Report on an inspection visit to police custody suites in Bedfordshire Police

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by

HM Inspectorate of Prisons and

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Contents

1. Introduction

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

Bedfordshire Police has three primary designated custody suites working 24 hours a day, at Bedford, Luton and Dunstable, and a further part-time suite at Ampthill. During this unannounced inspection, all suites were visited with the main concentration on the full-time facilities. The inspection was informed by a survey of prisoners at HMP Bedford, who had previously been held in Bedfordshire police cells.

We found that there was a clear strategic priority although the custody estate still required significant attention. There was a centralised model for staffing but there were concerns over the minimum levels, in particular at Luton. All staff received appropriate training however some detention officers were deployed before receiving the formal training.

Relations between staff and detainees were generally good. The needs of juveniles were well met but facilities for detainees with disabilities were poor. We were impressed that staff completed a dignity questionnaire on arrival of detainees – covering a range of issues relevant to their care and welfare. This resulted in a more proactive approach than we normally see to a range of care and welfare issues. However, booking-in areas were generally cramped and offered little privacy.

The three main suites were old and although well decorated, were generally very dirty. Levels of graffiti were minimal except for on the floor coverings in Bedford and Luton. Most cells had multiple ligature points, many due to old cell design. Health and safety checks and fire evacuation tests varied and not all staff carried anti-ligature knives.

Appropriate adults were provided for children but the service for vulnerable adults was poor and staff were unsure how to access the service. Handling and management of DNA and forensic samples within custody appeared good but there were unexplained backlogs elsewhere in the system which needed senior management attention. As we have seen elsewhere, complaints were not usually being taken whilst detainees were in custody.

The provision of health care services was generally good with access to health care professionals within reasonable timescales. There were concerns over infection control compliance and a number of discrepancies in medicine stock levels and controls. The establishment of an on-going care plan for one frequent detainee at Luton was considered to be good practice. Substance misuse services were good but there were too many detainees being held in police custody under section 136 of the mental health act.

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

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

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

Sir Denis O'Connor
HM Chief Inspector of Constabulary

Nick Hardwick
HM Chief Inspector of Prisons

September 2010

2. Background and key findings

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

2.2 At the time of this unannounced inspection, Bedfordshire Police had three primary custody suites designated under PACE for the reception of detainees across the county. These were located at Bedford, Luton and Dunstable. The suites operated 24 hours a day and dealt with detainees arrested as a result of mainstream policing. A further custody suite at Ampthill (two cells) could be opened if Operation Safeguard (prison overspill) was operating or in response to specific police operations, although we were told it had not been used for several months. The three operating suites were visited during this inspection. A survey of prisoners at HMP Bedford, who had formerly been detained at custody suites in the force area, was conducted by an HM Inspectorate of Prisons researcher and HMIC inspector to obtain additional evidence (see appendix III).

2.3 The force cell capacity was 51. Across all custody suites in the force area, 17,966 detainees had been dealt with in the year from 1 August 2009 to 3 July 2010. Luton, the largest suite with 21 cells, had dealt with 7,259 detainees, while Bedford, with 15 cells, and Dunstable, with 13, had dealt with 6,370 and 4,337 detainees respectively. In the same period, 222 detainees had been detained for immigration matters.

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

Strategy

2.5 A centralised model with permanent custody staff was used, although some staffing levels were of concern. Despite recent refurbishment, an historical lack of investment had left a legacy of old and tired custody suites. There was appropriate training for new custody staff, but detention officers sometimes started work in custody before attending the training. Governance structures were good, with a range of formal meetings to monitor custody-related matters. Dip sampling of custody records took place and action resulted. Partnerships appeared to be working well. The Police Authority reported a good relationship with the force and there was an active and enthusiastic independent custody visitors (ICV) scheme. Information about 'near misses' and Independent Police Complaints Commission (IPCC) Learning the Lessons bulletins were circulated to staff and used. There was little oversight of the use of force in custody and extremely limited data analysis.

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

Treatment and conditions

2.6 Relationships between staff and detainees were good. The diverse needs of juveniles were well met, but facilities for detainees with disabilities were poor. The 'dignity questionnaire' completed at the booking in stage was an excellent initiative. Booking in areas provided little privacy. Risk assessment on arrival in custody was usually thorough. Staff had an appropriate focus on the safety of detainees. A use of force form was completed, but contained limited useful information. Staff had regular personal protection training.

2.7 All three suites were old and tired and standards of cleanliness were generally poor. There were a large number of ligature points in cells and other detainee areas. Graffiti was kept to a minimum. Some staff were unclear about fire evacuation procedures. The use of cell call bells was routinely explained to detainees. The bells were regularly tested, although there were some delayed responses.

2.8 Blankets, mattresses and pillows were provided, but were not always clean. Sanitary packs for female detainees were offered on arrival. Showers were not always facilitated when needed. Toilet paper was provided only on request and the replacement clothing available was poor. The food provided at some custody suites was not adequate, particularly for those detained for longer periods. Outside exercise was regularly facilitated and reading materials were offered.

Individual rights

2.9 Custody sergeants critically reviewed the reasons for detention. Detainees were given a rights and entitlement leaflet, which was available in a range of languages, and interpreting services were used when needed. Staff asked detainees about any dependents for whom they were responsible on arrival. Pre-release risk assessments were completed, but not consistently. PACE was usually adhered to. Appropriate adults were provided for juveniles, but the service for vulnerable adults was poor. The management of PACE DNA samples was good in custody suites, but problematic elsewhere in the custody stations visited. Court cut-off times were often too early for vulnerable detainees. Detainees were not told how to make a complaint and were often referred to the police station front desk on release to do so.

Health care

2.10 Health services were delivered by a private company, G4S. There were appropriate partnership and strategic clinical governance structures. There was no audit of infection control compliance and health care consultation rooms were dusty and grubby. Medicines were stored securely, although there were a number of discrepancies in stock levels and poor governance arrangements surrounding stock control. Resuscitation equipment was accessible, but first aid kits were needlessly duplicated and it was not clear who was responsible for them.

2.11 Detainees who needed to see a health care professional (HCP) were seen in good time. Assessments were comprehensive. HCPs shared relevant information with custody staff using the IT custody record system, NSPIS, and we saw some care planning taking place. Good services for detainees with substance misuse problems were provided by the Westminster Drugs Project, Bedford. The drug intervention programme (DIP) workers sign-posted detainees with alcohol problems and juveniles to relevant services.

2.12 There was no formal service level agreement for the provision of secondary mental health services, although there was an adequate diversion scheme during the working day on weekdays. However, staff complained of delays outside these times. In-reach mental health services were not well understood by staff and there was a need for awareness training. Good multi-agency working was supported by an up-to-date section 136 policy and a joint working protocol that included information-sharing. Despite this, a significant number of detainees were held in police custody under section 136 of the Mental Health Act 1983.

Main recommendations

2.13 There should be sufficient staff in custody at all times to ensure the safety and well being of detainees.

2.14 Cells and other detainee areas should be clean and free of ligature points, which staff should be trained to identify. Where current resources do not allow ligature points to be removed, a strategy should be put in place to manage the new risks identified.

