Report on an unannounced inspection visit to police custody suites in

Devon and Cornwall

by HM Inspectorate of Prisons
and HM Inspectorate of Constabulary

22–30 October 2013
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Section 1. Introduction

This report is part of a programme of unannounced 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.

Devon and Cornwall was the last inspection of a Home Office force as our inspection programme was reaching the end of its first six-year cycle. There were several reasons for leaving this inspection until the end of the cycle, not least the logistics of inspecting across such a wide geographical area. Such logistics test the Devon and Cornwall force every day. It had a clear plan for its custody estate; it had reduced the number of suites to locations at strategic points across the area, and was upgrading them to ensure they were fit for purpose.

Throughout the inspection, we were struck by the obvious caring culture of the custody staff. We found evidence in records and witnessed first hand how staff ensured that detainees of all ages were cared for appropriately. We commend the force for its efforts in ensuring that detainees were treated respectfully.

However, we were concerned about the care of those detained for their own safety under section 136 of the Mental Health Act. Police custody is not an appropriate place of safety for such individuals, except in extreme circumstances, and yet this had become the accepted option in Devon and Cornwall in the majority of cases. This was unacceptable, and we urged the force to engage with its health partners to improve this situation urgently.

A further concern was the length of time that some detainees spent in police custody before they were able to go to court, because there were delays in the courts accepting them. These unacceptable delays were not always challenged by police staff. HMIP will examine this issue further as part of its inspection of court custody, but improvements to the situation need to be dealt with more quickly.

This report provides a small number of recommendations to assist the force and, the Police and Crime Commissioner to improve provisions 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.

Thomas P Winsor
HM Chief Inspector of Constabulary

Nick Hardwick
HM Chief Inspector of Prisons

January 2014
Section 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 the Authorised Professional Practice – Detention and Custody at force-wide strategies, treatment and conditions, individual rights and health care. They are also informed by a set of Expectations for Police Custody1 about the appropriate treatment of detainees and conditions of detention, developed by the two inspectorates to assist best custodial practice.

2.3 At the time of the inspection, Devon and Cornwall force had seven designated custody suites with a total of 142 cells – one, Plymouth, was a temporary designated suite while the larger suite was being refurbished. There were also four non-designated suites that could be used for holding detainees for less than six hours; as they could be designated if required for longer, we also visited them.

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<tr>
<th>Suite</th>
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<tbody>
<tr>
<td>Camborne</td>
<td>24</td>
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<tr>
<td>Newquay</td>
<td>11</td>
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<tr>
<td>Launceston</td>
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<td>Plymouth Crownhill</td>
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<td>Exeter</td>
<td>20</td>
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<td>Torquay</td>
<td>36</td>
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<tr>
<td>Barnstaple</td>
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<table>
<thead>
<tr>
<th>Non-designated suites</th>
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<td>8</td>
</tr>
<tr>
<td>Falmouth</td>
<td>4</td>
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<tr>
<td>St Mary's</td>
<td>2</td>
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<tr>
<td>Exmouth</td>
<td>5</td>
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1 http://www.justice.gov.uk/inspectorates/hmi-prisons/expectations.htm
2.4 This unannounced inspection was conducted across the whole force area. We examined the custody strategy, as well as treatment and conditions, individual rights and health care in the custody suites. In the financial year 2012-13, a total of 32,547 detainees had been held in the designated suites.

2.5 A survey of prisoners at HMP Exeter who had formerly been detained in custody suites in the force area was conducted by HM Inspectorate of Prisons researchers (see Appendix II).

Strategy

2.6 The force had a strategic focus that promoted the safe and decent delivery of custody. The assistant chief constable was the strategic lead on custody issues, and centralised custody provision was part of the crime and criminal justice department. There was a clear senior line management structure. The custody estates strategy (2011-15) included plans for a new 40-cell criminal justice centre in Exeter, as well as a programme of improvements to the custody suites following completion of an access audit.

2.7 There was a contingency plan for when suites reached capacity, which custody sergeants had confidence in using. Permanent sergeants and detention officers (DOs) were employed, and staff moved between suites where necessary. Inspectors were visible and active in custody. The DOs looked after the care and welfare of detainees but did not search them. There was good morale among the staff, who were, without exception, professional.

2.8 A range of internal meetings monitored all aspects of custody provision, but meetings with partner organisations were less well established. The local crime and justice board had only recently re-formed and the Peninsula health and criminal justice group had been in abeyance since 2010, although was due to reform in December 2013. The re-forming of these two strategic fora needed to be translated into improving mental health provision for detainees across the force area, in particular the provision of section 136 places of safety, with personal involvement at senior and strategic level by both the police and health services.

2.9 There were two independent custody visitor panels for the force and a coordinator in the Police and Crime Commissioner’s office. The scheme was active with a regular schedule of visits. There was regular and consistent police representation at panel meetings, and a good exchange of resources at training events.

