (0%)
Mixed heritage - Other	0 (0%)
Chinese	0 (0%)
Other ethnic group	0 (0%)

Q7 Are you a foreign national (i.e. you do not hold a British passport, or you are not eligible for one)?

Yes	3 (7%)
No	43 (93%)

Q8 What, if any, would you classify as your religious group?

None	18 (40%)
Church of England	13 (29%)
Catholic	8 (18%)
Protestant	0 (0%)
Other Christian denomination	3 (7%)
Buddhist	0 (0%)
Hindu	0 (0%)
Jewish	1 (2%)
Muslim	1 (2%)
Sikh	1 (2%)

Q9 How would you describe your sexual orientation?

Straight/heterosexual	43 (93%)
Gay/lesbian/homosexual	1 (2%)
Bisexual	2 (4%)

Q10 Do you consider yourself to have a disability?

Yes	9 (20%)
No	34 (76%)
Don't know	2 (4%)

Q11 Have you ever been held in police custody before?

Yes	45 (98%)
No	1 (2%)

Section 2: Your experience of this custody suite

Q12 How long were you held at the police station?

One hour or less	1 (2%)
More than one hour, but less than six hours	1 (2%)
More than six hours, but less than 12 hours	2 (4%)
More than 12 hours, but less than 24 hours	7 (15%)
More than 24 hours, but less than 48 hours (two days)	18 (39%)
More than 48 hours (two days), but less than 72 hours (three days)	12 (26%)
72 hours (three days) or more	5 (11%)

Q13 Were you given information about your arrest and your entitlements when you arrived there?

Yes	35 (76%)
No	7 (15%)
Don't know/can't remember	4 (9%)

Q14 Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')?

Yes	27 (60%)
No	12 (27%)
I don't know what this is/I don't remember	6 (13%)

Q15 If your clothes were taken away, were you offered different clothing to wear?

My clothes were not taken	27 (64%)
I was offered a tracksuit to wear	4 (10%)

I was offered an evidence suit to wear 9 (21%)
I was offered a blanket 2 (5%)

Q16 Could you use a toilet when you needed to?

Yes 40 (87%)
No 6 (13%)
Don't know 0 (0%)

Q17 If you have used the toilet there, were these things provided?

	Yes	*No*
Toilet paper	26 (59%)	18 (41%)
Sanitary protection	*0 (0%)*	*18 (100%)*

Q18 Did you share a cell at the police station?

Yes 2 (4%)
No 44 (96%)

Q19 How would you rate the condition of your cell:

	Good	*Neither*	*Bad*
Cleanliness	13 (29%)	13 (29%)	19 (42%)
Ventilation/air quality	7 (16%)	15 (35%)	21 (49%)
Temperature	4 (9%)	8 (19%)	31 (72%)
Lighting	25 (58%)	4 (9%)	14 (33%)

Q20 Was there any graffiti in your cell when you arrived?

Yes 25 (54%)
No 21 (46%)

Q21 Did staff explain to you the correct use of the cell bell?

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

Q22 Were you held overnight?

Yes 42 (91%)
No 4 (9%)

Q23 If you were held overnight, which items of clean bedding were you given?

Not held overnight 4 (9%)
Pillow 0 (0%)
Blanket 32 (71%)
Nothing 9 (20%)

Q24 Were you offered a shower at the police station?

Yes 3 (7%)
No 43 (93%)

Q25 Were you offered any period of outside exercise while there?

Yes 1 (2%)
No 45 (98%)

Q26 Were you offered anything to:

	Yes	*No*
Eat?	36 (80%)	9 (20%)
Drink?	42 (91%)	4 (9%)

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

I did not have any food or drink	6 (13%)
Yes	19 (41%)
No	21 (46%)

Q28 If you smoke, were you offered anything to help you cope with the smoking ban there?

I do not smoke	9 (19%)
I was allowed to smoke	1 (2%)
I was not offered anything to cope with not smoking	37 (77%)
I was offered nicotine gum	1 (2%)
I was offered nicotine patches	0 (0%)
I was offered nicotine lozenges	0 (0%)

Q29 Were you offered anything to read?

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

Q30 Was someone informed of your arrest?

Yes	21 (46%)
No	15 (33%)
I don't know	2 (4%)
I didn't want to inform anyone	8 (17%)

Q31 Were you offered a free telephone call?

Yes	17 (37%)
No	29 (63%)

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

My telephone call was not denied	18 (41%)
Yes	2 (5%)
No	24 (55%)

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

	Yes	*No*
Who was taking care of your children	4 (11%)	31 (89%)
Contacting your partner, relative or friend	22 (50%)	22 (50%)
Contacting your employer	8 (22%)	28 (78%)
Where you were going once released	6 (17%)	30 (83%)

Q34 Were you interviewed by police officials about your case?