2.15 Appropriate adults should be readily available to support vulnerable adults and juveniles aged 17 years.

3. Strategy

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

3.1 An assistant chief constable (ACC) was the senior portfolio holder for custody issues in Bedfordshire Police. Strategic priority was given to custody and clear strategic direction to its development. There had previously been an underinvestment in the custodial estate and a significant amount of work was still required despite recent refurbishment of the three main custody suites. There was a plan to upgrade the CCTV facilities in the custody suites. The force believed the current capacity of its custody estate was adequate to meet demand, but the facilities were old and in poor condition (see section on treatment and conditions).

3.2 The designated custody suites operated under the control of the central criminal justice department (CJD). There were two custody managers, one of whom managed the Luton suite while the other managed the remaining three suites. Duty operational inspectors were responsible for PACE issues and reviews of detention, although custody managers covered these duties when they were absent or not available. There were clear line management arrangements for all staff with custody responsibilities. A good range of formal meetings were held where custody issues were discussed, including a custody partners' forum attended by a range of external partners.

3.3 The custody managers line managed the custody sergeants, who in turn line managed the detention officers. The sergeants in the custody suites were posted into custody roles from patrol teams and were expected to remain in post for at least one year. Overall, there were 26 custody sergeants supported by 28 detention officers. There were a small number of vacancies within both groups, but these were scheduled to be filled through a recruitment campaign.

3.4 The current staffing model was of some concern. In Luton, the minimum staffing level was one sergeant to cover the booking in process for potentially 21 detainees, while at Dunstable it was one sergeant and one detention officer to cover 13 cells. The detention officer's duties included drug testing (for applicable offences), fingerprinting, photographing and DNA testing every detainee coming into custody, all of which could detract from their primary focus on ensuring the welfare and safety of detainees. Staff said they felt under pressure at busy times and there were a number of occasions during the inspection when operational staff had to assist when the suite was busy. (See main recommendations.)

3.5 All custody sergeants had received specific custody training before their deployment in custody suites. Detention officers were sometimes deployed to custody before being trained. They shadowed colleagues and training was provided within eight weeks, and while during this time they were required to carry out restricted duties, it did mean that essentially untrained staff were working in custody. The four-week in-force training course for custody sergeants was based on a nationally approved training programme. It covered PACE legal responsibilities for custody officers, training in the forces' custody system and first aid training specifically tailored for custody staff. The training course for detention officers was similar, but delivered regionally in collaboration with neighbouring forces. Refresher training planned for the near future was scheduled to cover mental health issues, safeguarding children, management of European arrest warrants and searching for concealed items.

3.6 Good working relationships with partners across Bedfordshire were strengthened through good interpersonal networks and quarterly meetings of the custody partners' forum. The Police Authority was very positive about its relationship with the force, which it described as approachable and responsive. A Police Authority lead for custody was responsible for liaising with the ICV scheme. ICVs visited the three primary custody suites at least once a week and the force was responsive to issues raised.

3.7 Quality assurance checks were carried out by the custody managers, who were required to dip sample one custody record per sergeant and a number of other records identified by the CJD performance and compliance officer (PCO) each month. Checks were carried out using a comprehensive checklist. Details were returned to the CJD, where a number were subject to a further quality assurance check by the PCO. The outcomes were discussed at monthly custody managers meetings and, where necessary, improvement action plans were drawn up for individual staff as part of their personal development review process. Common themes identified were circulated to all custody staff.

3.8 The custody sergeant was required to complete a 'near miss' form following any adverse incident. These were investigated and the relevant custody manager was responsible for instigating any action required to address issues arising. Outcomes were discussed at the custody managers meeting and learning points were circulated to custody staff. Staff were also circulated the IPCC Learning the Lessons bulletin. Details of adverse incidents and Learning the Lessons bulletins were held centrally on the force intranet. Not all staff were aware that this information was available, although others were using it when risk assessing detainees.

3.9 The use of force was recorded in an officer's pocket notebook, on a detainee's custody form and through the submission of a use of force monitoring form, although staff did not think all three steps would be followed. Completed forms were submitted to the officer safety training unit, which monitored the contents to prepare future training scenarios and identify any additional staff training needs. By not collating or further analysing the available information that could have been recorded on the monitoring form, the force could not identify patterns and trends.

Recommendations

3.10 Only trained staff should be allowed to work in the custody environment.

3.11 The force should collate the use of force and monitor for trends, for example by ethnicity, location and officer involved.

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 Detainees we spoke to had been transported to custody suites in police cars, usually with relatively short journeys. The interaction between custody staff and detainees ranged from appropriate to very good, with most custody officers effectively engaging detainees to establish any issues of concern to their welfare. First names were routinely used and detainees we spoke to said they had been treated respectfully. Staff completed a dignity questionnaire with newly arrived detainees, which asked questions about a range of issue relevant to their care and welfare in custody.

4.2 The layout of the booking in areas allowed little privacy for detainees disclosing often sensitive or private information. This was particularly the case at Bedford, where the booking in area was very cramped. Detainees were also given rub-down searches in these areas, usually directly in front of the custody sergeant's desk. During the inspection, one vulnerable female detainee was searched in full view of other detainees, custody staff, a solicitor and inspectors.

4.3 Female staff were on duty in all the custody suites we visited, although this might not always be the case depending on shift rotas. We were told that a female member of staff would be brought from the police station if required by a female detainee (see also section on health care). All suites issued female hygiene packs on request and their availability was also highlighted in the dignity questionnaire.

4.4 There were limited facilities for detainees with physical disabilities, and detention officers we spoke to were not aware of a policy for managing detainees with disabilities. There were no hearing loops, but a volunteer signing service was available during office hours. Custody staff demonstrated an awareness of the cultural and religious needs of detainees. Bibles, prayer mats and Qur'ans were available, as were interpreting services (see also section on individual rights).

4.5 Juvenile detainees were dealt with in an age appropriate and sensible way, and detention rooms closer to booking in desks for ease of monitoring were prioritised for them. At Dunstable, we observed custody staff actively engaging with three young detainees to establish who could act as an appropriate adult. We also saw a custody sergeant talk to an irate juvenile detainee in a particularly caring way and arranging for him to have time in the exercise yard to get some fresh air and calm down. At Bedford, staff arranged an appropriate adult while the young person was en route to the station and the custody sergeant tried to arrange immediate transfer to court to avoid placing the young person in a cell.

Recommendations

4.6 Some cells should be adapted for use by detainees with physical disabilities.

4.7 Booking in areas should allow effective and private communication between detainees and staff.

Housekeeping point

4.8 Searching of vulnerable detainees should be carried out in a dignified way out of sight of other detainees and visitors.

Good practice

4.9 *The dignity questionnaire completed on arrival highlighted a range of issues relevant to detainee care and welfare.*

Safety

4.10 Custody sergeants carried out initial risk assessments, taking into consideration verbal information from the arresting/escorting officer, the detainee and any safety markers on the computer systems. Staff also used their local knowledge of detainees. Subject to the level of risk identified, detainees were placed on an observation regime of periods up to 60 minutes. These were reviewed and were not overly predictable. When there was a perceived heightened level of risk, detainees were placed in a cell covered by CCTV or on a constant watch with a member of staff observing them at the cell door. Staff in custody worked 12-hour shifts and there was no built-in overlap between shifts to allow handovers of detainee information to take place. The system relied instead on staff good will to arrive before the official shift began.

