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

3–6 January 2012

by

HM Inspectorate of Prisons and

HM Inspectorate of Constabulary

Printed and published by:
Her Majesty's Inspectorate of Prisons
Her Majesty's Inspectorate of Constabulary

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Contents

1. Introduction

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

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

This unannounced inspection looked at the custody suites run by Humberside Police. At the time of the inspection the force operated six 24-hour suites designated under PACE. The force also had one standby suite used to cover contingencies. In total, the force had a cell capacity of 100.

There was good strategic leadership of custody, assisted by a positive relationship with the Police Authority and an active independent custody visitors scheme. Custody was managed locally by divisions, with oversight and support provided by the force's criminal justice unit. There was a good focus on learning lessons but quality assurance procedures needed to be improved. Staffing of custody suites was adequate, as was the training provided, but there was no regular refresher training.

Staff were respectful in their interactions with detainees. There was mixed awareness of some diversity issues, although there were examples of good practice, particularly for juveniles at Priory Road, Hull. Risk assessments of detainees received into custody were good and risk management arrangements generally proportionate. The booking-in arrangements allowed only limited privacy and some elements of care and welfare relied too heavily on detainees making requests. There was a lack of appropriate monitoring of the use of force. The physical environment of the suites was mixed. Most of the cells were clean but there was too much graffiti and we found a number of ligature points in cells.

There was an appropriate balance between progressing cases and the rights of individuals, and PACE was normally adhered to, but we found the necessity test to detain was not actively implemented by custody officers. Immigration detainees were too often held for long periods. Arrangements for providing appropriate adults were good for juveniles but less so for vulnerable adults. The process for making complaints needed improvement.

Health care provision was generally good but clinical rooms and medications management were inadequate. The management of the contract with the health provider was robust and should be seen as good practice. Substance use services were well developed, with the

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

exception of Goole and Bridlington. Mental health diversion services varied, with some significant gaps, and, despite some progress being made, there were too many detainees being held under section 136.

Overall, police custody in Humberside was well managed. Detainees were generally well treated and their rights respected. This report provides a small number of recommendations to assist the force and the Police Authority to improve provision further. We expect our findings to be considered in the wider context of priorities and resourcing, and for an action plan to be provided in due course.

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February 2012

2. Background and key findings

2.1 At the time of this unannounced inspection, Humberside Police had six custody suites designated under PACE for the reception of detainees, operating 24 hours a day. These dealt with detainees arrested as a result of mainstream policing. There was a further standby custody suite at Beverley, which could be used to cover specific contingencies. There was a total cell capacity of 100. The force had held 29,139 detainees, and 104 individuals had been detained for immigration matters, in 2011.

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

Custody suite	Number of cells
Hull Queens Gardens	22
Hull Priory Road	20
Grimsby	23
Scunthorpe	14
Bridlington	10
Goole	5
Beverley (standby)	6

2.3 HM Inspectorate of Prisons (HMIP) researchers and inspectors carried out a survey of prisoners at HMP Hull who had formerly been detained at custody centres in the force area, to obtain additional evidence (see Appendix II).[2]

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

Strategy

2.5 The assistant chief constable (ACC) with portfolio responsibility for custody was well engaged with strategic partners. Relationships between the Humberside Police Authority and the force were good. There was an active independent custody visitors (ICV) scheme.

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

2.6 Custody was managed day to day from the four policing divisions that make up the Humberside police area, with the criminal justice unit (CJU) having responsibility for policy development and some quality assurance arrangements. There was a well-advanced plan to replace the Hull Queens Gardens custody suite. There was a good focus on learning lessons, and training arrangements were strong, but some quality assurance measures were inadequate. The local custody intranet site was good.

2.7 Staff working in custody were permanent and staffing levels were adequate, although lacked resilience.

Treatment and conditions

2.8 Staff interactions with detainees were very good. There was mixed awareness of some diversity issues, although there were examples of good practice, particularly for juveniles at Priory Road. Some aspects of privacy were poor, which had implications for respectful treatment and the safety of detainees. Detainees were not routinely asked if they had any dependency obligations.

2.9 Initial risk assessments were good and risk management arrangements generally proportionate. Staff understood the importance of rousing detainees where necessary but we found examples where this had not happened appropriately. Staff handovers were reasonable but there was room for improvement, and staff did not carry anti-ligature knives. Arrangements to oversee the use of force needed to be improved. Pre-release risk assessments were generally well completed.

2.10 The physical environment of the custody suites was very mixed. Most of the suites were clean but there was too much graffiti. We found a number of ligature points in cells. There was a good focus on care and welfare, although some aspects of this, such as the provision of showers, were too reliant on detainees making requests.

Individual rights

2.11 Detainees held for immigration matters were often detained for too long, although we identified some excellent examples of care being provided. Arrangements for providing appropriate adults (AAs) for juveniles were good but less well developed for vulnerable adults.

2.12 Detainees were not told how to make a complaint and the arrangements for dealing with them were confused. The management of DNA and forensic samples needed some attention.

2.13 Custody sergeants authorised custody but there was limited examination of the necessity test or focus on alternatives to custody. PACE was generally adhered to, although in rural areas too many reviews were carried out by telephone.

Health care

2.14 There were good governance arrangements. Clinical rooms and medications management were inadequate. All custody suites had resuscitation equipment, and custody staff were trained in its use.

2.15 Primary health care provision was good and waiting times were reasonable.

2.16 Arrangements for providing symptomatic relief for substance users were adequate and detainees could continue to receive prescribed medications. Substance use services were well developed at most of the suites but not for Goole and Bridlington.

2.17 The quality of mental health diversion services varied but was poor in Goole and Bridlington. Too many detainees had been held in police custody under section 136 of the Mental Health Act 1983, although some progress had been made in this regard.[3] Staff had received limited mental health awareness training.

Main recommendation

2.18 Police custody should not be used as a place of safety for section 136 assessments.

National issues

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

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

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

3. Strategy

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

Strategic management

3.1 The force operated a devolved custody model. An ACC provided strategic leadership on custody issues. A criminal justice unit (CJU), led by a superintendent, had responsibility for custody policy and provided oversight and support on custody matters.

3.2 The force had a clear estates strategy, which included a custody suite in a new divisional headquarters in Clough Road, Hull; this was due to open in spring 2013, at which time the suite at Queens Gardens was to be closed. There had been good consultation and ongoing communication with staff and the public in respect of the new facilities. Although there was no police authority lead for custody, there was a lead member for estates, who was well engaged with the force's estates strategy.

3.3 Custody provision across Humberside was split into four divisions, each with an inspector who had responsibility for custody; however, they also had other responsibilities, and some were expected to cover abstractions on core shifts. Custody inspectors line-managed custody officers in their division, who line-managed detention officers (DOs) on their team.

3.4 Custody issues were discussed at regular force meetings. These included a bimonthly force custody board, chaired by the ACC lead for custody, and a custody user group, attended by custody inspectors and practitioners. Minutes of these meetings showed that they were proactive and well attended.