2.10 All staff had undergone custody-specific training before taking up custody duties, and refresher training was also built into the rota for sergeants and detention officers. Adverse incidents were reported, and the data analysed. Immediate issues were dealt with through the custody intranet site, which was a good system. There was a good corporate quality assurance process for sampling custody records, which included person escort records (PERS) and cross-referencing to CCTV.

2 Section 136 of the Mental Health Act 1983 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.
Treatment and conditions

2.11 Detainees were treated with respect and their diverse needs were met. There was evidence throughout the inspection and in our custody record analysis of a caring staff culture. Staff had good interpersonal skills with detainees, including young people. We witnessed some exceptionally good care, even when suites were busy. In our survey, significantly more respondents than the comparator said that they were treated well by staff.

2.12 All designated suites, apart from Barnstaple, had access for detainees with disabilities. Some suites had adapted cells, but some exercise yards were not wheelchair-accessible. At least one copy of the Bible and Qur’an were available at all custody suites, and some held a few other religious texts. There were Muslim prayer mats and compasses in all suites, but not all were stored respectfully.

2.13 Booking-in desks at all suites allowed sufficient privacy for detainees to disclose vulnerabilities or confidential information, but some desks were too high. Desks were in separate booking-in rooms, and sergeants working in them could be left unfocused on what was happening in the rest of the custody suite. Signs about CCTV were not prominently displayed and did not adequately advise detainees that they were subject to surveillance recording. Although cell camera screens were switched off appropriately during strip searches, detainees could be seen using the toilets in their cells, which was disrespectful.

2.14 Custody staff were competent to assess and manage detainee risks, which were identified early. Not all staff were clear on the levels of observation described in Authorised Professional Practice – Detention and Custody, but they understood the importance of regular rousing of intoxicated detainees and the need to obtain an appropriate response from them. The completion of PERs varied, which meant that information on some identified risks was not passed on to courts or prison staff. Staff handovers, which included all staff, were visually and audibly recorded. Pre-release risk assessments were completed, but some were sparse. We also found varying practices in giving detainees contact details for support organisations.

2.15 Use of force was proportionate and lawful. The force had a mechanism for recording the use of force in custody, but staff were confused about the process, and the non-submission of forms suggested under-reporting of incidents, which affected monitoring. There was inconsistency in the removal of handcuffs once a detained person had entered the custody suite.

2.16 Custody suites, including the non-designated suites, were clean and in good condition with very little graffiti in cells, although there was some in exercise yards. Some cells had potential ligature points, and we informed the force of these during the inspection. Staff checked cells between occupancy. The cleaners responded promptly to requests, even out of hours.

2.17 Some detainees told us that they had to request toilet paper, as well as blankets and reading materials in some suites. However, we also saw such items being offered and given as a matter of course. Cell call bells were answered promptly. In two suites, we saw showers offered to detainees before they left for court, but the showers were not used frequently overall, and not all showers had sufficient privacy. Replacement clothing and footwear were available but mostly only in large sizes, as was the rip-proof clothing.

3 This is contained in Safer Detention and Handling of Persons in Police Custody 2011 (SDHP), published by the College of Policing.
Individual rights

2.18 Voluntary attendance instead of the arrest and detention of suspects was encouraged. For those who were detained, we saw arresting officers provide ‘necessity’ reasons unprompted. There was evidence that custody staff progressed investigations through contacting solicitors early and good liaison with investigation teams. However, we noted that charging decisions by supervisory officers sometimes caused unnecessary delays.

2.19 Whenever possible, custody sergeants tried to use family members to act as appropriate adults for children and young people and vulnerable detainees, which was good. Arrangements for appropriate adults from statutory services were complicated but reasonably effective and well used. Custody sergeants bailed children and young people whenever possible if an appropriate adult could not attend within a reasonable time, which was good.

2.20 A poster, in a range of languages, advising detainees of the availability of legal advisers was displayed in or near charge rooms at most but not all suites. Interpreting services were mostly easily obtained where needed, and the ‘rights and entitlements’ information could be printed from the intranet in a range of languages. Some suites had an excellent easy-read booklet on rights and entitlements.

2.21 Detainees were told of their right to legal advice, and PACE codes of practice were available and offered to detainees at most suites. Solicitors were contacted promptly, including overnight. Due to the distances involved, many inspector reviews were conducted by telephone, and ranged from brief calls with little recorded to longer calls with a comprehensive entry in the record. However, detainees were involved in the reviews and understood their importance.

2.22 Not all detainees were able to appear in court promptly. The time at which some courts refused to accept detainees was far too early, even with the ‘virtual court’ at Barnstaple police station. There were also problems with the availability of court cells or female staff to escort detained women, which, on occasion prolonged their stay in police custody.

2.23 Detainees were given information about how to make a complaint and were able to do so. However, some staff told us that they would not take a complaint while a detainee was in custody, although this was force policy.

