Report on an inspection visit to police custody suites in Hampshire

12–16 November 2012

by

HM Inspectorate of Prisons and

HM Inspectorate of Constabulary

Glossary of terms

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1. Introduction

This report is part of a programme of inspections of police custody carried out jointly by our two inspectorates and which form a key part of the joint work programme of the criminal justice inspectorates. These inspections also contribute to the United Kingdom's response to its international obligation to ensure regular and independent inspection of all places of detention. The inspections look at strategy, treatment and conditions, individual rights and health care.

Strategic control had improved in the previous year with a move to centralised management of custody, and full staffing. Inspectors were managing the suites actively, there was clear communication with staff, and training was good, apart from a lack of refresher training for detention officers. Quality assurance of custody work through auditing of records was systematic but of insufficient depth. Future plans centred on the building of new suites, although sites had not yet been finalised.

Staff were positive and considerate in their treatment of detainees, and often very caring towards vulnerable people. Provision for people with disabilities was, however, weak in most suites. Reasonable care was taken to ensure detainee safety, although rousing checks for intoxicated people were not systematic, and continuous supervision of those at highest risk was not always carried out properly. Most suites showed their age and signs of wear and tear, but were kept clean. Facilities for detainees varied across the nine regular suites: in several, for example, showers and toilets afforded insufficient privacy.

Managers were fully aware that detention needed to be justified in each case. There was also good liaison with the Border Force and with armed services, which had many personnel based in the area. Reviews of detention were carried out properly, but not always on time. Appropriate adults were readily available for juveniles and vulnerable adults in the daytime, but less so out of hours. There was, on the whole, good attention to the legal rights of detainees, and to the specific needs of those who did not speak English well, but different approaches were taken at different suites to the taking of complaints.

Health care was the area most in need of attention. None of the medical rooms were fit for purpose, but more significant was the lack of strategic oversight and control. The performance of the main contracted provider of primary care was not monitored, and there was evidence that detainees had to wait too long to see a health care professional. There were some failings in clinical record-keeping and the control of medications, and the on-call system on the Isle of Wight was unsatisfactory. Arrangements for substance misuse interventions were patchy across the area, with a low referral rate; and mental health provision was similarly complex and inconsistent. The number of people detained on mental health grounds in police custody was reducing, but remained too high.

Overall, the force has recently improved its strategic grasp of custody work, but needs to extend this to health care provision, and this report highlights a number of other areas where consistency and compliance can be further improved across the force. The report provides a small number of recommendations to assist the force and the Police and Crime Commissioner 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 2013

2. Background and key findings

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

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

2.3 There were nine full-time designated custody suites and two reserve suites in the Hampshire police force area, with a total cell capacity of 158. The force had held 41,652 detainees from October 2011 to November 2012, and 214 detainees had been held for immigration matters in the 12 months to the end of October 2012.

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

Custody suite	Number of cells	Custody suite	Number of cells
Aldershot	13	Southampton	36
Basingstoke	14	Waterlooville	12
Fareham	14	Winchester	6
Lyndhurst	11	Alton (reserve)	6
Newport, Isle of Wight	11	Havant (reserve)	6
Portsmouth	29		

2.5 A survey of prisoners at HMP Winchester who had formerly been detained in the Hampshire custody suites was conducted by an HM Inspectorate of Prisons researcher and inspector (see Appendix II).[2]

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

[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

Strategy

2.6 The force had moved in 2011 to well-organised, centralised management of the custody function, and had reduced the number of suites. Plans to build four new police investigation centres, including custody, to replace seven of the present suites, were being progressed, with a view to completion in 2015, but the sites had not yet been finalised. Full staffing had recently been achieved, all staff being employed by the force. When cover was needed for staff absence, this was normally provided by trained personnel, although untrained police constables (PCs) were sometimes used as detention officers (DOs).

2.7 Inspectors managed the suites actively. There was good team working but no centralised cell allocation process. Communication was effective, with a monthly custody newsletter; relevant incidents were recorded systematically and the learning from them was communicated to staff. Learning from such sources as the Independent Police Complaints Commission (IPCC) was also effectively passed on to staff. The level of training was good, although DOs did not receive refresher training.

2.8 There was regular quality assurance of custody records but not, in general, of shift handovers. However, the dip-sampling was not cross-referenced to the corresponding closed-circuit television (CCTV) footage or to person escort records (PERs). Handovers in most suites did not include the whole staff team.

2.9 Partnership working was strong, with the exception of health agencies, which were not regularly represented at the Local Criminal Justice Board. The force was not actively managing its contract for the provision of health services, and there was inadequate liaison for managing those detained on mental health grounds (see section on health services). The network of independent custody visitors (ICV) was active and effective, and the force was well engaged with them.

Treatment and conditions

2.10 The attitude and behaviour of DOs towards detainees was good in almost all cases. Facilities in some cases made interaction difficult – for example, the very high desk front at Winchester. We saw some excessive waits in holding rooms, with no apparently adequate explanations. Sergeants and DOs generally worked together well as a team.

2.11 There was reasonable privacy for booking-in interviews: at the sites with smaller booking-in rooms, only one detainee was booked in at a time. This process was carried out thoroughly and with attention to the detainee's individual circumstances. Staff sometimes discussed detainees' health information in the hearing of others.

2.12 Staff looked after children and young people reasonably well. There was good attention to the needs of detained women, but some detainees were not asked if they had any dependency obligations, and not all DOs were aware that a female juvenile should be looked after by a female member of staff. Not all staff understood about the searching of transgender detainees.

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*.)

2.13 Staff were often considerate in supporting people with disabilities. Wheelchairs were available in most suites. There were significant adaptations for detainees with disabilities at Southampton, but not at some other sites, and hearing loops were only present at Southampton. All suites had at least a Bible and a Qur'an, and prayer mats were available, although these were not always stored respectfully. The direction of Mecca was not indicated any cells.

2.14 There was insufficient use of rousing and the organisation of these checks was not consistent. There was no use of rip-proof clothing for detainees at risk of self-harm. Police officers undertaking constant watch duties were not briefed by custody sergeants and did not always carry out this duty properly. All staff carried anti-ligature knives, of varying designs. There were some problems with ligature points, especially at Portsmouth, Fareham and Waterlooville.

2.15 PERs did not always give sufficient detail. Sergeants reviewed risk assessments and revised levels of observations appropriately when circumstances changed.

2.16 There were some detailed briefings at shift change times, but only at Waterlooville and Fareham did these involve all the staff coming together for a single, confidential handover. Generally, sergeants handed over sufficient information to those taking their place, and DOs informally handed over to their successors. Most suites had a whiteboard, which was usually shielded from general view, but Portsmouth had two separate whiteboards with inconsistent information.

2.17 There was little use of handcuffs, and they were generally taken off quickly on arrival at a custody suite. We saw some examples of thorough preparation for release, and there were useful leaflets with details of agencies, although our custody records analysis showed some deficiencies in pre-release risk assessments. Travel warrants and bus fares were no longer given out at most suites but sergeants sometimes arranged transport home for vulnerable detainees.

2.18 Most suites were reasonably clean, but run-down. The Southampton suite was a good environment, apart from the medical room. The environment at Aldershot and Basingstoke was poor. Staff carried out daily checks in most places, although there were gaps in the records. The call bell system at Portsmouth was unsatisfactory. Fire drills had taken place at some suites, although not all had sufficient handcuffs for an evacuation.

2.19 No pillows were issued at any suite. There was spare clothing at all suites, but most did not supply underwear. There was insufficient screening of some showers, and in the custody records we analysed, hardly any detainees had taken a shower. Toilet paper was available in cells at most suites. Cell toilets were not obscured on the closed-circuit television (CCTV) at some suites.

2.20 Food and drink provision was generally adequate, and exceptionally good at Southampton. Some detainees were given exercise, but the exercise yard at Waterlooville was indoors.

2.21 A reasonable range of reading matter was offered at Portsmouth, Southampton, Winchester and Fareham, including material that was suitable for younger people; other suites were less well equipped. Domestic visits were allowed in special circumstances at most suites.

Individual rights

2.22 Sergeants used their discretion to refuse detention in cases where they judged it unnecessary, and there was no evidence of undue pressure to detain. Detainees were generally booked in promptly after arrival at the custody suites but we found evidence of some long waits.

2.23 There was good liaison with the Royal Navy and the Royal Military Police for managing detainees who were from these services. The appropriate adult (AA) service worked well during the day, with various providers across the force area, but in practice no AAs were available after 11pm. For example, in our custody record analysis we came across a juvenile who had been held overnight because an AA could not be supplied.

2.24 All detainees were given their rights and entitlements properly, with good information sheets being offered. Access to legal advice was good but not all suites had private facilities for telephone conversations.

2.25 Professional telephone interpreting services were used routinely to inform detainees of their rights and for medical assessments, and interpreters were used for interviews, although exceptions occurred. Two-handset telephones were not available in all suites. Rights and entitlements were available in Braille at Lyndhurst. At Southampton audio files of rights were available in foreign languages but with no means of playing them. The collection of immigration detainees by the UK Border Force was relatively prompt.

2.26 Reviews of detainees in custody were thorough. During the inspection, when a review was carried out while the detainee was asleep, they were informed on waking; however, our custody record analysis did not record such detainees being informed on waking, and also showed that many reviews had been late.

2.27 Court cut-off times were generally between 2pm and 3pm, but were sometimes earlier at Lyndhurst, and much earlier at Portsmouth if the list was full. At the time of the inspection, five detainees arrested on a Saturday were held in custody for over 48 hours pending transfer to court on the following Monday, but then held for a further night. The processing of DNA samples was efficient in all suites.

2.28 There were varying practices across the force area on the taking of complaints. IPCC guidance on making a complaint was available at some suites, and there was evidence of it being given out in some cases.

Health care

2.29 There was an overall lack of ownership, and strategic and operational oversight of health-related issues in custody. G4SFMS, the main provider, had clinical governance systems, but the contract was not monitored by the force, and G4SFMS did not inform the force of clinical incidents.

2.30 None of the medical rooms across the suites was fit for purpose: most were multi-purpose and not appropriate for the taking of forensic samples. First-aid kits were not all stocked and some items were out of date. There were automated external defibrillators in each suite but there was no oxygen supply or suction equipment.

2.31 There were three nurses/paramedics on duty at any one time plus a forensic medical examiner (FME) for most of the force area, with an extra nurse over the weekend. Provision for the Isle of Wight was separate, and involved excessive continuous on-call periods.