Yes	36 (78%)	
No	10 (22%)	If No, go to Q36

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

	Yes	*No*	*Not needed*
Solicitor	28 (78%)	2 (6%)	6 (17%)

Appropriate adult	1 (4%)	8 (33%)	15 (63%)
Interpreter	0 (0%)	7 (29%)	17 (71%)

Q36 How long did you have to wait for your solicitor?

I did not requested a solicitor	13 (30%)
Two hours or less	3 (7%)
Over two hours but less than four hours	2 (5%)
Four hours or more	26 (59%)

Q37 Were you officially charged?

Yes	35 (80%)
No	7 (16%)
Don't know	2 (5%)

Q38 How long were you in police custody *after* being charged?

I have not been charged yet	7 (17%)
One hour or less	1 (2%)
More than one hour, but less than six hours	3 (7%)
More than six hours, but less than 12 hours	5 (12%)
12 hours or more	25 (61%)

Section 3: Safety

Q40 Did you feel safe there?

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

Q41 Had another detainee or a member of staff victimised (insulted or assaulted) you there?

Yes	13 (30%)
No	30 (70%)

Q42 If you have felt victimised, what did the incident involve? (Please tick all that apply to you.)

I have not been victimised	30 (63%)	*Because of your crime*	2 (4%)
Insulting remarks (about you, your family or friends)	5 (10%)	*Because of your sexuality*	0 (0%)
Physical abuse (being hit, kicked or assaulted)	6 (13%)	*Because you have a disability*	0 (0%)
Sexual abuse	0 (0%)	*Because of your religion/religious beliefs*	0 (0%)
Your race or ethnic origin	0 (0%)	*Because you are from a different part of the country than others*	1 (2%)
Drugs	4 (8%)		

Q43 Were you handcuffed or restrained while in the police custody suite?

Yes	15 (36%)
No	27 (64%)

Q44 Were you injured while in police custody, in a way that you feel was not your fault?

Yes	10 (23%)
No	33 (77%)

Q45 Were you told how to make a complaint about your treatment here if you needed to?

Yes	4 (10%)

No 37 (90%)

Section 4: Health care

Q47 **When you were in police custody were you on any medication?**

Yes 27 (60%)
No 18 (40%)

Q48 **Were you able to continue taking your medication while there?**

Not taking medication 18 (41%)
Yes 10 (23%)
No 16 (36%)

Q49 **Did someone explain your entitlements to see a health care professional if you needed to?**

Yes 18 (40%)
No 23 (51%)
Don't know 4 (9%)

Q50 **Were you seen by the following health care professionals during your time there?**

	Yes	*No*
Doctor	21 (51%)	20 (49%)
Nurse	13 (36%)	23 (64%)
Paramedic	0 (0%)	27 (100%)
Psychiatrist	0 (0%)	27 (100%)

Q51 **Were you able to see a health care professional of your own gender?**

Yes 17 (40%)
No 13 (31%)
Don't know 12 (29%)

Q52 **Did you have any drug or alcohol problems?**

Yes 30 (67%)
No 15 (33%)

Q53 **Did you see, or were offered the chance to see a drug or alcohol support worker?**

I didn't have any drug/alcohol problems 15 (34%)
Yes 14 (32%)
No 15 (34%)

Q54 **Were you offered relief or medication for your immediate symptoms?**

I didn't have any drug/alcohol problems 15 (34%)
Yes 10 (23%)
No 19 (43%)

Q55 **Please rate the quality of your health care while in police custody:**

	I was not seen by health care	*Very good*	*Good*	*Neither*	*Bad*	*Very bad*
Quality of health care	16 (36%)	2 (4%)	5 (11%)	6 (13%)	9 (20%)	7 (16%)

Q56 **Did you have any specific <u>physical</u> health care needs?**

No 26 (65%)

Yes 14 (35%)

Q57 Did you have any specific <u>mental</u> health care needs?

No 29 (73%)

Yes 11 (28%)