4.11 There was a system for rousing detainees when necessary and detainees were asked to carry out basic tasks to demonstrate their level of awareness. Most, but not all staff, carried anti-ligature knives, although we were told these had been issued to all staff.

4.12 Staff said the booking in area would be cleared before a detainee deemed to pose a risk to others was brought in.

4.13 In our prison survey, significantly fewer ex-detainees from Bedfordshire than the comparator[3] said insulting remarks had been made or that they had been victimised by a member of staff.

Recommendation

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

Housekeeping point

4.15 All staff working in custody should carry anti-ligature knives.

Use of force

4.16 In our prison survey, only 24% of detainees, against a comparator of 47%, said they had been subject to force in custody suites, but no adequate records were kept to substantiate this (see

[3] The comparator figure is calculated by aggregating all survey responses together and so is not an average across establishments

section on strategy). Custody staff were required to complete basic personal protection training. This was supposed to be refreshed each year, but a few we spoke to said they had not received any update/refresher training for over 12 months.

4.17 Detainees usually came into the custody suite wearing handcuffs, but these were removed at the booking in desk at the discretion of the custody sergeant.

Housekeeping point

4.18 All staff should receive annual personal protection training.

Physical conditions

4.19 Although the cells were generally well decorated, most were dirty with built up grime around toilet bases. Cleaning schedules were basic and cleaners spent little time cleaning cells. Levels of graffiti were minimal, apart from the poor quality flooring at Luton and Bedford that had been extensively damaged with graffiti over a long period of time. Staff did not understand what to look for in terms of ligature points. Most cells we inspected contained multiple ligature points, many of which were due to the cell design. The force was advised of this and took immediate remedial action. They had previously identified the need to upgrade custody provision and had carried out some remedial work to deal with ligature points identified, but lacked the resources to bring the estate up to current safety standards. (See main recommendations.)

4.20 All cells at Luton and Dunstable had low bed plinths, which presented significant problems for detainees with mobility issues. Only the cells at Bedford had in-cell washing facilities. Cells with CCTV coverage had the toilet areas pixelated to allow detainees some privacy. A clear no smoking policy was strictly enforced and staff said nicotine replacement was available on request.

4.21 Staff were expected to carry out daily checks of facilities to identify health and safety and maintenance issues. These were done using a basic checklist and their robustness varied across the force. Weekly checks were carried out by the estates department and monthly checks by the health and safety department. These did not involve the custody managers, although they received confirmation that checks had been completed.

4.22 Detainees were told how to use cell call bells. These were tested every day and tests were recorded on a cell check form. We observed mainly prompt response times, although there were some long waits at Dunstable. All suites had general fire instructions on display, although some staff were unclear about these procedures. There were no records of fire evacuation exercises conducted at Dunstable and Luton.

Recommendations

4.23 Health and safety checks should be formalised and consistent across all suites and staff given sufficient training to carry them out effectively.

4.24 All staff should be familiar with fire prevention procedures and practice evacuations should be carried out.

Personal comfort and hygiene

4.25 All suites had showers and more ex-detainees in our prison survey than the comparator said they had been offered a shower, although this still amounted to only 25% of respondents. No detainee in our custody record analysis (see appendix II) had been offered a shower, including one detainee held for 54 hours. One female detainee said she had not had a shower because of lack of privacy.

4.26 Mattresses and pillows were routinely issued, but were not included in the cleaning schedules and were not wiped down after each use. Some were in need of replacement. Toilet paper and wash kits were available only on request.

4.27 Clinical theatre garments (scrubs) were issued to detainees whose clothing was removed for evidential or hygiene reasons. We saw one detainee transferred to a neighbouring police force wearing these garments. Foam slippers were also available, but were poor quality. Paper underwear was available only to female detainees on request.

Recommendations

4.28 All detainees held overnight and those who require one should be offered a shower and should be able to take it with an appropriate degree of privacy.

4.29 Replacement clothing that maintains detainees' dignity should be provided.

Housekeeping points

4.30 Mattresses and pillows should be wiped down after each use.

4.31 Detainees should routinely be provided with a small supply of toilet paper.

4.32 Replacement underwear should be available to all detainees.

Catering

4.33 In our prison survey, more ex-detainees than the comparator said they had been offered something to eat and drink. Food was served at regular meal times or on request. Detainees were offered cereal for breakfast and a range of microwavable food designed to cater for most dietary requirements, although the quality was poor and insufficient for detainees held for longer periods. Some meals at Luton were provided from the staff canteen. Hot and cold drinks were provided on request. Food areas were mostly clean, although microwaves contained some food residue. Staff we spoke to had received basic food hygiene training as a part of their initial training, but had not attended any food handling training.

Recommendation

4.34 Food provided should be of sufficient quality and calorific content to sustain detainees for the duration of their stay.

Housekeeping points

4.35 Microwaves and food areas should be cleaned immediately after use.

4.36 Staff should be appropriately trained in food handling.

Activities

4.37 Each suite had an exercise yard and 36% of respondents in our prison survey, against a comparator of just 6%, said they had been offered outside exercise. During the inspection, one detainee who said he was claustrophobic was allowed to stay in the yard while the custody sergeant tried to expedite a court hearing. A reasonable selection of reading materials was available and offered to detainees. Visits were not normally allowed, although staff said these could be arranged in special circumstances at the custody sergeant's discretion.

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 Custody sergeants ensured that detention was used only when necessary and requested detailed accounts from arresting officers to establish that lawful procedures had been followed. We observed one custody sergeant asking the arresting officer to return to the scene of the initial investigation to gather further information. Custody sergeants we spoke to were clear about the role and function of the custody suite as a place of detention and said they would not permit it to be used as a formal place of safety for children and young people under section 46 of the Children Act 1989.

5.2 Custody sergeants said, and defence solicitors confirmed, that reviews were normally carried out at the times required by PACE and were seldom late. Duty operational inspectors were responsible for conducting the reviews and it was not normally difficult for custody sergeants to locate them. Most reviews consisted of personal interviews, although a small number were carried out by telephone when an inspector was not directly available.

5.3 Detainees being booked in were routinely given the opportunity to let someone know they were being held in custody. Staff said foreign national detainees could telephone a dependent abroad as long as this could be validated. All detainees were given a leaflet shortly after arrival outlining their rights and entitlements along with a summary of the PACE code of practice. This information was available in a wide range of languages.

5.4 Records showed that 222 immigration detainees had been held in custody between 1 August 2009 and 3 July 2010. Staff said it was not unusual for detainees to remain in detention for two or three days until they were collected by the UK Border Agency. They had been told that this was often due to delays in organising transport to move immigration detainees to the immigration custody estate. All suites had a poster on display advertising a professional telephone interpreting service. Staff also had quick access to a range of approved interpreters, whose contact details were held on a local database. Staff said they were able to use interpreting services when needed.