2.32 Clinical records were generally held securely but were of uneven quality. Confidentiality of records was not always properly observed. In our custody record analysis there were several instances of missing clinical records on NICHE (the police electronic case management system) and clinical interventions were not routinely recorded in the detention log.

2.33 Some medications were overstocked and we found discrepancies in stock recording. Medications were administered by health care professionals. Methadone was not always prescribed when appropriate. There was a lack of governance in relation to medications that custody staff could administer following telephone advice, and some discrepancies in lists of medications to be destroyed.

2.34 There were several commissioners and providers of substance misuse services across the force area. Most of these services did not have a regular presence in the custody suites. There were few referrals from custody to these services, and staff rarely offered access to them. Needle exchange was not available in custody.

2.35 Four mental health trusts provided services, with four separate local authorities providing approved mental health professionals, and the level of provision was very uneven. A chief inspector took the lead for mental health issues across the force. Innovative project work was being piloted to try to address some of the problems identified but its effectiveness had not yet been assessed. Services on the Isle of Wight were difficult to access.

2.36 There were seven section 136 suites (health facilities for those detained on mental health grounds) in the force area. The number of such detainees brought into police custody was too high, although it had been decreasing.

Main recommendations

2.37 The force should review its strategic governance arrangements of health care provision in custody and work with health care partners to ensure effective outcomes for detainees.

2.38 Intoxicated detainees should be roused, and this should be clearly recorded in the custody record.

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

National issues

2.40 Appropriate adults should be available at all times to support without undue delay detained juveniles aged 17, provided that informed consent has been given.[3]

[3] Although this met the current requirements of PACE, in all other UK law and international treaty obligations, 17-year-olds are treated as juveniles.

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 An assistant chief constable (ACC) provided strategic leadership on custody issues, with a centralised custody function delivered through the Custody and Criminal Justice department (CCJ). There was a police staff head of CCJ, and the head of custody in the CCJ was a chief inspector.

3.2 There were nine full-time designated custody suites and two stand-by suites in the Hampshire police force area. Recently, there had been no need to use suites on an unplanned basis or to utilise facilities in neighbouring forces.

3.3 The force estates strategy had reduced the number of suites to the current nine. There were plans to build four new police investigation centres, including custody, to replace seven of the present suites, with a view to completion in 2015. These plans did not yet have concrete shape, and there was not yet a clear plan for transition to the new arrangements in order to make full use of the opportunities that they would present. Full staffing had recently been achieved, all staff being employed by the force. The police authority (PA) was fully engaged with the estates strategy and had agreed the funding provision for the development of custody facilities with the force. There was a proactive lead PA member for custody. This member was due to stand down on the election of the Police and Crime Commissioner (PCC).

3.4 Staffing levels in custody suites were adequate, with limited requirement for cover from operational resources, and comprised permanent custody sergeants and DOs employed by Hampshire Police. There were also custody assistants (CAs) at the Southampton custody suite, although there had been a recent decision to convert these posts to DOs. Custody resources were managed under the centralised CCJ management structure. There was no use of 'acting sergeants' to undertake custody duties. DOs (and CAs in Southampton) looked after the ongoing care and welfare of detainees, and DOs in Southampton were involved in booking in detainees. Generally, there were good working relationships within the custody suites and there was consistency in most areas of custody delivery. Communication between custody sergeants and DOs was effective, except during shift handovers, which were not managed adequately (see section on treatment and conditions). There was no centralised cell allocation process, so that detainees were generally conveyed to the nearest facility regardless of occupancy levels. Police constable gaolers provided cover for DOs without receiving custody-specific training.

3.5 There were clear arrangements for custody management: dedicated custody inspectors reported to the head of custody, who had a small support team. The custody inspectors line-managed custody sergeants, who in turn line-managed DOs and CAs.

3.6 The ACC lead for custody held a weekly meeting with the head of CCJ, where custody matters could be escalated for resolution. She also held a quarterly custody steering group meeting to review performance. The head of CCJ held a monthly senior management team meeting, attended by the head of custody, where custody issues formed part of the agenda. There was a monthly custody inspectors' meeting/user group meeting, chaired by the head of custody.

User group representation included health and safety, Professional Standards Department (PSD), and Police Federation and Unison custody staff. A weekly round-up email was circulated at local level by custody inspectors. Staff reported good visibility of inspectors and chief inspectors in custody.

3.7 The force had a number of custody-related policies based on the National Policing Improvement Agency's (NPIA) SDHP (see paragraph 2.2); these were accessible to all staff on the force's custody intranet page. The force was working to rationalise policies as they came up for review. The IPCC 'learning the lessons' document was also available on the intranet site. There was a monthly 'Custody Courier' newsletter, which was used effectively to communicate a wide range of custody-related issues. Staff showed good awareness of the custody team computer drive and often received emails containing information about near misses and adverse incidents.

3.8 There was a thorough process for reporting near misses and adverse incidents, with a report being completed at the time of the incident on the accident management system (AMS). The health and safety department had responsibility for this system, and copies of the report were forwarded to relevant departments such as the CCJ and PSD. A separate spreadsheet was created for custody-related incidents and there was a 'force organisational learning matrix' system, containing a breakdown of custody issues. These were communicated through the custody intranet and the newsletter; when there was a need for immediate communication of issues to staff, this was done by email.

3.9 There was a quality assurance process for dip-sampling custody records, 20 records being sampled per month by each custody inspector using a corporate template. The template was accessible on the custody intranet and was auditable. The dip-sampling was overseen by the head of custody-but it was not cross-referenced to the corresponding CCTV footage and PERs. The custody inspector fed back any issues in person to the relevant staff member and any trends were communicated through the newsletter and included in custody sergeant refresher training. There was no quality assurance of shift handovers.

Recommendation

3.10 Police constable gaolers should receive custody-specific training.

Housekeeping points

3.11 Plans for the development of the estate should be confirmed, with provisional milestones towards the projected completion date.

3.12 Quality assurance should include checking custody records against closed-circuit television (CCTV) and person escort record forms, and also the monitoring of handovers.

Partnerships

3.13 There were effective partnership arrangements and there was active engagement with relevant criminal justice partners at the strategic level, with the exception of health agencies, which were not regularly represented at the Local Criminal Justice Board. There were concerns about the strategic governance of heath care, and specifically about management of the contract with G4S and the 'place of safety' arrangements under section 136 of the Mental

Health Act 1983.[4] The chief constable chaired the Local Criminal Justice Board, which was also attended by the head of CCJ. The head of CCJ also attended the LCJB Criminal Justice subgroup, which included representatives from the Crown Prosecution Service, courts, Probation Service and the Youth Offending Service.

3.14 The ICV scheme was active and comprised four panels covering the force area, providing a regular schedule of visits. There was a coordinator in the PA for the scheme. ICVs said that they were generally admitted to custody suites quickly and they were confident in challenging staff. The ICV panel convenors met the PA custody lead member quarterly, and the CCJ department of the force was consistently represented at these meetings.

Learning and development

3.15 All custody sergeants and DOs had undergone custody-specific training before undertaking custody duties. There was an initial course for custody sergeants, followed by a two-week mentoring period. The current course was linked to the NPIA National Custody Officer Learning Programme (NCOLP). There was biannual refresher training for custody sergeants. The CCJ had an input into refresher course content, linked to quality assurance issues, complaints and IPCC communications. DOs received an initial course, followed by a period of mentoring, but they had no refresher training. The force was seeking to address this. Code G PACE training was delivered across the force.

Housekeeping point

3.16 The force should introduce regular custody refresher training for detention officers.

[4] 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. 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 of the custody staff we observed were polite, friendly, caring and considerate towards detainees, using their first names or title and surname as appropriate. We saw exceptional care given to some vulnerable detainees. Detainees told us that staff treated them well throughout their time in the custody suites.

4.2 At Portsmouth, Fareham and Southampton, the booking-in desks provided good privacy. The booking-in areas at Newport, Lyndhurst, Aldershot, Basingstoke and Waterlooville offered little privacy but we were assured, and witnessed, that no more than one detainee was booked in at a time. There were two separate booking-in areas at Basingstoke, the second area being used when the custody suite was busy. There was a partition separating the second desk from the first, allowing for some privacy. At Portsmouth, the booking-in desks were located in three separate charge rooms, so that detainees were never booked in together. Access to these by other staff was suitably restricted. At Fareham, we observed staff taking care to ensure confidentiality by closing doors while booking in detainees. At Winchester, the desk was so high that it was difficult for the custody sergeant to see the detainee. This impeded communication, and during one booking-in we observed, the custody sergeant was not aware until several minutes into the process that the detainee was handcuffed.

4.3 During an evening visit at Portsmouth, we saw three detainees kept waiting unnecessarily for an hour in the holding room. Arresting officers in the same holding room made telephone calls to the Criminal Records Bureau (CRB) to initiate the custody record, so that names and other information were overheard by detainees waiting to be booked in. At Portsmouth a detainee's hepatitis C status was inappropriately displayed on a whiteboard, and at Winchester the custody sergeant needlessly warned staff that two detainees being brought in were HIV positive.

4.4 At all suites, staff asked female detainees if they wanted to speak to a female staff member in private. Not all the custody suites had designated women's cells but staff were aware of the need to ensure that they were held, and permitted to shower, exercise and move around the custody suite, separately from male detainees. We saw staff booking in a female at Newport sensitively and discreetly, and advising her that hygiene packs were available if required. At none of the suites were the staff aware that female juveniles should be in the care of a named female officer at all times.

4.5 Staff looked after children and young people reasonably well. None of the staff had received specific training in looking after juvenile detainees. Custody sergeants told us that they explored alternatives to detaining a child but that if they had to detain, they kept the period as brief as possible, although this was not always achieved (see section on individual rights). There were cells near the booking-in area designated as detention rooms at Portsmouth, Fareham, Basingstoke and Waterlooville. At Fareham and Winchester we were told that they had sometimes allowed particularly vulnerable detainees to sit in a cell with the door open, subject to risk assessment.

4.6 At Southampton there was a cell adapted for use by detainees with disabilities. It had a lowered cell call bell near the bed plinth. This cell was also located opposite the toilets adapted for those with disabilities. Southampton was also the only custody suite to have a hearing loop. None of the other custody suites had any adaptations for detainees with disabilities but staff were often considerate in supporting such people, and wheelchairs were available in most suites. At all suites we were told that there were always police officers able to sign, who could be called to the custody suite to help communicate with detainees who were hard of hearing.