3.5 Staffing levels in custody suites were adequate and comprised permanent custody sergeants and DOs, who were all divisional staff. However, there was no resilience in the permanent team and this had to be provided by trained staff from response teams when required.

3.6 The force had comprehensive custody procedures, with policies accessible to all staff through the force computer system. The CJU managed an excellent intranet-based custody website, containing custody-related information, including policies, guidance, good practice and links to Independent Police Complaints Commission (IPCC) 'learning the lessons' bulletins. Information was disseminated to staff by the CJU and custody inspectors. Custody staff told us that they visited the custody website regularly and found it useful.

3.7 The CJU carried out regular unannounced inspections of custody facilities. These were carried out against a set of agreed criteria and were followed up by a report and action plan. The force custody board had oversight of these processes.

3.8 There were quality assurance checks by custody inspectors, who carried out dip-sampling of custody records; however, these checks were limited and the number of records being dip-sampled was too small. There was no consistent dip-sampling of closed-circuit television (CCTV) recordings, and no consistent process for feeding back to staff any learning from the dip-sampling.

3.9 Learning the lessons from adverse incidents was well embedded in the force, with professional standards reporting on learning from internal investigations and national issues. Relevant cases were raised at the force custody board by the head of professional standards. There was also a process for capturing successful interventions and occurrences in custody, which appeared consistent and effective. These processes were reviewed centrally and information was disseminated to staff by various means, including publication on the custody website.

Housekeeping point

3.10 The force should review dip-sampling arrangements as part of their quality assurance processes.

Partnerships

3.11 Partnership arrangements were described as good, with active engagement with relevant criminal justice and health partners. The head of the CJU attended the Local Criminal Justice Board (LCJB), which was chaired by the chief constable.

3.12 A police authority employee was responsible for administering and coordinating the ICV scheme, which was seen as an important independent oversight mechanism. This was active and comprised four panels. The authority produced regular newsletters, as well as running training events for ICVs throughout the year. ICVs told us that they were generally admitted to custody centres quickly and had a good relationship with custody staff.

Learning and development

3.13 All custody staff had received role-specific training before working in custody, including first-aid and personal safety training. The force ensured that the knowledge and skills of sergeants covering in custody were up to date, and provided bespoke training for individuals who had not regularly performed the role. However, permanent custody staff did not receive regular, custody-specific refresher training.

Recommendation

3.14 The force should introduce regular refresher training for custody staff.

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 All of the custody staff we observed treated detainees with respect and consideration. This was confirmed by the detainees we spoke to and also by our survey, in which 50% of respondents said that they were treated well/very well by staff in the police custody suite, which was better than the 28% comparator.

4.2 Most suites had holding rooms or areas, which were screened from the booking-in area, where arresting officers waited with their detainees until called forward by a member of custody staff. However, the levels of privacy were poor. Detainees were asked to disclose sensitive, personal information there, often with other detainees being booked in at the same time and other people in the general vicinity. For example, at Scunthorpe, we observed a detainee having to disclose self-harm issues in front of other, non-custody staff. However, Grimsby had a booking-in desk outside the booking area and could afford some privacy. At Queens Gardens, the cell CCTV monitors were positioned above the custody desk and could be viewed by many people in the booking-in area.

4.3 Although staff were professional in the way they dealt with detainees, the focus on diversity was mixed. Generally, a 'one-size fits all' approach was adopted but with notable exceptions. Juveniles were mainly treated similarly to adults, and custody staff generally had little knowledge about child protection procedures, but there were some pockets of good work. For example, at Goole staff were willing to leave the cell doors open (contained behind a gate) if they deemed it safe and appropriate. At Hull, most juveniles were detained at Priory Road, which had the advantage of the youth offending team (YOT) being on site. Staff there had awareness of, and ready access to, support for juveniles, including issues around child protection. All suites had designated juvenile detention cells but these were usually the same as any other cell, and rarely contained toilets.

4.4 Female detainees were always given the opportunity of talking to a female member of staff, and our custody record analysis showed that all female detainees were asked about dependency issues during the booking-in process.

4.5 There was no accommodation for detainees with disabilities. Only two suites – Goole and Bridlington – had ready access to hearing loops and we found no evidence of Braille documentation.

4.6 Bibles, prayer mats and Qur`ans were available but were not always easily located, and the direction of Mecca was not always indicated.

4.7 At some suites, particularly Priory Road and Queens Gardens, custody staff struggled to control the number of people entering the suite, and the noise levels were frequently high.

Recommendations

4.8 Arrangements in booking-in areas should allow for private communication between detainees and staff.

4.9 There should be clear policies and procedures to meet the specific needs of female and juvenile detainees and those with disabilities.

Safety

4.10 Before carrying out the initial risk assessments, custody staff checked information held on the Police National Computer, as well as the force's own local intelligence system. Officers conducting the risk assessments asked detainees questions in a patient, reassuring manner and encouraged detainees to elaborate their answers. The assessments we saw were generally balanced and proportionate, although hampered by the lack of privacy in the booking-in area (see paragraph 4.2), and showed evidence that the level of risk was kept under constant review and that care plans were revisited and updated in the light of any new information gained.

4.11 Risk assessment information was also used to inform decisions about whether a detainee should undergo a strip-search. These had to be authorised by a custody sergeant, and data from the force showed that just under 9% of detainees had been strip-searched in 2011. Strip-searches were conducted in appropriately private rooms or in cells not covered by CCTV.

4.12 As well as looking after the ongoing care and welfare of detainees, DOs entered arrest and detainee details onto the national strategy for police information systems (NSPIS) custody system, overseen by the custody sergeant.

4.13 DOs carried out checks diligently at irregular intervals, in accordance with care plans, and recorded them in custody logs. The staff we spoke to knew how to check detainees and use proper rousing to elicit responses, and in some suites there were prominent aide-memoires displayed. However, in our custody record analysis, of the 13 detainees brought into custody intoxicated, only one had been assessed as requiring rousing, although it was not possible from the analysis to ascertain whether the lack of rousing had been inappropriate.

4.14 Detainees who were assessed as presenting a risk to themselves were monitored carefully. The level of monitoring varied on a four-point scale and we found no evidence of a 'default' monitoring position being adopted.

4.15 Few cells were monitored by CCTV; at Scunthorpe only two out of 14 cells, at Grimsby two out of 23 cells and at Queens Gardens three out of 22 were so equipped. There was no evidence of CCTV being used in place of personal checks.

4.16 Custody staff did not carry anti-ligature knives or shears; both of these items were stored by the charge desk and were readily accessible, although in some suites, such as Queens Gardens, there was a long distance between the furthest cell and the custody desk.

4.17 There were separate staff handovers for custody sergeants and DOs, which could have resulted in essential information about risk not being passed on. However, we observed a good handover at Grimsby, in which the outgoing custody sergeant briefed the whole of the incoming team and they then spent a few minutes with the individual they were replacing.