5.5 All detainees were routinely asked on arrival if they had any dependents. Any detainee who needed to make arrangements for dependents to be looked after was allowed to make a telephone call and, wherever possible and appropriate, bail was expedited as a priority. Social services were contacted to assist if detainees were unable to resolve situations themselves.

5.6 We were given various anecdotal accounts about special steps taken to support vulnerable people on release. At Luton, staff described a recent case when a group of homeless people had been taken in to custody and, with their consent, their details had been passed to the local homeless persons shelter. Senior managers expected pre-release plans to be produced for all detainees identified as vulnerable and requiring extra support on release. However, not all custody sergeants did this and instead produced plans only for cases they judged a high priority. For example, no action had been taken to address the problems of one man we interviewed who had nowhere to live. Most pre-release plans we looked at on the custody

records comprised simply a series of set questions asking detainees if they had somewhere safe to live on release and how they were going to get there.

Recommendations

5.7 There should be no undue delays in transporting immigration detainees to placements in the immigration custody estate (direct to UKBA).

5.8 Pre-release plans should be produced for all vulnerable detainees in line with the force policy.

Rights relating to PACE

5.9 Detainees were given the option to consult a copy of PACE. We were told that detainees were not interviewed while under, or thought to be under, the influence of alcohol or drugs except in extremely serious cases where formal approval had been obtained. We were also told that a medical opinion was always sought if there was any doubt. Custody sergeants ensured that detainees received adequate breaks between formal interviews.

5.10 Detainees could consult with their legal representatives free of charge and each suite contained sufficient adequately equipped interview rooms. We were told it was sometimes difficult, particularly at Dunstable, to obtain legal representatives for detainees who did not speak English.

5.11 Juveniles were always interviewed with an appropriate adult present. Cover during the day was provided by the local authority youth offending team and out of hours by the social services emergency duty team. This service worked efficiently and staff working in the custody suites were consistently positive about support for juveniles. Appropriate adults usually arrived within an hour of being called and custody staff described their approach as professional. The out of hours service usually took longer to provide support, but there was no evidence of a failure to provide an adequate service. Bedfordshire Police adhered to the PACE definition of a child instead of the Children Act (1989) definition, which meant those aged 17 were not provided with an appropriate adult unless otherwise deemed vulnerable. (See main recommendations.)

5.12 In contrast, the appropriate adult service for vulnerable adults provided jointly by social services and the mental health trust was poor. Adults vulnerable due to a learning disability were dealt with by social services and those with mental health difficulties by the trust. The situation for detainees with a learning disability was complicated by the fact that there were three geographical teams within the police boundary area. Custody sergeants we spoke to were very dissatisfied with the support provided for vulnerable adults. They said it was extremely difficult to obtain any provision at all without long and protracted negotiation. In general, staff we spoke to were unclear about what appropriate adult provision there was for vulnerable adults and how to access it. (See main recommendations.)

5.13 The management of DNA and forensic samples in the custody suite environments appeared good and no major issues were found. However, in a number of other locations in the custody stations, a large number of DNA samples were located, some dating as far back as 2003, which had not been submitted to the national DNA database or otherwise processed or disposed of in accordance with policies. Staff were unable to explain the backlogs, were unsure about procedures and could not identify any senior officer with responsibility for these issues.

5.14 None of the suites was a long way from the courts so detainees held overnight were produced at court on time. Cut-off times varied between 1.30pm at Luton and 2pm at Bedford. Custody staff did not have close working relationships with court staff and said courts were inflexible when asked to deal with late cases. We were given some recent examples where vulnerable detainees had been held in custody overnight because court officials had not been prepared to extend the cut-off time by even a short period. Custody records were available to detainees and their legal representatives on request.

Housekeeping points

5.15 The force should review how it manages DNA samples from detainees, volunteers and victims in departments outside of custody. The review should address the current backlogs, establish appropriate audit trails and identify a senior officer with responsibility for the implementation of an action plan to address these issues.

5.16 Police managers should agree with their equivalents in the court service a more flexible approach to making court appearances for vulnerable detainees.

Rights relating to treatment

5.17 Detainees were not routinely told how to make a complaint and staff were unclear about the formal complaint procedures. Staff said detainees who wanted to complain were asked to report the matter to a member of staff at the front desk on release from custody. If the complaint was considered very serious, some custody sergeants told us they would refer it to an inspector. When complaints were made, managers were given feedback from the professional standards department.

Recommendation

5.18 Detainees should be told how to make a complaint and should be able to do this before they leave custody. [4]

[4] IPCC statutory guidance to the police service and police authorities on the handling of complaints, 2010.

6. Health care

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

Clinical governance

6.1 G4S was contracted to provide the first line primary health care service. Health care professionals (HCPs), nurses, paramedics and doctors (forensic medical examiners and forensic physicians) provided the service. Secondary mental health services were provided by the South Essex Partnership NHS Foundation Trust (SEPT) in-reach team. Substance use services were provided by DIP workers employed by Westminster Drugs Project – Bedfordshire (WDP), a charitable organisation. A protocol for information-sharing had been agreed between the police, health care services and other agencies.

6.2 Detainees were treated respectfully and sensitively. Detainees could see a HCP of the same sex, although this could not always be guaranteed. A chaperone was routinely present at consultations. One detainee said *"There was someone else in the room and I felt like I could not talk to them about all my issues."* However, a HCP said detainees could be seen on their own if required, subject to risk assessment.

6.3 A chief inspector was responsible for monitoring service delivery and brought a strategic focus to health care issues. There were regular minuted partnership board and operational service meetings where contract and performance issues were discussed. G4S had a clinical governance group, from which information was sent to the operational service group. The police were reliant on performance data supplied by G4S, although some verification was obtained by comparing data with information from NSPIS. During April to June 2010, there had been over 600 medical requests a month. Working relationships between custody staff and HCPs were positive.

6.4 There was robust induction of new staff and ongoing training arrangements set according to the level at which staff worked. Mandatory training was available on line and at organised events. Custody staff undertook relevant life support training. Examples of further training included report writing, minor injuries and forensic sampling. Clinical staff were expected to maintain a professional portfolio. There was a system to ensure that all clinical staff were registered, and remained on the register without restriction, with their governing body. The contract with G4S had an escalation clause that enabled the police formally to register concerns over the performance of HCPs, including doctors.

6.5 Each site had a dedicated clinical room with an attached toilet and hand washing facilities. The rooms had natural lighting and reasonable ventilation. Call assistance buttons were available to summon help. A cleaning schedule was not available, but rooms were cleaned daily. The rooms were dusty above worktop height and some cupboard doors were grubby. Some tap fittings were heavily tarnished, some work surfaces were not to clinical standard and there was no evidence of an infection control audit or infection control procedures. Clinical rooms maintained decency, privacy and dignity. There were rooms capable of being used to take forensic samples and these were clean.