4.7 In our analysis of 60 custody records, there were five (8%) foreign nationals and all had been given their foreign national rights, although none had wanted their consulate or embassy to be informed of their detention. There was evidence that staff gave due consideration to the requirement for interpreters; in the one instance where this had been necessary, an interpreter had been present while the detainee had been given their rights and during the interview.

4.8 At most of the custody suites detainees were asked if they had any dependants. At Waterlooville the custody sergeant included asking detainees if they had any pets at home that would need taking care of, and facilitated a detainee making arrangements for his dog to be fed and walked. At Basingstoke a female detainee was upset at the prospect of not being released in time to collect her niece and the custody sergeant made efforts to contact family members to undertake the task. However, at Newport some detainees were not asked if they had any dependency obligations.

4.9 Not all staff were aware of the correct way to search transgender detainees according to Annex L, PACE Code C guidance; staff detailed varying ways in which they would deal with such a situation.

4.10 All suites had at least one copy of the Bible and Qur'an, and prayer mats were available, although these were not always stored respectfully. The direction of Mecca was not displayed in any cells but compasses were available at all suites.

Recommendations

4.11 At Winchester, sergeants should have a clear view of those whom they are booking in.

4.12 A hearing loop should be available at each suite and all custody staff should know how to use it.

Housekeeping points

4.13 Arresting officers who have to convey confidential information by telephone about detainees arriving at the custody suite should do so only where they cannot be overheard by other detainees, and confidential medical information should not be unnecessarily disclosed.

4.14 Female juveniles should be placed in the care of a named female officer at all times and custody staff should be aware of this requirement.

4.15 Staff should understand the contents of Annex L, PACE Code C in respect of searching transgender detainees.

4.16 Items of religious observance should be stored respectfully.

4.17 All detainees should be asked about their dependency obligations and given the opportunity to make arrangements.

Safety

4.18 Risk assessments were conducted thoroughly, and we observed custody sergeants asking supplementary questions about health and welfare when necessary. At Fareham we saw the custody sergeant patiently question a potentially vulnerable young woman in a highly sensitive manner about her health, mood and her comprehension of the process, thereby concluding that she required an AA.

4.19 The booking-in arrangement at Southampton was different from that at the other custody suites, in that DOs, closely supervised by the custody sergeants, booked in detainees and CAs looked after their welfare. We saw a custody sergeant there advise the DO to proceed straight to the health and welfare part of the risk assessment because the sergeant was concerned about the detainee's health and possible fitness to be detained, which was well judged. From our custody record analysis, it was apparent that custody staff's risk assessments generally added helpfully to the detainee's self-report.

4.20 The Police National Computer (PNC) was generally checked for warning markers by the DO while the custody sergeant was completing the risk assessment, but we were told at Portsmouth that, at busy times, the PNC was sometimes checked only after the detainee had been booked in. However, in our custody record analysis there were eight detainees identified with current or previous self-harm or suicide issues and in only one of these cases was there clear evidence that the PNC and the associated self-harm markers had been identified and had informed the subsequent care plan.

4.21 Most detainees we observed being booked in were placed on 60-minute observations, which was the default position for staff to adopt, unless other risks were identified. There was evidence that risk assessment was a dynamic process, with care plans amended appropriately as detainees' circumstances changed. At Waterlooville two vulnerable detainees were placed on constant observations which were later amended during their detention, once they had been seen by a health care professional.

4.22 We observed a constant watch at Aldershot. The police officer conducting it did not appear to be fully engaged with the task, as she was using her mobile telephone. She had received a briefing from a colleague she had relieved earlier in the day but had not been briefed by either of the custody sergeants on duty. She was subsequently relieved by another officer, who, again, was not briefed by either sergeant. After initially engaging with the detainee, we observed this officer typing up reports on the vehicle data recorder. The detainee in this case was awaiting a mental health assessment.

4.23 We had serious concerns about rousing checks. All custody staff with whom we discussed these told us that they would seek to obtain a response that indicated a normal level of consciousness. There were magnetic 'R' signs for attaching to cell doors, although staff were not all clear about whether these indicated 'risk' or 'rousing', and they were not always used in appropriate cases. Our custody record analysis showed that, of the 22 detainees who came into custody intoxicated, in only two instances was rousing explicitly mentioned in the care plan, and 16 had been placed on standard 60-minute observations without rousing. In several of these cases the risk assessments had included phrases such as '…detainee heavily in drink…' and '…has been drinking all day…'.

4.24 There was no use of rip-proof clothing for detainees at risk of self-harm, although staff told us that they would manage risk of self-harm by the use of observations instead. All staff carried anti-ligature knives.

4.25 The content of PERs being completed for detainees who were due to be transported to court was variable. We witnessed one detainee at Winchester being conveyed to hospital without a PER being completed, although the escorting officer was provided with some paperwork relating to the detainee's medical condition.

4.26 Most of the staff handovers we saw were detailed and thorough, although, partly due to shift patterns, most custody sergeants and DOs handed over separately. Staff indicated that the separate handovers were necessary because sergeants needed to know about PACE and investigation issues, while the DOs' focus was more on care and welfare. At Waterlooville DOs and custody sergeants congregated around the whiteboard in the back office to conduct a thorough handover, and at Fareham staff closed the doors to the cell corridors to ensure confidentiality, and the handover was very thorough. The handovers generally took place in front of whiteboards, which on most occasions were adequately screened from public view; however, on one occasion at Winchester we found the whiteboard unscreened and visible to a detainee being booked in. Some handovers were not well conducted. We saw an evening handover at Portsmouth take place in an office where some DOs were talking while others were trying to listen to the handover. There were two separate whiteboards at this suite, one used mainly by DOs and the other by custody sergeants; on both occasions that we visited the suite, some of the information on the whiteboards conflicted, which could result in confusion and mistakes being made about detainee care.

4.27 The custody record system incorporated a pre-release risk assessment (PRRA) form which prompted the person releasing a detainee to consider a number of different potential issues. In spite of this, in our custody record analysis we found one example where there was no record of a PRRA having been completed. The PRRAs in the analysis regularly showed that there were no perceived risks for the detainees being released, and in many an associated risk level had not been identified. Twelve (20%) detainees in the sample had had some level of vulnerability on release that appeared not to have been addressed because either the PRRA showed no risks, or the risks identified appeared not to have been acted on. One example was a female detainee with mental health issues and a known history of self-harm who was released at approximately 1am with no indication of how she was getting home, with the additional concern that her medication was overdue.

4.28 We saw some thorough preparation for release by staff, and vulnerable detainees were given a comprehensive leaflet detailing a list of support agencies when they left the custody suite, but this was available only in English. There was literature available about specialist organisations, such as Stop it Now! (for sex offenders) and advocacy services for people with learning difficulties. Staff told us that travel warrants had been withdrawn, resulting in ad hoc arrangements having to be implemented – for example, transporting detainees home in police vehicles. Staff at Newport said that they could purchase ferry tickets to enable detainees to return to the mainland, but this necessitated an officer attending at the port personally to purchase the ticket through a cost centre billing process. At Portsmouth, we observed a custody sergeant liaising effectively with social services about the safe release of an 11-year-old. He arranged for police officers to take the child back to his school because he did not want to return to his parents. Our custody record analysis found some examples of taxis being called for detainees or officers transporting them home.

Recommendations

4.29 Care plans should include information from the risk assessment process, to ensure adequate management of potential risk factors.

4.30 Handovers should be comprehensive and attended by all custody staff, with the area in which the handover takes place cleared of other staff and detainees.

4.31 Pre-release risk assessments should be detailed, meaningful and based on an ongoing assessment of detainees' needs while in custody, and the custody record should reflect the position on release and any action that needs to be taken.

Housekeeping points

4.32 Staff conducting constant watches should be briefed by the custody sergeant and advised how to carry out this duty.

4.33 Person escort records should be completed when detainees are being escorted to other venues/custody suites.

Use of force

4.34 We saw little use of force in the custody suites, and most detainees were brought in without the use of handcuffs. In most instances, handcuffs were removed before booking-in started. Most police officers we spoke to said that they would only use handcuffs when it was proportionate and necessary. We saw no detainees being strip-searched and we were told that this procedure was rarely carried out. Use of force was recorded on a form which was sent to Hampshire Police HQ for analysis, although custody officers told us that they were unaware of any analysis of trends and patterns in use of force. Custody staff at all suites were able to describe the de-escalation techniques they used, and we observed staff applying them to good effect. All custody staff had been trained in approved personal safety techniques and received annual refresher training.

Recommendation

4.35 Hampshire Police should collect and analyse data about use of force in accordance with the Association of Chief Police Officer's policy and National Policing Improvement Agency guidance.

Physical conditions

4.36 In our survey, more detainees than at comparator suites rated the cleanliness of their cell, as good (45% versus 34%). At all suites, any detainees found to have caused damage to the cells were charged with criminal damage. In our survey, 33% of respondents said that there had been graffiti in their cell, against a comparator of 55%.

4.37 Southampton was the newest of the custody suites and provided an excellent, clean environment. Each of the cells contained a blanket, box of tissues and paper cup for drinking water. Most of the other suites were reasonably clean – especially Waterlooville, Newport and Fareham. Portsmouth was clean but old and run-down. There was some ingrained dirt in the

floors there and some graffiti in the cells. Some of the cells at this suite had a laminated card beside the door, stating 'cleaned by (name) at (date and time)'. Portsmouth and Fareham each had one cell in which the CCTV camera had been pelted with matter that had not been properly cleaned off. Several cells at Lyndhurst were dirty but only two hours' cleaning each morning was provided. The environment at Aldershot and Basingstoke was poor, with inadequate ventilation at Basingstoke.

4.38 Fareham, Waterlooville and Portsmouth had ligature points – for example, on doors and plinth grilles. Staff and managers were aware of these issues.

4.39 At most suites, daily maintenance checks were carried out and recorded on a custody checklist. There were gaps in the recording of these checks at Lyndhurst, Southampton, Portsmouth and Basingstoke. At Aldershot we were told that daily checks were carried out but not recorded. Standby suites were used when major maintenance work was carried out in the main suites. Custody staff cleaned cells between uses, and mattresses were wiped with anti-bacterial cleaner. Staff told us that the recent centralisation of the process for obtaining repairs had resulted in slower response times. For example, one cell at Portsmouth had been out of action for more than two weeks because of delays in obtaining replacement parts for a faulty call bell (see below).