Prisoner survey responses for Avon and Somerset Police 2010

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

		Avon and Somerset 2010	Police custody comparator
	Significantly better than the comparator		
	Significantly worse than the comparator		
	A significant difference in prisoners' background details		
	No significant difference		
Number of completed questionnaires returned		46	1054
SECTION 1: General information			
2	Are you a police detainee?	**96%**	**89%**
3	Are you under 21 years of age?	**10%**	**9%**
4	Are you transgender/transsexual?	**0%**	**1%**
5	Are you from a minority ethnic group (including all those who did not tick white British, white Irish or white other categories)?	**20%**	**35%**
6	Are you a foreign national?	**6%**	**16%**
7	Are you Muslim?	**2%**	**12%**
8	Are you homosexual/gay or bisexual?	**6%**	**2%**
9	Do you consider yourself to have a disability?	**20%**	**19%**
10	Have you been in police custody before?	**98%**	**89%**
SECTION 2: Your experience of this custody suite			
For the most recent journey you have made either to or from court or between prisons:			
11	Were you held at the police station for over 24 hours?	**76%**	**65%**
12	Were you given information about your arrest and entitlements when you arrived?	**76%**	**73%**
13	Were you told about PACE [Police and Criminal Evidence Act]?	**59%**	**51%**
14	If your clothes were taken away, were you given a tracksuit to wear?	**25%**	**45%**
15	Could you use a toilet when you needed to?	**86%**	**90%**
16	If you did use the toilet, was toilet paper provided?	**58%**	**50%**
17	Did you share a cell at the station?	**4%**	**3%**
18	Would you rate the condition of your cell as 'good' for:		
18a	Cleanliness?	**29%**	**29%**
18b	Ventilation/air quality?	**17%**	**20%**
18c	Temperature?	**9%**	**14%**
18d	Lighting?	**57%**	**43%**
19	Was there any graffiti in your cell when you arrived?	**54%**	**56%**
20	Did staff explain the correct use of the cell bell?	**10%**	**23%**
21	Were you held overnight?	**92%**	**92%**
22	If you were held overnight, were you given **no** clean items of bedding?	**20%**	**30%**
23	Were you offered a shower?	**6%**	**9%**
24	Were you offered a period of outside exercise?	**2%**	**7%**
25a	Were you offered anything to eat?	**80%**	**80%**
25b	Were you offered anything to drink?	**92%**	**82%**
26	Was the food/drink you received suitable for your dietary requirements?	**48%**	**45%**
27	For those who smoke: were you offered **nothing** to help you cope with the ban there?	**80%**	**77%**
28	Were you offered anything to read?	**24%**	**14%**
29	Was someone informed of your arrest?	**46%**	**44%**
30	Were you offered a free telephone call?	**37%**	**52%**

Key to tables

		Avon and Somerset 2010	Police custody comparator
	Significantly better than the comparator		
	Significantly worse than the comparator		
	A significant difference in prisoners' background details		
	No significant difference		
31	If you were denied a free call, was a reason given?	7%	15%
32	Did you have any concerns about:		
32a	Who was taking care of your children?	11%	16%
32b	Contacting your partner, relative or friend?	50%	53%
32c	Contacting your employer?	23%	21%
32d	Where you were going once released?	18%	31%
34	If you were interviewed were the following people present:		
34a	Solicitor?	78%	74%
34b	Appropriate adult?	4%	8%
34c	Interpreter?	0%	8%
35	Did you wait over four hours for your solicitor?	85%	65%
37	Were you held 12 hours or more in custody after being charged?	73%	62%
SECTION 3: Safety			
39	Did you feel unsafe?	34%	41%
40	Has another detainee or a member of staff victimised you?	30%	41%
41	If you have felt victimised, what did the incident involve?		
41a	Insulting remarks (about you, your family or friends)	11%	21%
41b	Physical abuse (being hit, kicked or assaulted)	15%	14%
41c	Sexual abuse	0%	2%
41d	Your race or ethnic origin	0%	6%
41e	Drugs	9%	15%
41f	Because of your crime	4%	17%
41g	Because of your sexuality	0%	1%
41h	Because you have a disability	0%	3%
41i	Because of your religion/religious beliefs	0%	3%
41j	Because you are from a different part of the country than others	2%	5%
42	Were you handcuffed or restrained while in the police custody suite?	36%	46%
43	Were you injured while in police custody, in a way that you feel is not your fault?	23%	26%
44	Were you told how to make a complaint about your treatment?	9%	13%
SECTION 4: Health care			
46	Were you on any medication?	59%	43%
47	For those who were on medication: were you able to continue taking your medication?	39%	39%
48	Did someone explain your entitlement to see a health care professional if you needed to?	41%	35%
49	Were you seen by the following health care professionals during your time in police custody?		
49a	Doctor	51%	49%
49b	Nurse	36%	15%
49c	Paramedic	0%	4%
49d	Psychiatrist	0%	3%
50	Were you able to see a health care professional of your own gender?	41%	28%
51	Did you have any drug or alcohol problems?	67%	53%
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?	48%	41%
53	Were you offered relief medication for your immediate symptoms?	34%	32%
54	For those who had been seen by health care, would you rate the quality as good/very good?	25%	29%
55	Do you have any specific physical health care needs?	35%	33%
56	Do you have any specific mental health care needs?	27%	23%