6.6 The clinical room at Dunstable was congested with boxes of supplies stacked on the floor and several sharps bins in various places. There were multiple first aid and emergency response

boxes in each clinical room, none of which were complete and some of which included out-of-date items. There were also multiple stocks of clinical and forensic examination equipment. Some of the stock was over-supplied and out of date. It was unclear who was responsible for checking stock and maintaining in-date supplies. A police-employed contractor removed clinical waste for disposal.

6.7 All clinical rooms had keypad-activated medicine safes for which HCPs had the code. There was no over-stocking of products and all medicines were in date and correctly labelled. There was no record of stock ordering. Drug registers were not completed correctly. There were no clinical staff signatures in the Dunstable suite. Weekly checks were undertaken by a G4S driver. Records of stock counts of dihydrocodeine, diazepam and paracetamol showed regular discrepancies. Where discrepancies were detected, a telephone call was made to the G4S head office. Missing or unaccounted drugs issues were discussed at the medicines management committee, with ongoing monitoring of the situation. Staff were issued with a regular clinical governance magazine, 'learning the lessons', which identified clinical incidents and medicine issues, and letters were sent to staff explaining the seriousness of missing medicines. Despite this, there continued to be medicine errors or stock count discrepancies. There were plans to implement a system where two signatures were required when administering dihydrocodeine and diazepam. Some drug reference books were out of date.

6.8 Nurses and custody staff accepted telephone prescriptions for medicines from doctors and said the conversations were recorded, saved as computer files and kept for the same length of time as written clinical records. There was not always a written prescription or electronic medical record to validate the verbal message for custody staff to administer medicines. Custody staff had not received training on administration of medicines or their side effects.

6.9 The implementation and use of patient group directions (PGDs) was unclear. There was no written information on the use of PGDs, although PGDs could be accessed electronically. Drug reference materials were available in clinical rooms, but were out of date. Training in the use of PGDs was available to G4S staff. The use of PGDs had not been ratified for use in custody by the partnership board. Custody staff administered medicines such as paracetamol and salbutamol after consultation with a HCP. This included nurse HCPs, which was in breach of the Nursing and Midwifery Council Standards for Medicines Management (2007).

6.10 Each custody suite had an emergency bag of essential medical equipment and an automated external defibrillator (AED). These were stored at the custody desk. There was no evidence that equipment was regularly checked and oxygen was not available. All custody staff underwent resuscitation training, including the use of an AED, every six months. Some associated medical supplies held were incomplete. For example, both bottles of emergency eye irrigation fluid were missing at Luton.

Recommendations

6.11 There should be clear infection control procedures, including cleaning schedules that are adhered to and monitored.

6.12 The system for storing, checking and administering dihydrocodiene, diazepam and paracetamol should be subject to clinical audit.

6.13 The use of patient group directions should be formalised, consistently applied across all suites and monitored.

6.14 Responsibility for the management of, and determining the need for, first aid stock items in the clinical rooms should be clarified.

6.15 Health care professionals should not instruct non-health care professionals to administer prescribed medicines.

Housekeeping points

6.16 Old drug reference books should be discarded and only the most recent copy kept.

6.17 Resuscitation equipment should include oxygen and be checked at least weekly and there should be documentary evidence that such checks are completed.

Patient care

6.18 Custody officers referred detainees to see a HCP or detainees could ask to see one. The HCP on duty would respond by attending to see the detainee or give telephone advice as appropriate. HCPs were on call 24 hours a day. The expected response time to a referral was 60 minutes. We were told 85% of referrals in June 2010 were responded to within 60 minutes and 95% within two hours. Ten (33%) detainees in our custody record analysis had been seen by a HCP. In one case, a doctor had taken over four hours to respond and the average waiting time was one hour 38 minutes.

6.19 Ten (33%) detainees in our sample had arrived in custody with their own medicines. Those with their own prescribed and labelled medications had them administered to them by custody staff or an HCP once the HCP had telephoned a doctor to agree the continuation. Custody officers made reasonable attempts to request that police officers pick up prescribed medications from detainees' home addresses. The specification for medical services provided for the continuance of opiate substitution therapy during police custody. However, staff said Bedfordshire Police policy was not to permit the use of methadone.

6.20 There was a comprehensive medical assessment form used by all HCPs, body maps, emergency department referrals and mental health referral and assessment forms. Detainees signed to consent to medical assessment, examination and forensic sampling and recognising that information may be shared while in custody or revealed in court. A care plan and stored medical supplies were kept for one detainee with complex needs who regularly frequented the custody suite at Luton. Ethnicity data were not recorded. Clinical records were locked in a safe that only health care staff could access. Completed records were stored at G4S head office.

6.21 There were no health promotion leaflets for detainees to read and limited health promotion posters displayed in each suite. An A4 sheet given to detainees included contact details for community support services such as Shelter, Mind and Gamblers Anonymous.

6.22 HCPs entered their contacts with detainees and medications prescribed directly onto the NSPIS custody record, which was accessible from the clinical rooms. The in-reach team stored clinical records at its local SEPT premises. Results of clinical examinations were shared with detainees or their legal representatives on request.

Recommendation

6.23 Detainees should be able to continue with prescribed medications for any clinical condition, including opiate substitution therapy.

Good practice

6.24 *The care plan prepared for a detainee who frequently visited the custody suite demonstrated continuity of patient-centred care in a challenging setting.*

Substance use

6.25 WDP DIP workers were based in custody suites on weekday mornings and carried out 'cell sweeps' so that every detainee had access to them. They visited in the afternoons if called by custody officers. During out of hours, custody staff made an appointment for the detainee to see the DIP worker the next working day and attendance was a condition of bail for detainees released in this way. DIP workers provided adult detainees with opportunities for throughcare for up to 12 weeks and signposted juveniles or those with alcohol problems to appropriate services. Custody staff valued the DIP workers' services and the training they provided. There was good liaison between substance use and mental health workers. Intravenous drug users were offered clean needles and syringes on release. Detainees requiring substance use or alcohol withdrawal therapy were prescribed substitutes such as dihydrocodeine and diazepam.

Mental health

6.26 There was no formal contract or service level agreement for the provision of secondary mental health services, although there was an agreed role specification for mental health workers. The SEPT in-reach team worked from 9am to 5pm on weekdays. They had a joint caseload of 45 patients and maintained links with courts, the police, SEPT inpatient and outpatient teams, the prison in-reach team and learning disability services. Outside office hours, custody officers offered detainees mental health appointments on the next working day.

6.27 Detainees requiring formal assessment under the Mental Health Act were seen by the local social services emergency duty team (EDT). The multi-agency policy stipulated that the assessment should occur within four hours of referral, but custody officers said responses often took longer. We observed the EDT attending the custody suite at Bedford to assess a detainee and that response was within four hours.

6.28 HCPs referred detainees by telephone and completed a referral form. Following assessment, in-reach workers could give advice to custody staff, offer further support or refer for further mental health service inputs. There were concerns that the team was not always used to its best advantage as the role of the in-reach team was not clearly understood. Custody staff valued mental health support, but had not received mental health awareness training and were not always confident in what they were looking for in relation to mental health. Training was due to be provided by SEPT in the near future.