There was no time built into the shift patterns for this to happen, and the handovers were reliant on the incoming team arriving before their shift started.

4.18 Pre-release risk assessments were completed before detainees left the custody suites. In our custody record analysis, a pre-release risk assessment had been completed in 29 of the 30 cases we analysed. These plans related to detainees who had been identified as vulnerable in some way, and consisted mainly of details about additional support provided to ensure that a detainee arrived home safely. Good use was made of local contacts to provide relevant assistance to vulnerable detainees who were homeless. At Priory Road, we saw care being taken to ensure that a vulnerable female detainee was able to get home safely, and telephone calls being made at detainees' request to let family members know that they were being released.

Recommendations

4.19 Closed-circuit television coverage should be adequate to ensure the safety of detainees.

4.20 All custody staff should carry anti-ligature knives.

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

Use of force

4.22 Custody sergeants and DOs received annual training in the use of force. Detainees were not routinely seen by a health care professional after force had been used, unless an injury had been sustained, or the detainee requested it.

4.23 Many detainees arrived at the custody suites in handcuffs, which were rarely removed without custody sergeant authorisation. Although some of the police officers we spoke to understood the need for handcuffing to be justified, necessary and proportionate, we felt that there was a need for further refresher guidance in this area, to prevent the use of handcuffing becoming the norm. For example, one officer stated that, in his seven years of service, he had only *not* handcuffed two arrested persons. We were told that force was used in custody infrequently.

4.24 Staff that we spoke to placed a strong emphasis on the need to de-escalate situations and only used force as a last resort. When force was used, this was recorded on the custody record and a report was also filed centrally, although little use was made of this data and there was no analysis to identify any trends.

Recommendations

4.25 Detainees should be handcuffed only when a risk assessment indicates that it is necessary for the safety of staff, the public or the detainee.

4.26 Humberside police should monitor the use of force at each custody suite by ethnicity, age, location and officers involved, in line with Association of Chief Police Officers (ACPO) guidance.

Physical conditions

4.27 Cells were, in general, appropriately heated and ventilated and in a reasonable condition, although there was a lot of graffiti on the backs of doors. At all suites, any detainees found guilty of causing damage to the cell were charged with criminal damage. In our survey, 82% of respondents said that there had been graffiti in their cell, against a comparator of 55%.

4.28 Being an old suite, the physical conditions of Queens Gardens presented considerable challenges and it was due to be closed in the near future (see paragraph 3.2). Scunthorpe suite, although clean, was shabby and run down and in a poor state of decoration. Daily cleaning took place at all suites, and there were arrangements for deep cleaning to take place when required.

4.29 The cells at Scunthorpe were also shared with the courts and there were no cells specifically allocated for court detainees. We were concerned that there was confusion about who had responsibility for the care and welfare of detainees in cells being shared. The force and courts operated different standards. The force would allow a detainee to have a blanket, however, once responsibility for the detainee passed to GeoAmey who managed court custody, blankets were no longer allowed. This resulted in the removal of the police-issued blanket even though the detainee remained in the same cell.

4.30 Maintenance inspection checks were carried out at all suites, although there were inconsistencies in the application and recording of the regular checks. Quarterly and annual checks appeared to be carried out consistently.

4.31 All cells had functioning cell call bells, which were checked daily. DOs explained their use to detainees and we saw them responding to them promptly. A prompt and effective response to a call bell in Queens Gardens shortly before the inspection had averted a possibly fatal incident.

4.32 Some of the suites had cells containing ligature points but most of these presented a relatively low risk.

4.33 Most staff had received training in fire and evacuation procedures, although not all suites could readily produce evidence that a fire drill had taken place. Staff at Grimsby had taken part in a practice evacuation a few months before the inspection, as a result of which the fire evacuation procedure had been updated. At Scunthorpe, staff had recently had to evacuate the suite because a fire had broken out. A no-smoking policy was enforced at all the suites but nicotine replacement was not available to detainees.

Recommendations

4.34 Cells should be free of graffiti, and, when ligature points cannot be readily removed, the risks presented should be managed.

4.35 The use of police cells for court detainees at Scunthorpe should be reviewed, to ensure clarity about the delegation of responsibility for detainees held when the cells are shared.

Housekeeping point

4.36 The force should ensure that regular maintenance checks are carried out to a consistent standard.

Detainee care

4.37 All cells contained a mattress but no pillows. The practice of routinely wiping down these mattresses between uses varied between suites, as did the provision of blankets, which in some suites were provided only on request.

4.38 Most cells contained a toilet, and at Priory Road there were also hand-washing facilities. However, at Queens Gardens only six of the 22 cells contained toilets. In cells containing CCTV coverage, the toilet area was obscured on monitors, although detainees were not always informed of this. Toilet paper was provided in most cells, with 69% of respondents in our survey saying that this was the case, which was much better than the 48% comparator.

4.39 Showers were available at all the suites but were rarely used – usually only on request. In our custody record analysis, no detainees had had a shower while in custody. One detainee had gone to court from custody, after being held for over 38 hours, and not been offered a shower. The showers at Grimsby were poorly screened, allowing little privacy.

4.40 Hygiene items such as soap, toothbrushes, toothpaste and razors were available, and detainees were informed about this, but female detainees were not routinely offered feminine hygiene products.

4.41 Detainees who had their clothing removed were given either paper suits or tracksuit tops and bottoms, and plimsolls or slippers. Although there was a good supply of tracksuit tops and bottoms, our survey indicated that only 9% of detainees had been given a tracksuit to wear, against the 39% comparator. Replacement underwear was also available. We were told that family and friends could hand in replacement clothing at the front desk, in preparation for a court appearance.

4.42 Detainees generally received poor-quality microwave meals at recognised mealtimes, although at Priory Road and Queens Gardens the on-site canteen provided breakfast and lunch from Monday to Friday. Tea, coffee and water were available on request. Vegetarian and halal diets were provided for. In our survey, 27% of detainees who had been offered food and/or drinks said that it had been suitable for their dietary requirements, against a comparator of 44%.

4.43 Each custody suite had an exercise yard, although some were small and dark, and many contained graffiti and ligature points. Staff told us that detainees were always given exercise if they requested it, but that this rarely occurred. In our custody record analysis, only one of the 30 records we sampled recorded outdoor exercise being provided.

4.44 The provision of reading material varied considerably, ranging from the almost non-existent to a well-organised selection of books, magazines and newspapers at Bridlington, but there was little available that was age appropriate or in languages other than English.

4.45 Most suites had closed visits facilities but their use varied. For example, at Bridlington they were rarely used but they were actively promoted at Goole, where we were told that one or two visits regularly took place each week.

Recommendations

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

4.47 Food provided should be of sufficient quality and calorific content to sustain detainees for the duration of their stay and be suitable for detainees' dietary needs.

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

Housekeeping points

4.49 Pillows should be provided, every detainee should be offered a blanket and mattresses should be wiped down routinely between uses.