4.40 The use of cell call bells was not always explained to detainees. Call bells were answered within a reasonable time at all the suites, although the call bell system at Portsmouth was unsatisfactory. An extension to the suite had resulted in two systems being in operation, and one of the panels was incapable of generating an audible signal. At Southampton the call bell system allowed custody staff to speak to detainees in their cells and for detainees to have calls put through to their cells.

4.41 Most staff had been trained in fire and evacuation procedures, although not all suites could readily produce evidence that a fire drill had recently taken place. At Newport, Lyndhurst and Fareham there were insufficient handcuffs available to evacuate the cells safely if at full occupancy. Evacuation plans were detailed and staff were familiar with the roles they would take in the event of an emergency.

Recommendations

4.42 There should be thorough daily and weekly maintenance checks at all custody suites, including systematic identification and reporting of ligature points.

4.43 The cell call bell system at Portsmouth should be repaired or replaced.

Housekeeping points

4.44 Correct use of call bells should be explained to all detainees.

4.45 Fire evacuation drills should be carried out and records kept in all custody suites.

Detainee care

4.46 All cells contained a mattress and detainees were given a blanket, which was clean and in a good condition, but no pillows were available. If a detainee wanted to have a pillow, they were provided with an extra blanket that they rolled up. In our survey, more detainees than at

comparator custody suites said that they were given items of bedding (94% versus 83%). Staff at Lyndhurst reported a shortage of blankets, partly due to issues with a new laundry contractor. At Portsmouth the suite had run out of blankets; staff told us that it was often the case that fewer blankets than expected were returned from the laundry.

4.47 Most cells across the custody suites had in-cell sanitation. At Lyndhurst toilet paper was kept in the corridor and had to be requested, but elsewhere a quantity of toilet paper was available in the cells. At Portsmouth there was one toilet in an alcove in a corridor that had no screening (see Appendix III), and another toilet was only partially screened. Female detainees were taken to use the staff toilet. At Winchester a toilet in the main cell corridor was inadequately screened. Cell toilets were not electronically obscured on CCTV monitors at Aldershot, Basingstoke, Winchester or Waterlooville.

4.48 There were showers at all suites except Lyndhurst; they offered little privacy, especially for female detainees, and at Winchester there was no changing area and the shower was located at the far end of the male cell corridor. In our custody record analysis there was no evidence that showers were routinely offered. Cotton towels were available at all suites.

4.49 There were ample supplies of clean cotton towels, soap, shampoo, toothpaste and toothbrushes at all suites. There were disposable razors at all suites except Fareham, where detainees going to court or being released would be unable to shave. All suites had stocks of feminine hygiene packs. These were not proactively offered, except at Newport.

4.50 Replacement clothing was provided when detainees were unwilling to have cords removed from their clothing, or for evidential purposes. There were good stocks of replacement clothing, including jogging bottoms, sweatshirts and plimsolls. A quantity of surgical clothing ('scrubs'), comprising tops and trousers, were also available at most suites, although we were told that their use was being phased out. Only at Newport was underwear available for both men and women.

4.51 Nicotine replacement products were available; however, at Newport and Aldershot staff indicated that they always sought authorisation from a health care professional before administering the product. We witnessed such an authorisation being sought and granted at Aldershot.

4.52 Detainees at some of the custody suites received only microwave meals, with a limited calorific content, while others had a wider variety of food. However, staff indicated that they would serve these outside recognised mealtimes and would provide double portions if there was an obvious need. We saw a DO at Portsmouth bring a 14-year-old detainee who said he was hungry into the kitchen at 11am to choose a meal. All meals were in date and halal, vegetarian and vegan diets could be accommodated. At Southampton detainees were given freshly cooked meals, of good quality and choice, from the staff canteen in the morning and evening, and sandwiches or microwave meals at lunchtime. At Fareham and Basingstoke custody sergeants authorised staff to purchase specific meals suitable for a gluten-free diet and for a diabetic detainee who required a high carbohydrate meal. Across all the custody suites there was a good stock of drinks available and these were offered routinely. In our survey, 62% of respondents, against the 44% comparator, indicated that the food and drink supplied were suitable for their dietary requirements, and 22%, against the 12% comparator, that the quality of the food and drink provided was good/very good. The kitchens were clean, although the refrigerator at Portsmouth and the microwave oven at Fareham were dirty.

4.53 There was an exercise yard at all suites except Waterlooville. The yard at Fareham had much graffiti, but all the other yards were in good condition. At Waterlooville the area described as an

exercise yard was indoors and had a mattress in the corner. In our custody record analysis, only seven (12%) detainees had been given outside exercise.

4.54 There was a reasonable range of reading matter at Portsmouth, Southampton, Winchester and Fareham, including material that was suitable for younger people. Southampton had an arrangement with the local library to have first choice of books no longer needed. In the other suites reading material consisted mainly of old newspapers, magazines and books, none of which was in easy-read format, suitable for juveniles or in languages other than English. In our survey, 24% of respondents, against the 14% comparator, said that they had been offered something to read and we saw several detainees reading in cells, although we found some who had not been offered anything to read.

4.55 At Aldershot we were told that family members were not allowed to visit detainees because of the lack of appropriate facilities, and staffing levels at the suite. At most custody suites we were told that such visits would be facilitated in exceptional circumstances. At Southampton there was a closed visits room which was used regularly; we were told that it had been used during the previous week for a detainee who had been low in mood and had been allowed a visit from his girlfriend.

Recommendations

4.56 Pillows should be provided to all detainees.

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

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

Housekeeping points

4.59 There should be sufficient clean blankets at all custody suites.

4.60 The CCTV system should effectively obscure the toilet area.

4.61 A stock of disposable razors should be maintained at every suite so that, subject to risk assessment, detainees who wish to shave before attending court can do so.

4.62 Female detainees should routinely be offered hygiene packs.

4.63 Replacement underwear should be available at all suites.

4.64 A range of reading material should be available and routinely offered, including books and magazines in easy-read format and suitable for young people.

5. Individual rights

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

Rights relating to detention

5.1 We observed detainees being booked in promptly after arrival at the custody suites throughout the day but this was not the case during our evening visits. At Winchester one detainee waited over two hours 20 minutes to be booked in during the evening; this was because of DO duties being covered by a PC gaoler who was not trained in the PNC, and the custody sergeant having to cope with the demands of the suite, which was full to capacity. At Portsmouth during one evening, three people were kept waiting for up to an hour in a holding room with a very intoxicated and noisy detainee; there were several custody sergeants on duty, and the intoxicated detainee could have been processed much earlier.

5.2 Custody sergeants checked the reasons for detention with arresting officers to ensure that they were appropriate. All the custody sergeants we spoke to gave us recent examples of when detention had been refused, where there had been insufficient evidence or where there had been alternative ways of dealing with the detainees.

5.3 Staff at Fareham police station had a good relationship with the Royal Navy (RN) for managing detainees from that service. The Royal Navy Provost contacted the suite daily to see if any serving staff were in custody. During the inspection, police were better able to manage a serving member of RN staff with mental health problems because of additional information received from the Provost. There were similar arrangements with the Royal Military Police at Aldershot.

5.4 The force had a good relationship with the UK Border Force and the collection of immigration detainees by the UK Border Force was relatively prompt.

5.5 Staff assured us that the custody suite was never used as a place of safety for children under section 46 of the Children Act 1989.[5] They told us that they contacted social services to confirm the availability of secure PACE beds for young people held overnight who could not be bailed, although they were not aware of these beds ever having been used.

5.6 Hampshire Police adhered to the PACE definition of a child instead of that in the Children Act, which meant that those aged 17 were not provided with an AA unless they were otherwise deemed vulnerable (see recommendation 2.40). Family members were usually contacted initially to act as an AA, although this could contribute to delays in detention while they were awaited. In our custody record analysis, we found some unacceptably long waits, up to three hours, before custody staff had contacted an AA. The longest wait for an AA to attend had been 14 hours; in this case the young person had arrived in custody at approximately 8pm and staff had initially attempted to use his mother as an AA, but that arrangement had been deemed unsuitable. The alternative AA had finally arrived at approximately 10am. In another example, a young person had had to wait over seven hours for his mother to become available

[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.

to attend the custody suite. All five juveniles in our sample had had an AA present for the reading of their rights and during interview.

5.7 At Southampton, Aldershot, Fareham and Lyndhurst, The Appropriate Adult Service (TAAS) delivered AA services for children and vulnerable adults. At Newport and Basingstoke, separate organisations provided this service for children and vulnerable adults. Custody staff at Southampton and most other suites said that the arrangements were good, although staff at Newport and Basingstoke complained of delays and difficulties in getting AAs to attend. At Winchester, AA services were provided by the youth offending team (YOT) during office hours, TAAS during evenings and weekends for juveniles, and TAAS for vulnerable adults. There was no AA service across the force area after 11pm. At Portsmouth AAs were provided by the South Eastern Advocacy Provider (SEAP) for vulnerable adults, and by YOTs for juveniles. AAs we spoke to were complimentary about their treatment by custody staff.

5.8 Leaflets about legal rights were available in several languages and were easily accessible. A professional telephone interpreting service was available, used through two-handset telephones, and a face-to-face interpreting service. At Basingstoke there were no two-handset telephones and interpreting had to be conducted via the speakerphone, which was not private. We saw telephone interpreting services being used to inform detainees of their rights and for medical matters, and interpreters for interviews. At Southampton audio files of rights were available in foreign languages but with no means of playing them. There were police liaison officers for the deaf, who were trained in using sign language and could be called on to assist with detainees with hearing difficulties.

Recommendation

5.9 Hampshire Police should engage with the local authority to ensure the provision of safe beds for juveniles who have been charged but cannot be bailed.

Housekeeping point

5.10 Two-handset telephones should be provided in all suites to facilitate telephone interpreting services.

Rights relating to PACE

5.11 Posters were on display in all the custody suites in a range of languages advising detainees of their right to free legal advice. Not all suites had private facilities for telephone conversations, and we saw, and heard, detainees speaking to their legal representatives on the telephone in the presence of other people. In our custody record analysis, all detainees had been routinely offered legal advice. However, the reasons for detainees declining legal advice were rarely recorded. At Basingstoke custody staff did not fully explain the role of a solicitor to a French-speaking detainee who was in custody for the first time and was clearly confused.