6.29 Good multi-agency working was supported by an up-to-date Section 136 policy and a joint working protocol that included information-sharing. The protocol was reviewed annually by the police liaison committee. Partners included the police, SEPT, the ambulance service,

Bedfordshire County Council and Luton Borough Council. Partner agencies were encouraged to use this forum to discuss what worked well, problems and areas for improvement. There were two NHS Section 136 suites in use at Weller Hospital Wing, Bedford and Calnwood Court in Luton. These had dedicated staff. Police risk assessments were shared with NHS partners as appropriate. We were told that 64 section 136 detainees had been held in Bedfordshire custody suites in the 12 months to 31 July 2010.

Recommendations

6.30 The commissioning of mental health services should be formalised to ensure the needs of all detainees with mental health issues are met.

6.31 There should be out-of-hours cover for mental health workers to meet the needs of detainees.

6.32 Custody staff should have appropriate training to recognise and take appropriate action when a detainee may have mental health problems and work effectively with health staff to ensure a detainee's care.

6.33 Section 136 detainees should be held in police cells only as a last resort.

7. Summary of recommendations

Main recommendations — To Bedfordshire Police

7.1 There should be sufficient staff in custody at all times to ensure the safety and well being of detainees. (2.13)

7.2 Cells and other detainee areas should be clean and free of ligature points, which staff should be trained to identify. Where current resources do not allow ligature points to be removed, a strategy should be put in place to manage the new risks identified. (2.14)

7.3 Appropriate adults should be readily available to support vulnerable adults and juveniles aged 17 years. (2.15)

Recommendation — To UKBA

Individual rights

7.4 There should be no undue delays in transporting immigration detainees to placements in the immigration custody estate. (5.7)

Recommendations — To Bedfordshire Police

Strategy

7.5 Only trained staff should be allowed to work in the custody environment. (3.10)

7.6 The force should collate the use of force and monitor for trends, for example by ethnicity, location and officer involved. (3.11)

Treatment and conditions

7.7 Some cells should be adapted for use by detainees with physical disabilities. (4.6)

7.8 Booking in areas should allow effective and private communication between detainees and staff. (4.7)

7.9 An overlap period should be built into all shifts to facilitate an effective handover between staff. (4.14)

7.10 Health and safety checks should be formalised and consistent across all suites and staff given sufficient training to carry them out effectively. (4.23)

7.11 All staff should be familiar with fire prevention procedures and practice evacuations should be carried out. (4.24)

7.12 All detainees held overnight and those who require one should be offered a shower and should be able to take it with an appropriate degree of privacy. (4.28)

7.13 Replacement clothing that maintains detainees' dignity should be provided. (4.29)

7.14 Food provided should be of sufficient quality and calorific content to sustain detainees for the duration of their stay. (4.34)

Individual rights

7.15 Pre-release plans should be produced for all vulnerable detainees in line with the force policy. (5.8)

7.16 Detainees should be told how to make a complaint and should be able to do this before they leave custody. (5.18)

Health care

7.17 There should be clear infection control procedures, including cleaning schedules that are adhered to and monitored. (6.11)

7.18 The system for storing, checking and administering dihydrocodiene, diazepam and paracetamol should be subject to clinical audit. (6.12)

7.19 The use of patient group directions should be formalised, consistently applied across all suites and monitored. (6.13)

7.20 Responsibility for the management of, and determining the need for, first aid stock items in the clinical rooms should be clarified. (6.14)

7.21 Health care professionals should not instruct non-health care professionals to administer prescribed medicines. (6.15)

7.22 Detainees should be able to continue with prescribed medications for any clinical condition, including opiate substitution therapy. (6.23)

7.23 The commissioning of mental health services should be formalised to ensure the needs of all detainees with mental health issues are met. (6.30)

7.24 There should be out-of-hours cover for mental health workers to meet the needs of detainees. (6.31)

7.25 Custody staff should have appropriate training to recognise and take appropriate action when a detainee may have mental health problems and work effectively with health staff to ensure a detainee's care. (6.32)

7.26 Section 136 detainees should be held in police cells only as a last resort. (6.33)

Housekeeping points

Treatment and conditions

7.27 Searching of vulnerable detainees should be carried out in a dignified way out of sight of other detainees and visitors. (4.8)

7.28 All staff working in custody should carry anti-ligature knives. (4.15)

7.29 All staff should receive annual personal protection training. (4.18)

7.30 Mattresses and pillows should be wiped down after each use. (4.30)

7.31 Detainees should routinely be provided with a small supply of toilet paper. (4.31)

7.32 Replacement underwear should be available to all detainees. (4.32)

7.33 Microwaves and food areas should be cleaned immediately after use. (4.35)

7.34 Staff should be appropriately trained in food handling. (4.36)

Individual rights

7.35 The force should review how it manages DNA samples from detainees, volunteers and victims in departments outside of custody. The review should address the current backlogs, establish appropriate audit trails and identify a senior officer with responsibility for the implementation of an action plan to address these issues. (5.15)

7.36 Police managers should agree with their equivalents in the court service a more flexible approach to making court appearances for vulnerable detainees. (5.16)

Health care

7.37 Old drug reference books should be discarded and only the most recent copy kept. (6.16)

7.38 Resuscitation equipment should include oxygen and be checked at least weekly and there should be documentary evidence that such checks are completed. (6.17)

Good practice

Treatment and conditions

7.39 The dignity questionnaire completed on arrival highlighted a range of issues relevant to detainee care and welfare. (4.9)

Health care

7.40 The care plan prepared for a detainee who frequently visited the custody suite demonstrated continuity of patient-centred care in a challenging setting. (6.24)

Appendix I: Inspection team

Sean Sullivan	HMIP team leader
Ian MacFadyen	HMIP inspector
Paul Rowlands	HMIP inspector
Peter Todd	HMIC Assistant HM Inspector of Constabulary
Fiona Shearlaw	HMIC inspector
Paddy Craig	HMIC inspector
Paul Tarbuck	HMIP health care inspector
Helen Carter	HMIP health care inspector
Catherine Nichol	HMIP researcher

Appendix II: Custody record analysis

Background

As part of the inspection of Bedfordshire police custody, a sample of the custody records of detainees held were analysed for the following three random dates: Tuesday 20 July, Friday 23 July and Saturday 24 July. Custody records were held electronically on NSPIS. A total sample of 30 records were analysed from across Bedfordshire:

Custody suite	Number of records analysed
Dunstable	6
Bedford	12
Luton	12
Total	30

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

Demographic information

- Seven of the detainees were female and 23 were male.
- Three people under the age of 17 were included in the sample.
- There were 22 detainees in our sample with a White ethnic background and eight from a Black or minority ethnic background.
- Three in the sample were foreign nationals, all three were given their foreign national rights and all declined the opportunity to have their embassy informed of their arrest. However, one record suggested that the embassy was informed of arrest, despite the detainee declining this right.
- Five detainees had been held for more than 24 hours. Fourteen (47%) had been in custody overnight, including those who had arrived during the night and were not released until the morning. Twelve (40%) detainees had been held for less than six hours.