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

4.51 Detainees whose clothing is removed should be offered a track suit as a replacement.

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

5. Individual rights

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

Rights relating to detention

5.1 In the cases we observed, detention lasted no longer than necessary. DOs ascertained the reasons for detention, and custody sergeants then reviewed the case before granting authority to detain. Although staff at most suites said that arresting officers were making increasing use of alternatives to detention, such as street bail, fixed penalties and voluntary attendance at police stations, this was still underdeveloped and custody staff indicated that it was rare that detention would be refused.

5.2 The UK Border Agency telephoned all custody suites every morning to ascertain if any foreign nationals were being detained. Despite this good early identification, too many foreign nationals spent more than 24 hours in detention. Across the Humberside police area, 104 immigration detainees had been held in 2011; of these, 34 had been held for more than 24 hours, 12 of whom for more than 48 hours; the longest period of detention had been three days and 12 hours. Not all DOs were aware of the Legal Service Commission's Police Station Immigration Advice helpline, which enabled foreign national detainees to receive free legal advice from specialist solicitors.

5.3 We found some good examples of care being provided to detainees who were held for long periods, including a woman who was allowed visits from her family who provided her with clean replacement clothing. She was also provided with the opportunity to pray and a prayer mat.

5.4 A leaflet explaining detainees' rights in relation to PACE was available in different languages from the force's intranet. A telephone with two handsets was available on the booking-in desks, to enable professional interpreting services to be used. Staff were familiar with how to use these services and told us that they were normally able to obtain the services of a suitable interpreter.

5.5 Detainees were advised that they could have someone told of their whereabouts.

5.6 No custody suite was used as a place of safety for children under section 46 of the Children's Act 1989.[5]

5.7 Children and young people under the age of 17 were not interviewed unless an AA was present. The force adhered to the PACE definition of a child instead of that in the Children Act 1989, which meant that those aged 17 were not provided with an AA unless otherwise deemed vulnerable (see recommendation 2.19). Staff told us that they usually tried to find relatives to act as AAs. When relatives were unavailable, AA arrangements, including out of hours, for detainees aged under 17 were very good, especially at Priory Road, where there was a YOT based on-site; in Hull, anyone under the age of 17 was taken to Priory Road, rather than

[5] Section 46(1) of the Children Act 1989 empowers a police officer, who has reasonable cause to believe that a child would otherwise be likely to suffer significant harm, to remove the child to suitable accommodation and keep him/her there.

Queen's Gardens, for this reason. The YOT workers checked for juvenile detainees several times each day and those who were suitable were diverted away from the formal criminal justice process and instead worked with the YOT on interventions that included a restorative element.

5.8 Staff told us that whenever a juvenile was refused bail, they always contacted the local authority but that, in practice, facilities were never available to place juveniles in PACE remand beds or remand foster placements. This sometimes resulted in children being held in custody overnight unnecessarily.

5.9 Arrangements for vulnerable adults were less robust and staff often struggled to provide an AA for those they deemed in need of one. Detainees suspected of having a mental incapacity were required to undertake a mental health assessment. Following the assessment, an AA would be arranged if necessary but custody officers told us that there were long delays in this process. Out of hours, the emergency duty team of the relevant social services department attended, if possible, but this again often resulted in delays.

Recommendations

5.10 Humberside police should liaise with the UK Border Agency to ensure that immigration detainees are held in police custody suites for the shortest possible time.

5.11 Senior police officers should engage with the local authorities to ensure the provision of local authority accommodation for juveniles who have had bail denied.

5.12 Appropriate adults should be available to support without undue delay vulnerable adults in custody, including out of hours.

Housekeeping point

5.13 Notices promoting the Legal Service Commission's Police Station Immigration Advice helpline should be displayed prominently and immigration detainees should be encouraged to use it.

Rights relating to PACE

5.14 Detainees' right to free legal representation was clearly explained to them. Those who refused the offer were asked the reasons why, and these were recorded on the custody record, and they were reminded that they could change their mind at any time.

5.15 Detainees were provided with a 'notice of rights and entitlements' and could consult the PACE codes of practice, several copies of which were available at each suite. Legal representatives could easily obtain copies of detainees' custody records. The legal representatives we spoke to described a professional relationship with the police, and considered that PACE issues were applied efficiently and fairly. Detainees were not interviewed while under the influence of drugs or alcohol.

5.16 In our custody record analysis, reviews of detention were, in most cases, held in line with statutory requirements and time frames. However, in one case the inspector's review had been late and in another three there was no record of a review taking place. In several cases, reviews had been undertaken while the detainee had been asleep and there was not always evidence that such detainees had later been informed of these reviews. We were also told that

because of the relative remoteness of some of the custody suites, approximately 75% of all inspector reviews were conducted by telephone, which was an unusually large percentage.

5.17 There were sufficient interview rooms in all suites but the accommodation at Goole was cramped.

5.18 The management of DNA and forensic samples was generally sound but there was some confusion among staff about who was responsible for the management of the samples. In most suites, DNA samples were held in the same freezers as other forensic samples, and this had led to DNA samples being missed during regular collections.

5.19 Court cut-off times were reasonably flexible, although could be as early as 1pm on weekdays and 10am on Saturdays. Staff at Goole expressed concerns about the recent closure of the Goole court, which was adjacent to the police cells. Detainees at Goole now had to travel approximately 25 miles to Beverley to attend court. It was too early to determine the impact of this change but staff at Goole believed that it would result in an increased number of detainees failing to appear and a consequent rise in the number of warrants being issued. We were told that, given the difficulties associated with organising transport and liaising with a more distant court, any detainee now arriving at Goole custody suite after 10.30am would be unlikely to be dealt with at court until the following day.

Housekeeping points

5.20 Humberside police should review the arrangements for carrying out PACE reviews by inspectors, to ensure that they are normally carried out in person.

5.21 The force should keep DNA samples separate from other samples.

5.22 The force should liaise with court managers to ensure that court cut-off times are suitably flexible and monitor the possible impact on detainees from the Goole area.

Rights relating to treatment

5.23 The arrangements for detainees to make complaints needed to be improved. Notices were displayed in some, but not all, suites and few detainees were told that there was a complaints system. If a detainee raised a complaint, DOs advised them to attend the police station reception and request a form. This was at odds with the published policy, which many staff were unaware of. The force did not analyse or monitor trends in complaints.

Recommendation

5.24 Unless there is a clear reason not to do so, complaints should be taken while the detainee is still in custody. The force should monitor and analyse trends in complaints, and take corrective action where necessary.

6. Health care

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

Governance

6.1 Primary health services were provided Medacs, and the contract was managed robustly by the force. There were several providers for both substance misuse and mental health services, owing to the location of the force, which covered several local authority boundaries.

6.2 Custody staff told us that the health professionals were courteous, caring and respectful. We observed doctors and nurses treating detainees at Grimsby and Scunthorpe, and the time taken to see each person appeared to be appropriate to the individual's needs. Interpreting services were available but not in the medical rooms.