5.12 There were sufficient interview rooms at all custody suites. At Newport these were very hot and there were long-standing problems with the air conditioning. At most suites, legal representatives described a professional relationship with the police, with mutual understanding of respective roles, and said that PACE issues were generally applied efficiently and fairly. We saw copies of client custody records routinely being printed out and offered to legal representatives.

5.13 Detainees were told that they could inform someone of their arrest. In our custody record analysis, 15 (25%) detainees had requested that someone be informed of their arrest. In eight of these cases it did not appear that any notification had been made – or it may not have been recorded. We saw one immigration detainee at Fareham making a long call to his family to make arrangements following his detention and subsequent receipt of an intention to deport him.

5.14 All detainees were offered the opportunity to consult the PACE codes of practice, and there were several copies of the code at each suite. In our survey, 76% of respondents, against the 51% comparator, said that they had been told about PACE. Detainees were not routinely offered a 'notice of rights and entitlements'. At Lyndhurst, this was available in pictorial format for detainees with learning difficulties or limited literacy, and also in Braille.

5.15 Reviews of detainees in custody were undertaken by the response inspector (critical incident inspector) or by the custody inspector, if available. The reviews we observed were carried out face to face and were thorough. When a review was carried out while a detainee was asleep, we saw them being informed of this process on waking, although our custody record analysis did not record such detainees being informed on waking, and also showed that many reviews had been late. During a review of detention at Basingstoke, we saw an inspector updating detainees on progress in their cases, reiterating their rights and entitlements and checking on their welfare. Even though an interpreter was available in the custody suite, the inspector spoke to a French-speaking detainee in English.

5.16 The handling and processing of DNA and forensic samples were well managed and samples were collected promptly.

5.17 Detainees were transported to court in a timely manner in most cases; however, at Lyndhurst we were told that the court cut-off times (for Southampton Magistrates' Court) could be as early as noon, and at Portsmouth as early as 9.30am if the list was full. However, at other courts the cut-off time was approximately 2pm on weekdays and 9.30am at weekends. We saw five detainees, already in custody for 48 hours, being taken from Aldershot custody suite to Basingstoke Magistrates' Court at approximately 3.30pm. They were not accepted that day at the court and as a result were held at Basingstoke custody suite, pending transfer to court the following day.

Recommendation

5.18 Hampshire Police should engage with HM Court and Tribunal Service to ensure that early court cut-off times do not result in unnecessarily long stays in custody.

Housekeeping points

5.19 The reasons for detainees declining legal advice should be recorded in the custody record.

5.20 The air conditioning in the interview rooms at Newport should be fixed.

5.21 Subject to the limitations of the Police and Criminal Evidence Act 1984, a telephone call should be made when detainees request that someone be informed of their arrest, and a record to this effect should be made in the custody record.

5.22 All detainees should be offered a copy of their rights and entitlements.

5.23 Reviews should be carried out at the appropriate times.

5.24 Detainees should be informed of any reviews carried out while they were sleeping, and a record to this effect should be made in the custody record.

Rights relating to treatment

5.25 When detainees arrived in custody, they were not told how to make a complaint but the process was detailed in a document entitled 'What should you expect when detained in custody?'. There were no notices about the complaints procedure on display but copies of the IPCC complaints process were available in several custody suites. Although there was an expectation from the force that complaints from detainees would be taken while the detainee was still in custody, practice varied. Most staff we spoke to said that they would simply give the detainee the IPCC leaflet on how to make a complaint and then direct them to attend at their local police station on release. At Portsmouth and Winchester we were told that if a detainee expressed the wish to make a complaint, an inspector would visit them in their cell, and at Newport and Waterlooville we saw an inspector taking a complaint. In our custody record analysis, one custody record indicated that the detainee had wished to make a complaint against staff relating to force used during his arrest. The custody record noted that a copy of the IPCC complaints procedure had been printed off and stored with the detainee's property, and that the detainee's complaint should be considered after their release. There was no further mention of the complaint on the custody record.

Recommendation

5.26 Detainees should be able to make a complaint about their care and treatment, and be able to do this before they leave custody.

6. Health care

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

Governance

6.1 There was an overall lack of strategic and operational oversight of health-related issues in custody. The force was working with the NHS in preparation for the latter to commission health services for detainees in the near future, but was hampered by the lack of both information and of a background of previous partnership working. G4S Forensic Medical Services (G4SFMS) provided primary health services, and had recently started the fifth year of their contract. Although they supplied contract monitoring information to the force, it was not used. There were no contract monitoring meetings, the information was not challenged and no one could recall any penalties for non-compliance with the contract. Custody staff had no systematic form of redress if G4SFMS failed to attend, and some custody staff were unaware of the response times detailed in the contract. G4SFMS did not inform the force of any reported clinical incidents that occurred in custody. It was difficult to ascertain who provided substance misuse services and mental health services to the force; this was complicated by a multiplicity of commissioners and providers of services, and we were concerned about the lack of knowledge about these services (see main recommendation 2.37).

6.2 G4SFMS had reasonable clinical governance structures in relation to the management and training of staff. There were relevant e-learning modules for staff to complete, including reflection studies for interesting or difficult cases, and a lead nurse carried out yearly appraisals. The team had twice-yearly meetings which included guest speakers and peer support. The lead FME for Hampshire was the officer responsible for the doctors' revalidation and appraisals across G4SFMS and also provided training for new custody officers.

6.3 None of the clinical rooms were fit for purpose; most were multi-purpose and not appropriate for the taking of forensic samples, and not all were locked when empty. For example, at Lyndhurst the room was dusty and the examination couch was torn. At Waterlooville the flooring was scuffed, surfaces at higher level were dusty and there was no desk or telephone. Cupboards were untidy, one cupboard was broken and the couch was split. Some clinical rooms were also used to house the breathalyser and finger/palm print equipment. There was a lack of sharps bins across the estate; those we saw were not signed or dated and some were used for general rubbish in the absence of clinical waste bins. Most of the rooms had fabric chairs, some lacked appropriate hand wash facilities, in some there was no room for a couch, and there was woodchip wallpaper on the walls in Aldershot. Even the rooms at the new suite in Southampton were not suitably equipped: the hand wash facilities were poor, the couch was the wrong way round and the cupboards did not lock.

6.4 The first-aid kits used by the police were inadequate: they were not always stocked and some items had been opened and were therefore unsterile, while others were out of date. There were automated external defibrillators in each suite, and G4SFMS had a bag containing airways and a re-breathing bag and oxygen tubing, even though none of the suites contained an oxygen supply or any suction equipment. Staff were trained in resuscitation and the use of the defibrillators.

Recommendations

6.5 The force should monitor the contract with G4SFMS to ensure that detainees receive the appropriate level of care.

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

Housekeeping point

6.7 All first-aid equipment should be appropriate for the environment, regularly checked and maintained.

Patient care

6.8 G4SFMS provided a total of four health care professionals (HCPs), comprising nurses or paramedics, across the force area throughout the day and night, plus one FME. There was an extra HCP on duty for the force area (excluding the Isle of Wight) from Thursday evening until Monday morning; the one whom we met on our night visit said that she was also covering custody suites in Wiltshire. We were concerned by the staffing arrangements for the Isle of Wight, which were disjointed from those of the main team. A paramedic and an FME covered the rota between them, which meant that, on occasion, one of them was on call for several days and nights in a row, which we considered to be poor practice.

6.9 All the suites we inspected were adequate in terms of their physical layout, although staff recognised the need for improvements. In our survey, 28% of respondents said that their entitlement to see an HCP had been explained, which was in line with the comparator, but only 14%, against the 26% comparator, had been able to see an HCP of their own gender. In our analysis of custody records, the longest wait to see a HCP had been nine hours; this was unusual and if this figure was excluded from the calculation, the average wait was 90 minutes. The contract specification for most cases was 60 minutes. In our survey, 45% of respondents rated the care given as good or very good. Not all the HCPs wore uniform; some we met looked untidy and unprofessional, and none wore name badges.

6.10 Most clinical records were held securely. We found some reasonable examples of record keeping, although some was poor. It was not evident whether consent to share clinical information was always sought. G4SFMS staff used proformas to record their clinical findings and separate proformas for information they provided to custody staff. The latter were scanned onto the custody computer system. There was no consistency in what happened to the paper copy thereafter – some staff shredded it, while others filed it – and we could not always find evidence of it being scanned. In our analysis of custody records there were several instances of missing clinical records on NICHE (the police electronic case management system) and clinical interventions were not routinely recorded in the detention log. We found a number of sheets of paper with some clinical details on them in the kitchen at Portsmouth.

6.11 Most medications were held securely but some were overstocked. For example, in Basingstoke we found 412 diazepam and 480 dihydrocodeine tablets. Stocks were checked regularly. HCPs used patient group directions (PGDs) to administer medications for most detainees. They took medications from stock and put them into bags that they then labelled, which is not good practice. HCPs also left these medications to be administered by custody staff, which contravened the rules for PGDs.

6.12 In our survey, detainees told us that they did not always receive medications that they had previously been prescribed. This was a particular problem for those receiving substitution medications as part of a drug recovery programme.

6.13 In Southampton custody staff told us that methadone was not allowed to be given in custody. We found several examples of detainees who had been in custody for over 24 hours without staff making any attempts to check what substitution medications they had been prescribed or to obtain them. However, we also saw evidence of custody staff making arrangements for detainees' medications to be collected from their homes.

6.14 Custody staff could administer some 'over the counter' medications, including nicotine replacement therapy, following telephone advice from G4SFMS, although at Lyndhurst staff said that they would issue these products as and when required, without consultation with a health care professional. We noted several examples where these administrations were not recorded. We found patient-named medication in some of the cupboards, and opened medications (glyceryl trinitrate spray and salbutamol) that had been returned and which appeared to have been used for more than one detainee. We were not assured there were sufficient audit processes for this aspect of medicines management.

6.15 We had concerns about the security of medications that were prepared but not administered because the detainee had left custody before they were due. There was a locked container in each suite where custody staff 'posted' medicines that detainees had not used and a register where staff were supposed to record the type and quantity of the medicine deposited. The container was emptied by G4S staff. We found examples of medicines in the box but not entered into the register and one instance where the register had not been signed since May 2012, even though the container had been emptied during that time.

Recommendations

6.16 Detainees should be able to see a health care professional within the timeframe specified in the G4S Forensic Medical Services contract.

6.17 All medications should be administered safely and in accordance with relevant laws and guidance from professional bodies.