Risk assessments

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

- Nine detainees (30%) were brought in to custody intoxicated and seven of these were seen by a doctor according to the notes in their detainee logs.
- Seven (23%) detainees had previously self-harmed or attempted suicide. This information was recorded in the risk assessment and detention log and considered when deciding the level of observations required.
- Eight (27%) detainees in our sample had reported mental health problems. It was noted that an appropriate adult was required for three of these detainees and social services were contacted for two of the individuals in order to supply an appropriate adult. An appropriate adult was present for all three for their interview, but was only recorded as present for one detainee for a re-reading of their rights.
- Ten detainees in our sample reported being on medication on arrival in custody. Seven of these detainees were seen by a health care professional and the other two detainees were in the station for less than six hours, so their medication was not due until later. However,

for the one detainee who did not see a health care professional and needed to take medication, it was authorised to be taken over the telephone by a doctor.

- Five detainees in our sample came in to custody with an injury. All but one were seen by a health care professional. Two detainees had their injuries photographed by SOCO, but one, who wanted his injuries recorded, was told SOCO were no longer on duty and was informed of their drop in surgeries.
- In three (10%) risk assessments, it was noted to be a detainee's first time in custody.

Removal of clothing

One detainee had outer clothing seized as evidence. There was nothing in the record outlining what was given to replace it.

Young people

There were three young people in our sample under the age of 17. It was noted that an appropriate adult was required for all these young people.

- One young person was released immediately from custody.
- The other two had appropriate adults from social services and a member of the family respectively. The appropriate adult was present when the young people were re-read their rights and entitlements and during interview. The format of entries in NSPIS allows a clear recognition of who is present during the interview.

Women

- Of the seven female detainees in the sample, four had a 'dignity' questionnaire completed, which asks about female hygiene packs and dependants.
    - During a review, one woman asked for a call to arrange child care, but there is no record of this being granted – she was told at the time that she could have a call if practicable.
    - Hygiene packs offered as part of the dignity questionnaire led to one being issued.
    - The female detainees generally had better quality entries into dignity and pre-release plans.

Interpreters

- Three detainees required the use of an interpreter. All three were booked in using a professional telephone interpreting service and one person spoke to their solicitor using this service, but the second call appeared to be in a language that was not identified in their record as one they spoke.
- For one detainee, the reviews did not mention interpreters or the interpreting service and their rights were signed as they could 'read limited English' and so were able to read them. They were not interviewed.
- Another detainee had a review conducted without a professional telephone interpreting service. It was not clear if there was an interpreter present during interview, but was charged via the service.

Inspector reviews

Inspector reviews were held in line with requirements, usually at the required times. There were a number of exceptions when reviews were late, which were recorded and due to being busy with 'operational matters' such as critical incidents or 'supt. briefings'.

Services

- Seven detainees had made a telephone call during their time in custody. One detainee had requested to make a call, but there was no record of this request being granted.
- All detainees were offered the right to legal advice and 16 (53%) accepted to have legal advice. It was notable that when a detained person changed their mind about having a solicitor, the case was not progressed until an inspector had spoken to the individual to ascertain why. However, in both cases where the individual had changed their mind and declined legal advice after initially requesting it, it was in order to speed up the process.
- Ten (30%) detainees were seen by the FME.
    - The longest wait was approximately four hours. No reason for the delay was given, but a mental health assessment for fitness to detain and interview was required. The shortest wait was eight minutes.
    - The average wait for an FME was one hour 38 minutes.
    - All detainees were offered a referral to a drug or alcohol worker as part of their risk assessment. However, no one in the sample was recorded as seeing a drug or alcohol worker during their time in custody.
    - Telephone advice about medication was given on a number of occasions, normally about medication the detainee had with them or requests for paracetamol.
- Twenty-four (80%) detainees in our sample were offered at least one meal while in custody. Meals were offered to all detainees who had been in custody for more than six hours, except for two: one was held overnight and missed breakfast and the other during the day missing lunch.
- Three detainees had been given outside exercise during their time in custody. Two detainees had been taken out multiple times. Sometimes exercise could not be facilitated as the exercise yard was occupied. The length of exercise was sometimes not recorded. Where it was noted, it appeared that detainees could spend up to two hours in exercise.
- One detainee had a shower while in custody. Nine detainees subsequently went to court. Five detainees stayed in custody for over 24 hours and one detainee was held for almost 54 hours.
- Three detainees had been provided with reading materials.
- One detainee shared a cell. They were an immigration detainee and did not want to be separated from the person they were found with. This was risk assessed and allowed.
- The one immigration detainee in the records was dealt with extremely quickly, being in custody for only 16 hours.
- One detainee had a supervised visit.

Appendix III: Summary of detainee questionnaires and interviews

Prisoner survey methodology

A voluntary, confidential and anonymous survey of the prisoner population, who had been through a police station in Bedfordshire, 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 26 July 2010. A list of potential respondents to have passed through Luton, Bedford, Dunstable or Ampthill police stations was created, listing all those who had arrived from Luton or Bedford Magistrates court within the past two months.

Selecting the sample

In total, 63 respondents were approached. Eleven respondents reported being held in police stations outside Bedfordshire and two could speak no English and so it was impossible to determine the police station they had been in. On the day, the questionnaire was offered to 50 respondents; there were two refusals, one questionnaire returned blank and four non-returns. All of those sampled had been in custody within the last two months.

Completion of the questionnaire was voluntary. Interviews were carried out with any respondents with literacy difficulties. In total, two respondents were interviewed.

Methodology

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

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

- fill out the questionnaire immediately and hand it straight back to a member of the research team
- have their questionnaire ready to hand back to a member of the research team at a specified time
- seal the questionnaire in the envelope provided and leave it in their room for collection.

Response rates

In total, 43 (86%) 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 31 police areas since April 2008.

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

Summary

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

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

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

Police custody survey

Section 1: About you

Q2 What police station were you last held at?
Luton: 15; Bedford: 15; Dunstable: 13

Q3 What type of detainee were you?

Police detainee	34 (83%)
Prison lock-out (i.e. you were in custody in a prison before coming here)	5 (12%)
Immigration detainee	0 (0%)
I don't know	2 (5%)

Q4 How old are you?

16 years or younger	0 (0%)	*40-49 years*	4 (9%)
17-21 years	3 (7%)	*50-59 years*	3 (7%)
22-29 years	27 (63%)	*60 years or older*	0 (0%)
30-39 years	6 (14%)		

Q5 Are you:

Male	43 (100%)
Female	0 (0%)
Transgender/transsexual	0 (0%)

Q6 What is your ethnic origin?