6.3 Medacs had clear clinical governance structures, including clinical supervision, regular training sessions and peer review. However, staff told us that some training had to be sourced and paid for privately and that they had difficulty getting the time to attend courses. Staff from the force met Medacs senior managers regularly; all meetings were minuted and the minutes, plus other information relating to the contract, were readily available to custody staff via the force intranet. Staff in the CJU had access to the Medacs computer system, so they could monitor activity in 'real time'; they also monitored complaints about the service and carried out their own investigations, rather than just relying on a response from Medacs.

6.4 At any one time, there were two Medacs nurses on duty – one to cover the north of the force area and one for the south. In reality, one nurse worked mainly in the two suites in Hull, while the other was based in Grimsby, as these were the busiest custody suites. Response times to the outlying suites at Bridlington and Goole were longer than those at the other suites. Given that Medacs also held the contract for health services to neighbouring forces, it was unclear why health professionals were not used for 'cross border' work, to reduce delays for detainees. There was only one forensic medical examiner (FME) for the whole force area, resulting in some delays.

6.5 The condition of clinical rooms varied; the room at Goole was unfit for purpose, and the room at Queens Gardens was used by officers to take statements. None of the rooms were locked and none met current infection control guidance. For example, none of the sharps bins were signed or dated, some of the rooms had fabric-covered chairs and none of the rooms had examination lights. We found out-of-date dressings and bandages in some of the rooms and broken equipment at Goole.

6.6 All of the suites had automated external defibrillators (AEDs) and oxygen. Disposable resuscitation face masks were strategically placed around the suites. Not all the suites had suction available; at Grimsby, we assembled the suction kit, as it was not ready for use, but then found that it did not work. AEDs were checked daily by police staff, all of whom were trained to use the equipment.

Recommendation

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

Housekeeping point

6.8 All emergency equipment should be serviceable and ready for use.

Good practice

6.9 *The management of the contract with the health provider was robust, and a model that should be adopted by other forces.*

Patient care

6.10 In our survey, only 31% of respondents said that they were seen by a health professional while in custody but, of these, 80% rated the quality of care as good or very good, against a comparator of 29%. Detainees only had the option of seeing whoever was on duty; staff were unclear who would accompany a female detainee being seen by a male health professional if there were only male custody staff on duty.

6.11 Custody staff called a central telephone number to request the attendance of a health care professional; although we were assured by senior managers that calls were dealt with by clinical priority rather than time booked, custody staff were not convinced that this was the case.

6.12 The contract with Medacs stated that the response time for calls was 60 minutes, and this had been met in 83% of cases in the previous three months. In our analysis of custody records, in seven of the 30 (23%) records we sampled, detainees had been seen by a doctor or nurse in custody. Of these, the longest wait had been approximately one hour 40 minutes, while the average wait was just over an hour.

6.13 While police staff expressed satisfaction with the amount of information and guidance that they received, we were concerned that detainees had not given consent for all their clinical details to be shared. Furthermore, in some of the records that we viewed, the care plans were over-complicated. Paper records (body maps) were stored in locked cabinets but it was unclear if some doctors took these records away for storage elsewhere.

6.14 Each custody suite had a reasonable stock of medications but some we found in the Bridlington suite were out of date. In most suites, the stocks of scheduled drugs were correct, although we found some evidence of discrepancies, and it was not clear whether these were always reported to the police. Nurses used patient group directions for common conditions. Medicines prescribed by FMEs were placed in labelled Henley bags, with instructions about when they were to be given, and kept with detainees' property; there was a system on NSPIS to remind staff when they were to be administered. Custody staff made attempts to retrieve medications, including methadone, from a detainee's home or pharmacy if required. While there was a clear policy on the force intranet regarding the administration of soluble paracetamol, in reality there was confusion across the suites, with different practices adopted in each.

Recommendation

6.15 Care plans should be succinct and easy to understand.

Housekeeping points

6.16 Detainees should give clear consent for clinical information to be shared with the police.

6.17 All medication errors should be reported to the contractor.

6.18 All staff should be reminded of the policies for the administration of medications.

Substance use

6.19 In our survey, 33% of respondents said that they had had a substance misuse issue on arrest, of whom 73%, considerably more than the 42% comparator, had seen a drug or alcohol worker while in custody.

6.20 Three of the four local authority areas covered by the force had intensive drug intervention programmes in place, resulting in good services for those with substance misuse issues. For example, in both custody suites in Hull, drug workers were available 14 hours a day. They saw adults who had had positive drug tests and those who wished to be referred on a voluntary basis. Since September 2011, the team had also provided a service for alcohol dependency. Uptake of the alcohol service was good, with 20% of people attending appointments at the alcohol project. Detainees could be referred to prescribing services, as well as providing one-to-one counselling and brief interventions work. Similar services ran in Scunthorpe and Grimsby. However, detainees in Goole and Bridlington did not have access to a drugs worker during their time in custody and relied on a paper referral system. We were told that this could take several weeks to be enacted. Needle exchange schemes operated in some, but not all, of the suites.

Recommendation

6.21 All detainees should have equal access to a substance misuse worker while in custody.

Mental health

6.22 At least three different NHS mental health trusts were responsible for mental health services across the force area, with others at the borders of the force area.

6.23 Humber Mental Health Foundation Trust covered the suites in Hull, Bridlington and Goole, although in the case of the latter two, if the detainee lived outside the Trust's catchment area, other trusts were responsible for their care. The small mental health diversion and liaison team provided services from Monday to Friday, 7am until 5pm, at Queens Gardens and Priory Road, during which they saw detainees referred by custody staff or Medacs. However, in reality they visited the suite early each day and only revisited if requested, so custody staff did not consider them to be readily available. Staff at Goole and Bridlington told us that, depending on the home address of the detainee, they could have to liaise with teams from Humberside, Lincolnshire or the East Riding about Mental Health Act assessments and transfers, which added complexity and prolonged the process. Staff tried to ensure that detainees who required

a mental health screen were seen before appearing in court. There was a mental health court on Tuesday mornings in Hull magistrates' court, attended by a forensic psychiatrist. Out of hours, the Trust's crisis team was available to the police by telephone. Psychiatrists in the Trust insisted on doctor-to-doctor referrals, which effectively added time to the process, as it required the input of an FME.

6.24 At Grimsby and Scunthorpe, similar services were available. A not-for-profit social enterprise called NAViGO provided mental health services in Grimsby; Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust provided these services in Scunthorpe.

6.25 A total of 111 detainees had been held in police custody under section 136 of the Mental Health Act in 2011 (see main recommendation 2.18). The force had a section 136 protocol with Humber NHS Mental Health Trust, and others were in the process of being finalised. Custody staff told us that joint working was effective, other than for occasional disputes about a detainee's level of intoxication and the acceptability of this to NHS services. Such disputes were taken to liaison meetings for discussion.