6.18 Detainees should be able to receive appropriate medication for their condition.

Housekeeping points

6.19 All clinical records should be held securely at all times and the quality of record keeping should be improved.

6.20 All medications should be stored and disposed of safely and securely.

Substance misuse

6.21 There were several commissioners and providers of substance misuse services across the force area, and this resulted in a lack of consistency. In our survey only 21% of respondents, against a comparator of 42%, were offered the services of a drug or alcohol worker. Our analysis of custody records reflected this: we only found two [3%] examples of a detainee being offered access to a drug or alcohol worker. Workers told us, and data confirmed, that the

level of referrals from custody was extremely low (2% for the main provider in the previous quarter). While some of this was explained by the way that the data were recorded, with only those not previously known to services being recorded as a referral, it was of concern.

6.22 In Southampton the Society of St James (SSJ) provided a drugs worker to the custody suite, visiting the suite each weekday morning and on some afternoons; there was no alcohol arrest referral worker, although there were plans to draw up referral pathways to the local provider of services. SSJ offered a referral service for both drugs and alcohol in the rest of Hampshire, excluding Portsmouth; custody or G4SFMS staff faxed referral forms to this organisation, and their staff then contacted the individuals concerned, to provide interventions, advice and treatment.

6.23 In Portsmouth drug services were provided by Surrey Borders NHS Foundation Trust. There were good working relationships with the local drug intervention programme (DIP) team, who attended the custody suite three times a day on weekdays and once a day at weekends. The DIP workers had not received key training and were unable to hold keys or see detainees on their own, which meant that they sometimes spent a long time waiting for an officer to accompany them. DIP services included arrest referral, assessments, prescribing and stabilisation for approximately three months. There was access to a consultant in substance misuse three days per week for rapid prescribing. South Coast Ambulance Service (SCAS) community health practitioners offered support to detainees with alcohol dependence, seven days a week. These practitioners had received training and held keys, which meant that they could visit detainees on their own and have confidential conversations with them. They provided harm minimisation advice, risk assessment and referral to other services.

6.24 Catch22, a drug and alcohol service for young people, provided drug and alcohol services for young people in Hampshire. The services included drug and alcohol psychosocial interventions and substitution prescribing. The drug/alcohol arrest referral workers signposted young people when required.

6.25 On the Isle of Wight, Cranston drug and alcohol workers attended the suite daily to assess and signpost detainees. There were established links with the courts, Probation Services and the Island Drug and Alcohol Service.

6.26 Needle exchange was not available in custody and in some suites custody staff were unable to tell us where intravenous drug users could obtain clean needles and syringes.

Recommendations

6.27 There should be a consistent and comprehensive service for all drug and alcohol users in custody.

6.28 Needle exchange services should be available in custody.

Mental health

6.29 Mental health services across the force area were similarly complex. Four separate mental health trusts provided services and four local authorities were also involved in supplying approved mental health professionals (AMHPs). In our survey, 34% of respondents said that they had had a mental health problem while in custody, of whom only 3% had been seen by a mental health professional. There was an inequity of service provision across the force area.

6.30 A chief inspector took the lead for mental health issues across the force, chairing a quarterly meeting at which mental health issues were discussed. Some innovative project work was being piloted to try to address some of the problems identified. None of the projects had been evaluated at the time of the inspection. The force and Southern Health NHS Foundation Trust (SHT) had developed common documentation using the guidance published by the Royal College of Psychiatry and had developed a plan to address problem areas. The links between the constabulary and the other providers were less clear; we found it particularly difficult to establish the relevant referral pathway for custody staff in Newport to make referrals to mental health services.

6.31 In Portsmouth there was a specific mental health and criminal justice court liaison team. A member of the team visited the suite each morning and cross-referenced the list of those in custody with the Trust's database to identify potential clients. They also took referrals at any time of the day. They provided a comprehensive service to detainees, including follow-up for up to six months after initial engagement or referral to other services as required.

6.32 SHT provided a 'mentally disordered offenders' (MENDOS) worker to Basingstoke, Aldershot and Southampton custody suites, but there was no service for detainees with mental health problems in Lyndhurst or Winchester. The workers assessed detainees if requested to do so and referred on to services as appropriate.

6.33 In Newport a duty team provided mental health services during the working day and the crisis team provided a service out of normal working hours. There was a 24-hour service for mental health assessments, although an AMPH or section 12-approved GP was not always available, particularly during the night. The Isle of Wight Council provided a filter service (single point of contact) for referral to an AMHP; however, when we tested the referral procedure we found three different routes into the system. We concluded that mental health services were fragmented and reliant on local knowledge and networks. Outcomes for detainees were poor and referrers could spend many hours trying to arrange a mental health assessment for detainees held in custody. There were good strategic meetings for the island; however, when we informed service managers of the difficulties in referring patients for an assessment they were not aware of the problems. Organisational changes were affecting the potential care of detainees.

6.34 Although there were seven section 136 suites (health facilities for those detained on mental health grounds) across the force area, police custody was used regularly for the detention of people under section 136 of the Mental Health Act. In the previous six months there had been a decrease in the total number of those taken into police custody, from 63% to 43%, but the average was 53%, which was unacceptable.

6.35 Four of the suites were provided by SHT and served most of the county. Solent Health NHS Trust provided a suite for Portsmouth. One suite was provided by the Surrey and Borders Partnership NHS Foundation Trust (SBPT), which, although located in Surrey, served the north of Hampshire. Officers from the force attended section 136 meetings with the SBPT. A further suite was located on the Isle of Wight.

6.36 At some suites, staff said that breathalysers were used to determine if a detainee was intoxicated; however, they said that this was only a guide and that the decision to accept the detainee was based on clinical criteria.

Recommendation

6.37 There should be a consistent and comprehensive liaison and diversion scheme across the force area which enables detainees with mental health problems to be identified and diverted into appropriate mental health services.

7. Summary of recommendations

Main recommendations

7.1 The force should review its strategic governance arrangements of health care provision in custody and work with health care partners to ensure effective outcomes for detainees. (2.37)

7.2 Intoxicated detainees should be roused, and this should be clearly recorded in the custody record. (2.38)

7.3 Police custody should not be used as a place of safety for section 136 assessments. (2.39)

National issues

7.4 Appropriate adults should be available at all times to support without undue delay detained juveniles aged 17, provided that informed consent has been given. (2.40)

Recommendations

Strategy

7.5 Police constable gaolers should receive custody-specific training. (3.10)

Treatment and conditions

7.6 At Winchester, sergeants should have a clear view of those whom they are booking in. (4.11)

7.7 A hearing loop should be available at each suite and all custody staff should know how to use it. (4.12)

7.8 Care plans should include information from the risk assessment process, to ensure adequate management of potential risk factors. (4.29)

7.9 Handovers should be comprehensive and attended by all custody staff, with the area in which the handover takes place cleared of other staff and detainees. (4.30)

7.10 Pre-release risk assessments should be detailed, meaningful and based on an ongoing assessment of detainees' needs while in custody, and the custody record should reflect the position on release and any action that needs to be taken. (4.31)

7.11 Hampshire Police should collect and analyse data about use of force in accordance with the Association of Chief Police Officer's policy and National Policing Improvement Agency guidance. (4.35)

7.12 There should be thorough daily and weekly maintenance checks at all custody suites, including systematic identification and reporting of ligature points. (4.42)

7.13 The cell call bell system at Portsmouth should be repaired or replaced. (4.43)

7.14 Pillows should be provided to all detainees. (4.56)

7.15 All detainees held overnight, or who require one, should be offered a shower, which they should be able to take in private. (4.57)

7.16 Detainees held for long periods should be offered outside exercise. (4.58)

Individual rights

7.17 Hampshire Police should engage with the local authority to ensure the provision of safe beds for juveniles who have been charged but cannot be bailed. (5.9)

7.18 Hampshire Police should engage with HM Court and Tribunal Service to ensure that early court cut-off times do not result in unnecessarily long stays in custody. (5.18)

7.19 Detainees should be able to make a complaint about their care and treatment, and be able to do this before they leave custody. (5.26)

Health care

7.20 The force should monitor the contract with G4SFMS to ensure that detainees receive the appropriate level of care. (6.5)

7.21 All clinical rooms should be fit for purpose and meet infection control guidelines. (6.6)

7.22 Detainees should be able to see a health care professional within the timeframe specified in the G4S Forensic Medical Services contract. (6.16)

7.23 All medications should be administered safely and in accordance with relevant laws and guidance from professional bodies. (6.17)

7.24 Detainees should be able to receive appropriate medication for their condition. (6.18)

7.25 There should be a consistent and comprehensive service for all drug and alcohol users in custody. (6.27)

7.26 Needle exchange services should be available in custody. (6.28)

7.27 There should be a consistent and comprehensive liaison and diversion scheme across the force area which enables detainees with mental health problems to be identified and diverted into appropriate mental health services. (6.37)

Housekeeping points

Strategy

7.28 Plans for the development of the estate should be confirmed, with provisional milestones towards the projected completion date. (3.11)

7.29 Quality assurance should include checking custody records against closed-circuit television (CCTV) and person escort record forms, and also the monitoring of handovers. (3.12)

7.30 The force should introduce regular custody refresher training for detention officers. (3.16)

Treatment and conditions

7.31 Arresting officers who have to convey confidential information by telephone about detainees arriving at the custody suite should do so only where they cannot be overheard by other detainees, and confidential medical information should not be unnecessarily disclosed. (4.13)

7.32 Female juveniles should be placed in the care of a named female officer at all times and custody staff should be aware of this requirement. (4.14)

7.33 Staff should understand the contents of Annex L, PACE Code C in respect of searching transgender detainees. (4.15)

7.34 Items of religious observance should be stored respectfully. (4.16)

7.35 All detainees should be asked about their dependency obligations and given the opportunity to make arrangements. (4.17)

7.36 Staff conducting constant watches should be briefed by the custody sergeant and advised how to carry out this duty. (4.32)

7.37 Person escort records should be completed when detainees are being escorted to other venues/custody suites. (4.33)

7.38 Correct use of call bells should be explained to all detainees. (4.44)

7.39 Fire evacuation drills should be carried out and records kept in all custody suites. (4.45)

7.40 There should be sufficient clean blankets at all custody suites. (4.59)

7.41 The CCTV system should effectively obscure the toilet area. (4.60)

7.42 A stock of disposable razors should be maintained at every suite so that, subject to risk assessment, detainees who wish to shave before attending court can do so. (4.61)