White - British	21 (49%)
White - Irish	0 (0%)
White - other	8 (19%)
Black or black British - Caribbean	1 (2%)
Black or black British - African	5 (12%)
Black or black British - other	0 (0%)
Asian or Asian British - Indian	0 (0%)
Asian or Asian British - Pakistani	5 (12%)
Asian or Asian British - Bangladeshi	0 (0%)
Asian or Asian British - other	0 (0%)
Mixed heritage - white and black Caribbean	2 (5%)
Mixed heritage - white and black African	0 (0%)
Mixed heritage- white and Asian	0 (0%)
Mixed heritage - Other	0 (0%)
Chinese	0 (0%)
Other ethnic group	1 (2%)

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

Yes	11 (27%)
No	30 (73%)

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

None	16 (40%)
Church of England	11 (28%)
Catholic	4 (10%)
Protestant	0 (0%)
Other Christian denomination	3 (8%)
Buddhist	0 (0%)
Hindu	0 (0%)

Jewish 0 (0%)
Muslim 6 (15%)
Sikh 0 (0%)

Q9 How would you describe your sexual orientation?

Straight/heterosexual 42 (100%)
Gay/lesbian/homosexual 0 (0%)
Bisexual 0 (0%)

Q10 Do you consider yourself to have a disability?

Yes 8 (19%)
No 35 (81%)
Don't know 0 (0%)

Q11 Have you ever been held in police custody before?

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

Section 2: Your experience of this custody suite

Q12 How long were you held at the police station?

1 hour or less 0 (0%)
More than 1 hour, but less than 6 hours 1 (2%)
More than 6 hours, but less than 12 hours 1 (2%)
More than 12 hours, but less than 24 hours 12 (29%)
More than 24 hours, but less than 48 hours (2 days) 14 (33%)
More than 48 hours (2 days), but less than 72 hours (3 days) 9 (21%)
72 hours (3 days) or more 5 (12%)

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

Yes 37 (86%)
No 5 (12%)
Don't know/can't remember 1 (2%)

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

Yes 24 (56%)
No 12 (28%)
I don't know what this is/I don't remember 7 (16%)

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

My clothes were not taken 30 (73%)
I was offered a tracksuit to wear 4 (10%)
I was offered an evidence suit to wear 5 (12%)
I was offered a blanket 2 (5%)

Q16 Could you use a toilet when you needed to?

Yes 38 (88%)
No 5 (12%)
Don't know 0 (0%)

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

	Yes	*No*
Toilet paper	21 (50%)	21 (50%)

Q18 Did you share a cell at the police station?

Yes	0 (0%)
No	43 (100%)

Q19 How would you rate the condition of your cell:

	Good	*Neither*	*Bad*
Cleanliness	12 (28%)	18 (42%)	13 (30%)
Ventilation/air quality	11 (26%)	14 (33%)	18 (42%)
Temperature	7 (17%)	13 (31%)	22 (52%)
Lighting	22 (51%)	13 (30%)	8 (19%)

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

Yes	19 (49%)
No	20 (51%)

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

Yes	19 (45%)
No	23 (55%)

Q22 Were you held overnight?

Yes	41 (95%)
No	2 (5%)

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

Not held overnight	2 (3%)
Pillow	21 (34%)
Blanket	29 (48%)
Nothing	9 (15%)

Q24 Were you offered a shower at the police station?

Yes	10 (24%)
No	32 (76%)

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

Yes	15 (37%)
No	26 (63%)

Q26 Were you offered anything to:

	Yes	*No*
Eat?	39 (93%)	3 (7%)
Drink?	40 (93%)	3 (7%)

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

I did not have any food or drink	6 (14%)
Yes	23 (55%)
No	13 (31%)

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

I do not smoke	12 (29%)
I was allowed to smoke	1 (2%)
I was not offered anything to cope with not smoking	24 (59%)
I was offered nicotine gum	0 (0%)
I was offered nicotine patches	0 (0%)
I was offered nicotine lozenges	4 (10%)

Q29 Were you offered anything to read?

Yes	17 (40%)
No	25 (60%)

Q30 Was someone informed of your arrest?

Yes	18 (43%)
No	15 (36%)
I don't know	3 (7%)
I didn't want to inform anyone	6 (14%)

Q31 Were you offered a free telephone call?

Yes	15 (37%)
No	26 (63%)

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

My telephone call was not denied	19 (50%)
Yes	4 (11%)
No	15 (39%)

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

	Yes	*No*
Who was taking care of your children	2 (6%)	30 (94%)
Contacting your partner, relative or friend	24 (62%)	15 (38%)
Contacting your employer	3 (10%)	26 (90%)
Where you were going once released	9 (29%)	22 (71%)

Q34 Were you interviewed by police officials about your case?

Yes	37 (90%)	
No	4 (10%)	If No, go to Q36

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

	Yes	*No*	*Not needed*
Solicitor	31 (84%)	5 (14%)	1 (3%)
Appropriate adult	1 (4%)	11 (42%)	14 (54%)
Interpreter	5 (19%)	7 (27%)	14 (54%)

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

I did not requested a solicitor	4 (10%)
2 hours or less	5 (13%)
Over 2 hours but less than 4 hours	5 (13%)
4 hours or more	26 (65%)

Q37 Were you officially charged?

Yes	40 (95%)
No	1 (2%)
Don't know	1 (2%)

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

I have not been charged yet	1 (3%)
1 hour or less	0 (0%)
More than 1 hour, but less than 6 hours	2 (5%)
More than 6 hours, but less than 12 hours	7 (18%)
12 hours or more	29 (74%)

Section 3: Safety

Q40 Did you feel safe there?

Yes	30 (73%)
No	11 (27%)

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

Yes	9 (22%)
No	32 (78%)

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

I have not been victimised	32 (67%)	*Because of your crime*	3 (6%)
Insulting remarks (about you, your family or friends)	1 (2%)	*Because of your sexuality*	0 (0%)
Physical abuse (being hit, kicked or assaulted)	3 (6%)	*Because you have a disability*	1 (2%)
Sexual abuse	0 (0%)	*Because of your religion/religious beliefs*	1 (2%)
Your race or ethnic origin	2 (4%)	*Because you are from a different part of the country than others*	1 (2%)
Drugs	4 (8%)		

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

Yes	9 (24%)
No	28 (76%)

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

Yes	9 (24%)
No	29 (76%)

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

Yes	10 (26%)
No	28 (74%)

Section 4: Health care

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

Yes	11 (28%)
No	29 (73%)

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

Not taking medication	29 (74%)
Yes	3 (8%)
No	7 (18%)

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

Yes	12 (31%)
No	21 (54%)
Don't know	6 (15%)

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

	Yes	*No*
Doctor	10 (29%)	25 (71%)
Nurse	5 (17%)	24 (83%)
Paramedic	1 (4%)	26 (96%)
Psychiatrist	0 (0%)	27 (100%)

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

Yes	5 (15%)
No	22 (65%)
Don't know	7 (21%)

Q52 Did you have any drug or alcohol problems?

Yes	11 (28%)
No	28 (72%)

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

I didn't have any drug/alcohol problems	28 (72%)
Yes	5 (13%)
No	6 (15%)

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

I didn't have any drug/alcohol problems	28 (74%)
Yes	1 (3%)
No	9 (24%)

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

	I was not seen by health care	*Very good*	*Good*	*Neither*	*Bad*	*Very bad*
Quality of health care	22 (59%)	2 (5%)	4 (11%)	3 (8%)	5 (14%)	1 (3%)

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

No	29 (74%)
Yes	10 (26%)

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

No	34 (85%)
Yes	6 (15%)