Recommendation

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

7. Summary of recommendations

Main recommendations

7.1 Police custody should not be used as a place of safety for section 136 assessments. (2.18)

National issues

7.2 Appropriate adults should be available to support without undue delay juveniles aged 17 in custody, including out of hours. (2.19)

Recommendations

Strategy

7.3 The force should introduce regular refresher training for custody staff. (3.14)

Treatment and conditions

7.4 Arrangements in booking-in areas should allow for private communication between detainees and staff. (4.8)

7.5 There should be clear policies and procedures to meet the specific needs of female and juvenile detainees and those with disabilities. (4.9)

7.6 Closed-circuit television coverage should be adequate to ensure the safety of detainees. (4.19)

7.7 All custody staff should carry anti-ligature knives. (4.20)

7.8 All custody staff should be involved in the same shift handover and, wherever possible, this should be away from the booking-in area and recorded. (4.21)

7.9 Detainees should be handcuffed only when a risk assessment indicates that it is necessary for the safety of staff, the public or the detainee. (4.25)

7.10 Humberside police should monitor the use of force at each custody suite by ethnicity, age, location and officers involved, in line with Association of Chief Police Officers (ACPO) guidance. (4.26)

7.11 Cells should be free of graffiti, and, when ligature points cannot be readily removed, the risks presented should be managed. (4.34)

7.12 The use of police cells for court detainees at Scunthorpe should be reviewed, to ensure clarity about the delegation of responsibility for detainees held when the cells are shared. (4.35)

7.13 All detainees held overnight, or who require one, should be offered a shower, which they should be able to take in private. (4.46)

7.14 Food provided should be of sufficient quality and calorific content to sustain detainees for the duration of their stay and be suitable for detainees' dietary needs. (4.47)

7.15 Detainees held for long periods should be offered outside exercise. (4.48)

Individual rights

7.16 Humberside police should liaise with the UK Border Agency to ensure that immigration detainees are held in police custody suites for the shortest possible time. (5.10)

7.17 Senior police officers should engage with the local authorities to ensure the provision of local authority accommodation for juveniles who have had bail denied. (5.11)

7.18 Appropriate adults should be available to support without undue delay vulnerable adults in custody, including out of hours. (5.12)

7.19 Unless there is a clear reason not to do so, complaints should be taken while the detainee is still in custody. The force should monitor and analyse trends in complaints, and take corrective action where necessary. (5.24)

Health care

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

7.21 Care plans should be succinct and easy to understand. (6.15)

7.22 All detainees should have equal access to a substance misuse worker while in custody. (6.21)

7.23 All detainees should have equal access to mental health services across the force area. (6.26)

Housekeeping points

Strategy

7.24 The force should review dip-sampling arrangements as part of their quality assurance processes. (3.10)

Treatment and conditions

7.25 The force should ensure that regular maintenance checks are carried out to a consistent standard. (4.36)

7.26 Pillows should be provided, every detainee should be offered a blanket and mattresses should be wiped down routinely between uses. (4.49)

7.27 All female detainees should be offered a hygiene pack on arrival. (4.50)

7.28 Detainees whose clothing is removed should be offered a track suit as a replacement. (4.51)

7.29 Reading materials suitable for a range of detainees, including young people and those whose first language is not English, should be made available. (4.52)

Individual rights

7.30 Notices promoting the Legal Service Commission's Police Station Immigration Advice helpline should be displayed prominently and immigration detainees should be encouraged to use it. (5.13)

7.31 Humberside police should review the arrangements for carrying out PACE reviews by inspectors, to ensure that they are normally carried out in person. (5.20)

7.32 The force should keep DNA samples separate from other samples. (5.21)

7.33 The force should liaise with court managers to ensure that court cut-off times are suitably flexible and monitor the possible impact on detainees from the Goole area. (5.22)

Health care

7.34 All emergency equipment should be serviceable and ready for use. (6.8)

7.35 Detainees should give clear consent for clinical information to be shared with the police. (6.16)

7.36 All medication errors should be reported to the contractor. (6.17)

7.37 All staff should be reminded of the policies for the administration of medications. (6.18)

Good practice

Health care

7.38 The management of the contract with the health provider was robust, and a model that should be adopted by other forces. (6.9)

Appendix I: Inspection team

Nick Hardwick	Chief Inspector
Sean Sullivan	HMIP team leader
Gary Boughen	HMIP inspector
Peter Dunn	HMIP inspector
Angela Johnson	HMIP inspector
Peter Dunn	HMIP inspector
Colin Carrroll	HMIP inspector
Ian MacFadyen	HMIP inspector
Paul Davies	HMIC inspector
Mark Ewan	HMIC inspector
Elizabeth Tysoe	HMIP health care inspector
Kate Tucker	CQC inspector
Michael Skidmore	HMIP researcher
Hayley Cripps	HMIP researcher

Appendix II: Summary of detainee questionnaires and interviews

Detainee survey methodology

A voluntary, confidential and anonymous survey of the prisoner population, who had been through a police station in Humberside, 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 19th December 2011. A list of potential respondents to have passed through Grimsby, Hull, Scunthorpe, Bridlington and Goole police stations was created, listing all those who had arrived from Grimsby, Hull, Scunthorpe, Bridlington, Goole and Beverley Magistrates' courts within the previous two months.[6]

Selecting the sample

In total, 99 respondents were approached. Forty-nine respondents reported being held in police stations outside of Humberside. On the day, the questionnaire was offered to 50 respondents; one questionnaire was returned blank and three were not returned. All of those sampled had been in custody within the previous 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:

- 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.

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

Response rates

In total, 46 (92%) 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 were excluded from the analysis.

The current survey responses were analysed against comparator figures for all prisoners surveyed in other police areas. This comparator is based on all responses from prisoner surveys carried out in 48 police areas since April 2008.

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

Summary

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

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

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

Police custody survey

Section 1: About you

Q2 Which police station were you last held at?

Hull Priory Road – 15; Hull Queen's Gardens – 13; Grimsby – 7; Scunthorpe – 6; Bridlington – 3; Goole – 1; Hull unknown – 1.

Q3 How old are you?

16 years or younger	0 (0%)	*40-49 years*	1 (2%)
17-21 years	8 (18%)	*50-59 years*	0 (0%)
22-29 years	26 (58%)	*60 years or older*	0 (0%)
30-39 years	10 (22%)		

Q4 Are you:

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

Q5 What is your ethnic origin?

White - British	42 (93%)
White - Irish	0 (0%)
White - other	0 (0%)
Black or black British - Caribbean	0 (0%)
Black or black British - African	0 (0%)
Black or black British - other	0 (0%)
Asian or Asian British - Indian	0 (0%)
Asian or Asian British - Pakistani	2 (4%)
Asian or Asian British - Bangladeshi	0 (0%)
Asian or Asian British - other	0 (0%)
Mixed heritage - white and black Caribbean	0 (0%)
Mixed heritage - white and black African	0 (0%)
Mixed heritage- white and Asian	0 (0%)
Mixed heritage - Other	0 (0%)
Chinese	0 (0%)
Other ethnic group	1 (2%)
Please specify:	4 (100%)

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

Yes	3 (8%)
No	36 (92%)

Q7 What, if any, is your religion?