7.43 Female detainees should routinely be offered hygiene packs. (4.62)

7.44 Replacement underwear should be available at all suites. (4.63)

7.45 A range of reading material should be available and routinely offered, including books and magazines in easy-read format and suitable for young people. (4.64)

Individual rights

7.46 Two-handset telephones should be provided in all suites to facilitate telephone interpreting services. (5.10)

7.47 The reasons for detainees declining legal advice should be recorded in the custody record. (5.19)

7.48 The air conditioning in the interview rooms at Newport should be fixed. (5.20)

7.49 Subject to the limitations of the Police and Criminal Evidence Act 1984, a telephone call should be made when detainees request that someone be informed of their arrest, and a record to this effect should be made in the custody record. (5.21)

7.50 All detainees should be offered a copy of their rights and entitlements. (5.22)

7.51 Reviews should be carried out at the appropriate times. (5.23)

7.52 Detainees should be informed of any reviews carried out while they were sleeping, and a record to this effect should be made in the custody record. (5.24)

Health care

7.53 All first-aid equipment should be appropriate for the environment, regularly checked and maintained. (6.7)

7.54 All clinical records should be held securely at all times and the quality of record keeping should be improved. (6.19)

7.55 All medications should be stored and disposed of safely and securely. (6.20)

Appendix I: Inspection team

Martin Kettle	HMIP team leader
Peter Dunn	HMIP inspector
Fiona Shearlaw	HMIP inspector
Vinnett Pearcy	HMIP inspector
Karen Dillon	HMIP inspector
Colin Carroll	HMIP inspector
Paul Davies	HMIC inspector
Mark Ewan	HMIC inspector
Paul Eveleigh	HMIC inspector
Rob Bowles	HMIC inspector
Elizabeth Tysoe	HMIP health care inspector
Huw Jenkins	CQC inspector
Annie Crowley	HMIP researcher
Rachel Murray	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 the borough of Hampshire, 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 7 November 2012. A list of potential respondents to have passed through Aldershot, Basingstoke, Fareham, Lyndhurst, Newport, Portsmouth, Southampton, Waterlooville or Winchester police stations was created, listing all those who had arrived from Portsmouth, Andover, Alton, Aldershot, Basingstoke, Lyndhurst, Southampton or Newport courts within the previous two months.

Selecting the sample

In total 155 respondents were approached. Forty-four respondents reported being held in police stations outside Hampshire and one could speak no English, and so it was impossible to determine the police station he had been in. On the day, the questionnaire was offered to 110 respondents; there were 10 refusals seven questionnaires returned blank and eight non-returns. 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.

Response rates

In total, 85 (85%) 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 59 police areas since April 2008.

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

Summary

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

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

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

Survey results

Section 1: About you

Q2 Which police station were you last held at?

Southampton – 42; Basingstoke – 17; Aldershot – 8; Winchester – 6; Portsmouth – 5; Lyndhurst – 4; Fareham – 2; Newport – 1.

Q3 How old are you?

16 years or younger	0 (0%)	*40-49 years*	16 (19%)
17-21 years	3 (4%)	*50-59 years*	2 (2%)
22-29 years	37 (44%)	*60 years or older*	0 (0%)
30-39 years	27 (32%)		

Q4 Are you:

Male	85 (100%)
Female	0 (0%)
Transgender/transsexual	0 (0%)

Q5 What is your ethnic origin?

White - British	66 (80%)
White - Irish	3 (4%)
White - other	3 (4%)
Black or black British - Caribbean	4 (5%)
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	1 (1%)
Asian or Asian British - Bangladeshi	1 (1%)
Asian or Asian British - other	0 (0%)
Mixed heritage - white and black Caribbean	1 (1%)
Mixed heritage - white and black African	1 (1%)
Mixed heritage- white and Asian	1 (1%)
Mixed heritage - other	1 (1%)
Chinese	0 (0%)
Other ethnic group	1 (1%)

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

Yes	10 (12%)
No	73 (88%)

Q7 What, if any, is your religion?

None	29 (37%)
Church of England	30 (38%)
Catholic	11 (14%)
Protestant	1 (1%)
Other Christian denomination	3 (4%)
Buddhist	0 (0%)

Hindu 0 (0%)
Jewish 1 (1%)
Muslim 3 (4%)
Sikh 0 (0%)

Q8 How would you describe your sexual orientation?
Straight/heterosexual 82 (100%)
Gay/lesbian/homosexual 0 (0%)
Bisexual 0 (0%)

Q9 Do you consider yourself to have a disability?
Yes 13 (16%)
No 69 (84%)

Q10 Have you ever been held in police custody before?
Yes 81 (98%)
No 2 (2%)

Section 2: Your experience of the police custody suite

Q11 How long were you held at the police station?
Less than 24 hours 28 (34%)
More than 24 hours, but less than 48 hours (2 days) 30 (36%)
More than 48 hours (2 days), but less than 72 hours (3 days) 18 (22%)
72 hours (3 days) or more 7 (8%)

Q12 Were you told your rights when you first arrived there?
Yes 70 (83%)
No 7 (8%)
Don't know/can't remember 7 (8%)

Q13 Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')?
Yes 63 (76%)
No 14 (17%)
I don't know what this is/I don't remember 6 (7%)

Q14 If your clothes were taken away, what were you offered instead?
My clothes were not taken 53 (64%)
I was offered a tracksuit to wear 15 (18%)
I was offered an evidence/ paper suit to wear 5 (6%)
*I was **only** offered a blanket* 5 (6%)
Nothing 5 (6%)

Q15 Could you use a toilet when you needed to?
Yes 75 (89%)
No 8 (10%)
Don't know 1 (1%)

Q16 If you used the toilet there, was toilet paper provided?
Yes 52 (63%)

No 31 (37%)

Q17 How would you rate the condition of your cell:

	Good	*Neither*	*Bad*
Cleanliness	36 (46%)	27 (34%)	16 (20%)
Ventilation/air quality	16 (21%)	27 (35%)	34 (44%)
Temperature	15 (19%)	22 (28%)	43 (54%)
Lighting	41 (54%)	16 (21%)	19 (25%)

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

Yes 27 (33%)
No 56 (67%)

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

Yes 20 (24%)
No 63 (76%)

Q20 Were you held overnight?

Yes 72 (86%)
No 12 (14%)

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

Not held overnight 12 (14%)
Pillow 6 (7%)
Blanket 66 (79%)
Nothing 4 (5%)

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

Not held overnight/did not get any bedding 16 (21%)
Yes 41 (54%)
No 19 (25%)

Q23 Were you offered a shower at the police station?

Yes 12 (14%)
No 72 (86%)

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

Yes 8 (10%)
No 74 (90%)

Q25 Were you offered anything to:

	Yes	*No*
Eat?	66 (80%)	17 (20%)
Drink?	68 (84%)	13 (16%)

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

Very good	*Good*	*Neither*	*Bad*	*Very bad*	*N/A*
5 (6%)	13 (15%)	23 (27%)	19 (23%)	20 (24%)	4 (5%)

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

I did not have any food or drink	4 (5%)
Yes	46 (59%)
No	28 (36%)

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	12 (14%)
I was allowed to smoke	1 (1%)
I was offered a nicotine substitute	5 (6%)
I was not offered anything to cope with not smoking	66 (79%)

Q29 Were you offered anything to read?

Yes	20 (24%)
No	64 (76%)

Q30 Was someone informed of your arrest?

Yes	40 (48%)
No	29 (35%)
I don't know	8 (10%)
I didn't want to inform anyone	7 (8%)

Q31 Were you offered a free telephone call?

Yes	42 (50%)
No	42 (50%)

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

My telephone call was not denied	49 (63%)
Yes	5 (6%)
No	24 (31%)

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

	Yes	*No*
Who was taking care of your children	8 (11%)	62 (89%)
Contacting your partner, relative or friend	42 (53%)	37 (47%)
Contacting your employer	9 (13%)	60 (87%)
Where you were going once released	16 (22%)	57 (78%)

Q34 Were you offered free legal advice?

Yes	72 (86%)
No	12 (14%)

Q35 Did you accept the offer of free legal advice?

Was not offered free legal advice	12 (15%)
Yes	46 (56%)
No	24 (29%)

Q36 Were you interviewed by police about your case?

Yes	69 (82%)
No	15 (18%)

Q37 Was a solicitor present when you were interviewed?

Did not ask for a solicitor/was not interviewed	21 (26%)
Yes	46 (56%)
No	15 (18%)

Q38 Was an appropriate adult present when you were interviewed?

Did not need an appropriate adult/was not interviewed	50 (60%)
Yes	6 (7%)
No	27 (33%)

Q39 Was an interpreter present when you were interviewed?

Did not need an interpreter/was not interviewed	49 (59%)
Yes	3 (4%)
No	31 (37%)

Section 3: Safety

Q41 Did you feel safe there?

Yes	47 (57%)
No	36 (43%)

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

Yes	24 (29%)
No	58 (71%)

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

I have not been victimised	58 (71%)	*Because of your crime*	11 (13%)
Insulting remarks (about you, your family or friends)	9 (11%)	*Because of your sexuality*	0 (0%)
Physical abuse (being hit, kicked or assaulted)	8 (10%)	*Because you have a disability*	2 (2%)
Sexual abuse	1 (1%)	*Because of your religion/religious beliefs*	0 (0%)
Your race or ethnic origin	2 (2%)	*Because you are from a different part of the country than others*	1 (1%)
Drugs	10 (12%)		

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

Yes	51 (61%)
No	19 (23%)
I wasn't handcuffed	14 (17%)

Q45 Were you restrained whilst in the police custody suite?

Yes	13 (16%)
No	69 (84%)

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

Yes	18 (22%)
No	64 (78%)

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

Yes	8 (10%)
No	71 (90%)

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

Very well	*Well*	*Neither*	*Badly*	*Very badly*	*Don't remember*
4 (5%)	25 (31%)	24 (30%)	19 (23%)	8 (10%)	1 (1%)

Section 4: Health care

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

Yes	23 (28%)
No	52 (64%)
Don't know	6 (7%)

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

	Yes	*No*
Doctor	14 (20%)	57 (80%)
Nurse	22 (30%)	51 (70%)
Paramedic	6 (10%)	56 (90%)

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

Yes	11 (14%)
No	38 (49%)
Don't know	29 (37%)

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

Yes	38 (47%)
No	43 (53%)

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

Not taking medication	43 (55%)
Yes	11 (14%)
No	24 (31%)

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

Yes	44 (54%)
No	38 (46%)

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	38 (46%)
Yes	9 (11%)
No	35 (43%)

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

I didn't have any drug/alcohol problems	38 (46%)
Yes	12 (15%)
No	32 (39%)

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*
48 (60%)	3 (4%)	11 (14%)	4 (5%)	10 (13%)	4 (5%)

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

Yes	23 (28%)
No	58 (72%)

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

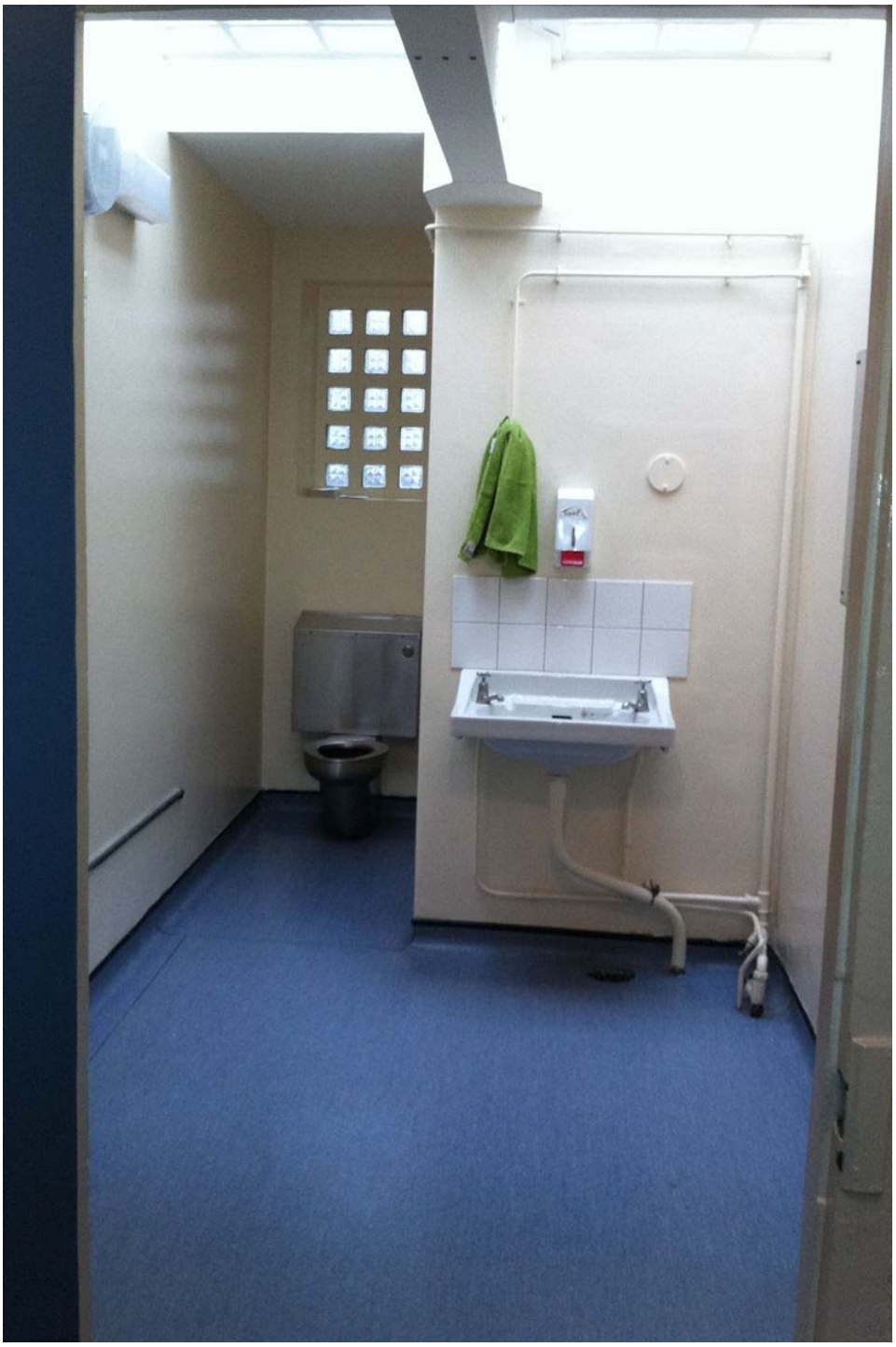
Yes	28 (34%)
No	54 (66%)

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	54 (67%)
Yes	1 (1%)
No	26 (32%)

Appendix III: Photographs

An unscreened toilet in a corridor at the Portsmouth custody suite



Prisoner survey responses for Hampshire Police 2012

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

Key to tables

		Hampshire Police Custody	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		85	2163
SECTION 1: General information			
3	Are you under 21 years of age?	**4%**	**10%**
4	Are you transgender/transsexual?	**0%**	**0%**
5	Are you from a minority ethnic group (including all those who did not tick white British, white Irish or white other categories)?	**13%**	**29%**
6	Are you a foreign national?	**12%**	**15%**
7	Are you Muslim?	**4%**	**10%**
8	Are you homosexual/gay or bisexual?	**0%**	**2%**
9	Do you consider yourself to have a disability?	**16%**	**20%**
10	Have you been in police custody before?	**98%**	**92%**
SECTION 2: Your experience of this custody suite			
11	Were you held at the police station for over 24 hours?	**66%**	**68%**
12	Were you told your rights when you first arrived?	**83%**	**80%**
13	Were you told about PACE?	**76%**	**51%**
For those who had their clothing taken away:			
14	Were you given a tracksuit to wear?	**50%**	**37%**
15	Could you use a toilet when you needed to?	**89%**	**90%**
16	If you used the toilet, was toilet paper provided?	**62%**	**47%**
17	Would you rate the condition of your cell, as 'good' for:		
17a	Cleanliness?	**45%**	**34%**
17b	Ventilation/air quality?	**21%**	**23%**
17c	Temperature?	**19%**	**16%**
17d	Lighting?	**54%**	**45%**
18	Was there any graffiti in your cell when you arrived?	**33%**	**55%**
19	Did staff explain the correct use of the cell bell?	**25%**	**23%**
20	Were you held overnight?	**86%**	**92%**
For those who were held overnight:			
21	Were you given any items of bedding?	**94%**	**83%**
For those who were held overnight and were given items of bedding:			
22	Were these clean?	**69%**	**60%**
23	Were you offered a shower?	**14%**	**9%**
24	Were you offered a period of outside exercise?	**9%**	**6%**
25a	Were you offered anything to eat?	**80%**	**81%**
25b	Were you offered anything to drink?	**84%**	**84%**
For those who had food/drink:			
26	Was the quality of the food and drink you received good/very good?	**22%**	**12%**
27	Was the food/drink you received suitable for your dietary requirements?	**62%**	**44%**

Key to tables

		Hampshire Police Custody	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		
For those who smoke:			
28	Were you offered anything to help you cope with not being able to smoke?	**7%**	**7%**
29	Were you offered anything to read?	**24%**	**14%**
30	Was someone informed of your arrest?	**48%**	**43%**
31	Were you offered a free telephone call?	**50%**	**50%**
If you were denied a free telephone call:			
32	Was a reason given?	**18%**	**15%**
33	Did you have any concerns about:		
33a	Who was taking care of your children?	**11%**	**14%**
33b	Contacting your partner, relative or friend?	**53%**	**52%**
33c	Contacting your employer?	**13%**	**19%**
33d	Where you were going once released?	**22%**	**30%**
34	Were you offered free legal advice?	**86%**	**89%**
For those who were offered free legal advice:			
35	Did you accept the offer of free legal advice?	**66%**	**69%**
For those who were were interviewed and needed them:			
37	Was a solicitor present when you were interviewed?	**75%**	**81%**
38	Was an appropriate adult present when you were interviewed?	**18%**	**29%**
39	Was an interpreter present when you were interviewed?	**10%**	**13%**
SECTION 3: Safety			
41	Did you feel unsafe?	**57%**	**62%**
42	Has another detainee or a member of staff victimised you?	**29%**	**33%**
43	If you have felt victimised, what did the incident involve?		
43a	Insulting remarks (about you, your family or friends)	**11%**	**16%**
43b	Physical abuse (being hit, kicked or assaulted)	**9%**	**11%**
43c	Sexual abuse	**1%**	**2%**
43d	Your race or ethnic origin	**2%**	**3%**
43e	Drugs	**12%**	**9%**
43f	Because of your crime	**13%**	**12%**
43g	Because of your sexuality	**0%**	**1%**
43h	Because you have a disability	**2%**	**2%**
43i	Because of your religion/religious beliefs	**0%**	**1%**
43j	Because you are from a different part of the country than others	**1%**	**3%**
44	Were your handcuffs removed on arrival at the police station?	**73%**	**74%**
45	Were you restrained whilst in the police custody suite?	**16%**	**19%**
46	Were you injured whilst in police custody, in a way that was not your fault?	**22%**	**23%**
47	Were you told how to make a complaint about your treatment?	**10%**	**13%**
48	Were you treated well/very well by staff in the police custody suite?	**36%**	**36%**

Key to tables

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SECTION 4: Health care			
50	Did someone explain your entitlements to see a health care professional if you needed to?	**28%**	**35%**
51	Were you seen by the following health care professionals during your time in police custody:		
51a	Doctor	**20%**	**43%**
51b	Nurse	**30%**	**21%**
	Percentage seen by either a doctor or a nurse	**39%**	**51%**
51c	Paramedic	**10%**	**4%**
52	Were you able to see a health care professional of your own gender?	**14%**	**26%**
53	Did you need to take any prescribed medication when you were in police custody?	**47%**	**41%**
For those who were on medication:			
54	Were you able to continue taking your medication while in police custody?	**32%**	**33%**
55	Did you have any drug or alcohol problems?	**54%**	**52%**
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?	**21%**	**42%**
57	Were you offered relief or medication for your immediate withdrawal symptoms?	**27%**	**24%**
For those who were seen by health care:			
58	Would you rate the quality as good/very good?	**45%**	**30%**
59	Did you have any specific physical health care needs?	**28%**	**32%**
60	Did you have any specific mental health care needs?	**34%**	**23%**
For those who had any mental health care needs:			
61	Were you seen by a mental health nurse/psychiatrist?	**3%**	**13%**