None	19 (44%)
Church of England	17 (40%)
Catholic	4 (9%)
Protestant	0 (0%)
Other Christian denomination	0 (0%)
Buddhist	0 (0%)
Hindu	0 (0%)
Jewish	0 (0%)

Muslim 3 (7%)
Sikh 0 (0%)
Any other religion, please specify 2 (100%)

Q8 How would you describe your sexual orientation?
Straight/heterosexual 43 (100%)
Gay/lesbian/homosexual 0 (0%)
Bisexual 0 (0%)
Other (please specify): 7 (100%)

Q9 Do you consider yourself to have a disability?
Yes 3 (7%)
No 41 (93%)

Q10 Have you ever been held in police custody before?
Yes 43 (98%)
No 1 (2%)

Section 2: Your experience of the police custody suite

Q11 How long were you held at the police station?
Less than 24 hours 11 (24%)
More than 24 hours, but less than 48 hours (2 days) 19 (42%)
More than 48 hours (2 days), but less than 72 hours (3 days) 7 (16%)
72 hours (3 days) or more 8 (18%)

Q12 Were you told your rights when you first arrived there?
Yes 36 (78%)
No 8 (17%)
Don't know/can't remember 2 (4%)

Q13 Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')?
Yes 21 (46%)
No 22 (48%)
I don't know what this is/I don't remember 3 (7%)

Q14 If your clothes were taken away, what were you offered instead?
My clothes were not taken 25 (56%)
I was offered a tracksuit to wear 2 (4%)
I was offered an evidence/paper suit to wear 15 (33%)
*I was **only** offered a blanket* 2 (4%)
Nothing 1 (2%)

Q15 Could you use a toilet when you needed to?
Yes 39 (85%)
No 7 (15%)
Don't know 0 (0%)

Q16 If you used the toilet there, was toilet paper provided?
Yes 30 (68%)
No 14 (32%)

Q17 How would you rate the condition of your cell:

	Good	*Neither*	*Bad*
Cleanliness	14 (31%)	11 (24%)	20 (44%)

Ventilation/air quality	12 (27%)	11 (24%)	22 (49%)
Temperature	7 (16%)	3 (7%)	34 (77%)
Lighting	25 (56%)	10 (22%)	10 (22%)

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

Yes 37 (82%)
No 8 (18%)

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

Yes 9 (20%)
No 36 (80%)

Q20 Were you held overnight?

Yes 40 (89%)
No 5 (11%)

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

Not held overnight 5 (11%)
Pillow 2 (4%)
Blanket 37 (82%)
Nothing 3 (7%)

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

Not held overnight/did not get any bedding 8 (19%)
Yes 21 (50%)
No 13 (31%)

Q23 Were you offered a shower at the police station?

Yes 6 (13%)
No 39 (87%)

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

Yes 4 (9%)
No 41 (91%)

Q25 Were you offered anything to:

	Yes	*No*
Eat?	40 (89%)	5 (11%)
Drink?	42 (93%)	3 (7%)

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

Very good	*Good*	*Neither*	*Bad*	*Very bad*	*N/A*
0 (0%)	2 (4%)	7 (16%)	8 (18%)	24 (53%)	4 (9%)

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

I did not have any food or drink 4 (9%)
Yes 11 (25%)
No 29 (66%)

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

I do not smoke 4 (9%)
I was allowed to smoke 0 (0%)
I was offered a nicotine substitute 1 (2%)
I was not offered anything to cope with not smoking 40 (89%)

Q29 **Were you offered anything to read?**

Yes	8 (18%)
No	37 (82%)

Q30 **Was someone informed of your arrest?**

Yes	20 (44%)
No	10 (22%)
I don't know	5 (11%)
I didn't want to inform anyone	10 (22%)

Q31 **Were you offered a free telephone call?**

Yes	18 (41%)
No	26 (59%)

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

My telephone call was not denied	22 (50%)
Yes	3 (7%)
No	19 (43%)

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

	Yes	*No*
Who was taking care of your children	5 (14%)	32 (86%)
Contacting your partner, relative or friend	19 (45%)	23 (55%)
Contacting your employer	9 (25%)	27 (75%)
Where you were going once released	6 (17%)	30 (83%)

Q34 **Were you offered free legal advice?**

Yes	39 (87%)
No	6 (13%)

Q35 **Did you accept the offer of free legal advice?**

Was not offered free legal advice	6 (13%)
Yes	27 (60%)
No	12 (27%)

Q36 **Were you interviewed by police about your case?**

Yes	34 (83%)	
No	7 (17%)	If No, go to Q41

Q37 **Was a solicitor present when you were interviewed?**

Did not ask for a solicitor/was not interviewed	12 (29%)
Yes	27 (66%)
No	2 (5%)

Q38 **Was an appropriate adult present when you were interviewed?**

Did not need an appropriate adult/was not interviewed	26 (63%)
Yes	3 (7%)
No	12 (29%)

Q39 **Was an interpreter present when you were interviewed?**

Did not need an interpreter/was not interviewed	24 (59%)
Yes	1 (2%)
No	16 (39%)

Section 3: Safety

Q41 **Did you feel safe there?**

Yes	31 (76%)
No	10 (24%)

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

Yes	15 (34%)
No	29 (66%)

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

I have not been victimised	29 (66%)	*Because of your crime*	3 (7%)
Insulting remarks (about you, your family or friends)	8 (18%)	*Because of your sexuality*	1 (2%)
Physical abuse (being hit, kicked or assaulted)	7 (16%)	*Because you have a disability*	1 (2%)
Sexual abuse	2 (5%)	*Because of your religion/religious beliefs*	3 (7%)
Your race or ethnic origin	3 (7%)	*Because you are from a different part of the country than others*	2 (5%)
Drugs	2 (5%)		
Please describe:			19 (100%)

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

Yes	25 (57%)
No	11 (25%)
I wasn't handcuffed	8 (18%)

Q45 **Were you restrained while in the police custody suite?**

Yes	11 (26%)
No	32 (74%)

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

Yes	4 (9%)
No	39 (91%)

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

Yes	6 (14%)
No	38 (86%)

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

Very well	*Well*	*Neither*	*Badly*	*Very badly*	*Don't remember*
5 (11%)	17 (39%)	8 (18%)	8 (18%)	5 (11%)	1 (2%)

Section 4: Health care

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

Yes	12 (27%)
No	28 (64%)
Don't know	4 (9%)

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

	Yes	*No*
Doctor	7 (18%)	33 (83%)
Nurse	12 (27%)	32 (73%)

	Paramedic	1 (3%)	35 (97%)

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

Yes	7 (17%)
No	21 (50%)
Don't know	14 (33%)

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

Yes	13 (30%)
No	31 (70%)

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

Not taking medication	31 (70%)
Yes	3 (7%)
No	10 (23%)

Q55 Did you have any drug or alcohol problems?

Yes	15 (34%)
No	29 (66%)

Q56 Did you see, or were you offered the chance to see a drug or alcohol support worker?

I didn't have any drug/alcohol problems	29 (67%)
Yes	10 (23%)
No	4 (9%)

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

I didn't have any drug/alcohol problems	29 (67%)
Yes	1 (2%)
No	13 (30%)

Q58 Please rate the quality of your health care while in police custody:

I was not seen by health care	*Very good*	*Good*	*Neither*	*Bad*	*Very bad*
31 (69%)	2 (4%)	9 (20%)	0 (0%)	2 (4%)	1 (2%)

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

Yes	9 (20%)
No	36 (80%)

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

Yes	7 (16%)
No	38 (84%)

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

I didn't have any mental health care needs	38 (84%)
Yes	2 (4%)
No	5 (11%)

Prisoner survey responses for Humberside Police 2012

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

Key to tables

		Humberside Police 2012	Police custody comparator
	Any percentage highlighted in green is significantly better		
	Any percentage highlighted in blue is significantly worse		
	Any percentage highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
Number of completed questionnaires returned		46	1718
SECTION 1: General information			
3	Are you under 21 years of age?	**18%**	**9%**
4	Are you transgender/transsexual?	**0%**	**0%**
5	Are you from a minority ethnic group (including all those who did not tick white British, white Irish or white other categories)?	**6%**	**30%**
6	Are you a foreign national?	**7%**	**14%**
7	Are you Muslim?	**6%**	**11%**
8	Are you homosexual/gay or bisexual?	**0%**	**2%**
9	Do you consider yourself to have a disability?	**6%**	**20%**
10	Have you been in police custody before?	**98%**	**91%**
SECTION 2: Your experience of this custody suite			
11	Were you held at the police station for over 24 hours?	**76%**	**67%**
12	Were you told your rights when you first arrived?	**78%**	**80%**
13	Were you told about PACE?	**46%**	**52%**
For those who had their clothing taken away:			
14	Were you given a tracksuit to wear?	**9%**	**39%**
15	Could you use a toilet when you needed to?	**84%**	**90%**
16	If you used the toilet, was toilet paper provided?	**69%**	**48%**
17	Would you rate the condition of your cell, as 'good' for:		
17a	Cleanliness?	**31%**	**32%**
17b	Ventilation/air quality?	**27%**	**22%**
17c	Temperature?	**17%**	**15%**
17d	Lighting?	**55%**	**44%**
18	Was there any graffiti in your cell when you arrived?	**82%**	**55%**
19	Did staff explain the correct use of the cell bell?	**20%**	**22%**
20	Were you held overnight?	**90%**	**92%**
For those who were held overnight:			
21	Were you given any items of bedding?	**93%**	**83%**
For those who were held overnight and were given items of bedding:			
22	Were these clean?	**62%**	**59%**
23	Were you offered a shower?	**14%**	**9%**
24	Were you offered a period of outside exercise?	**8%**	**6%**
25a	Were you offered anything to eat?	**90%**	**81%**
25b	Were you offered anything to drink?	**94%**	**83%**
For those who had food/drink:			
26	Was the quality of the food and drink you received good/very good?	**4%**	**9%**
27	Was the food/drink you received suitable for your dietary requirements?	**27%**	**44%**

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For those who smoke:			
28	Were you offered anything to help you cope with not being able to smoke?	**2%**	**7%**
29	Were you offered anything to read?	**18%**	**13%**
30	Was someone informed of your arrest?	**45%**	**43%**
31	Were you offered a free telephone call?	**42%**	**49%**
If you were denied a free telephone call:			
32	Was a reason given?	**13%**	**14%**
33	Did you have any concerns about:		
33a	Who was taking care of your children?	**13%**	**14%**
33b	Contacting your partner, relative or friend?	**46%**	**53%**
33c	Contacting your employer?	**26%**	**20%**
33d	Where you were going once released?	**18%**	**31%**
34	Were you offered free legal advice?	**86%**	**86%**
For those who were offered free legal advice:			
35	Did you accept the offer of free legal advice?	**69%**	**72%**
For those who were were interviewed and needed them:			
37	Was a solicitor present when you were interviewed?	**94%**	**77%**
38	Was an appropriate adult present when you were interviewed?	**19%**	**27%**
39	Was an interpreter present when you were interviewed?	**6%**	**19%**
SECTION 3: Safety			
41	Did you feel unsafe?	**24%**	**39%**
42	Has another detainee or a member of staff victimised you?	**33%**	**28%**
43	If you have felt victimised, what did the incident involve?		
43a	Insulting remarks (about you, your family or friends)	**19%**	**14%**
43b	Physical abuse (being hit, kicked or assaulted)	**17%**	**7%**
43c	Sexual abuse	**4%**	**4%**
43d	Your race or ethnic origin	**6%**	**3%**
43e	Drugs	**4%**	**7%**
43f	Because of your crime	**6%**	**6%**
43g	Because of your sexuality	**2%**	**0%**
43h	Because you have a disability	**2%**	**1%**
43i	Because of your religion/religious beliefs	**6%**	**1%**
43j	Because you are from a different part of the country than others	**4%**	**4%**
44	Were your handcuffs removed on arrival at the police station?	**69%**	**73%**
45	Were you restrained while in the police custody suite?	**26%**	**18%**
46	Were you injured while in police custody in a way that was not your fault?	**9%**	**23%**
47	Were you told how to make a complaint about your treatment?	**15%**	**13%**
48	Were you treated well/very well by staff in the police custody suite?	**50%**	**28%**

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SECTION 4: Health care			
50	Did someone explain your entitlements to see a health care professional if you needed to?	**27%**	**35%**
51	Were you seen by the following health care professionals during your time in police custody?		
51a	Doctor	**18%**	**46%**
51b	Nurse	**27%**	**20%**
	Percentage seen by either a doctor or a nurse	**31%**	**52%**
51c	Paramedic	**3%**	**4%**
52	Were you able to see a health care professional of your own gender?	**17%**	**26%**
53	Did you need to take any prescribed medication when you were in police custody?	**29%**	**44%**
For those who were on medication:			
54	Were you able to continue taking your medication while in police custody?	**21%**	**37%**
55	Did you have any drug or alcohol problems?	**33%**	**54%**
For those who had drug or alcohol problems:			
56	Did you see, or were offered the chance to see a drug or alcohol support worker?	**73%**	**42%**
57	Were you offered relief or medication for your immediate withdrawal symptoms?	**7%**	**13%**
For those who were seen by health care:			
58	Would you rate the quality as good/very good?	**80%**	**29%**
59	Did you have any specific physical health care needs?	**20%**	**33%**
60	Did you have any specific mental health care needs?	**16%**	**24%**
For those who had any mental health care needs:			
61	Were you seen by a mental health nurse/psychiatrist?	**29%**	**30%**