Health care

2.24 Serco Health provided good primary health services, with appropriate contract monitoring by the force. The quality of care was generally good. The services were nurse-led with forensic medical examiner (FMEs) on call. There were some problems with staff response times, particularly for FMEs and community mental health teams. The health care rooms were well resourced but most needed attention to comply with infection control guidelines. The provision and maintenance of resuscitation equipment was excellent at all suites. Most detainees could continue prescribed medications while in custody, including controlled drugs, and the supply, storage and administration of medications was well organised.

2.25 In our survey, more respondents than the comparator said that they had drug or alcohol problems. Service provision varied across the force area but included support for both drug and alcohol misuse, and there were good links with the mental health teams.

2.26 The number of detainees with mental health issues was very high. As part of the criminal justice mental health liaison and diversion initiative, mental health nurses worked in the
custody suites on weekdays and were developing good relationships with custody staff, but the service was too slow and cumbersome.

2.27 Too many detainees were held in custody suites under section 136 of the Mental Health Act. Criteria for admission to NHS section 136 places of safety were overly restrictive, and staff consistently told us about difficulties in getting these suites to accept detainees. There was no strategic oversight of this issue, which needed urgent attention.

Main recommendations

2.28 There should be urgent work at a strategic level by the police and health services to ensure that custody suites are only used as Mental Health Act 1983 section 136 places of safety in exceptional circumstances.

2.29 Devon and Cornwall police should engage with HM Courts and Tribunals Service to ensure that early court cut-off times and the lack of court availability do not result in unnecessarily long stays in custody.
Section 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 well-being 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 crime and criminal justice department (CJD). A chief superintendent, head of crime and criminal justice, line managed the superintendent head of criminal justice, who line managed the chief inspector head of custody. This was a clear management structure.

3.2 The 2011-15 estate strategy contained three key priorities – to fund a new 40-cell criminal justice centre at Exeter, address health and safety, security, and equality and diversity requirements, and implement a programme of custody improvements following completion of an access audit – with funding for these included in the current financial plan. The estates strategy had been effective in the refurbishment of the 42-cell Charles Cross custody suite at Plymouth, due for completion in November 2013, and the good standard of custody suites. However, some remedial work was required at the Exeter custody suite before work on the new criminal justice centre started in 2014. There was one standby suite at Crownhill, Plymouth, which was in use during the inspection, and four non-designated suites.

3.3 Detainees were generally taken to their area custody facility where they were arrested. There was a process to identify when suites were reaching or had reached capacity. This was determined by custody sergeants based on the risks they were managing in the suites and communicated to the control room and core custody inspector. This process was implemented appropriately and effectively during our inspection, and it was a good approach to managing demand and ensuring detainee care.

3.4 Staffing levels in custody suites during the inspection were adequate. The staff included permanent custody sergeants, senior detention officers and detention officers (DOs) employed by Devon and Cornwall police. Re-rostering, moving staff between suites and overtime ensured that there were adequate custody sergeants and DOs, and back-up from other operational areas was rarely required. When it was, sergeants who had been custody-trained provided back up for custody sergeants.

3.5 Custody sergeants had operational line management of senior detention officers and DOs, who were responsible for the care and welfare of detainees. DOs were allocated specific and consistent roles in all suites, provided a good standard of care for detainees, and were professional and positive in their role. However, DOs were not always used to search detainees. The shift handover process included all staff (in line with national guidance), and was particularly good in sharing risk information, which encouraged a safer environment for detainees.
3.6 There were seven dedicated custody inspectors supervised by the head of custody, who also had a dedicated criminal justice strategic support team. A rota ensured the provision of a core custody inspector between 7am and 11pm, which included Police and Criminal Evidence Act (PACE) coverage for the custody suites. Outside these hours, PACE coverage was provided by the critical incident inspector. The custody inspectors line managed the custody sergeants at their respective custody suites, and were visible and active. Recent and proposed changes at Head of CJD and Head of Custody, presented further opportunities for engagement and support through their visible presence in the suites.

3.7 An internal meeting structure discussed and reviewed custody matters. The ACC custody lead met the heads of custody and criminal justice weekly and reviewed performance and risk. The ACC also chaired a monthly meeting with portfolio leads, which included custody. The Police and Crime Commissioner (PCC) held the ACC to account at the monthly performance accountability board meeting, and there was a monthly custody inspectors’ meeting chaired by the head of custody. These meetings discussed detailed monthly performance data, which were produced centrally and used to manage performance. However, these meetings lacked scrutiny and checks of data and performance on section 136 of the Mental Health Act 1983 (see below and main recommendation 2.28). The head of custody also chaired a quarterly safer detention meeting, where inspectors, sergeants and DOs discussed and shared good practice; this was a positive initiative.

Good practice

3.8 There was a quarterly safer detention meeting, chaired by the head of custody and attended by inspectors, sergeants and detention officers, which discussed and shared good practice.

Partnerships

3.9 The chief constable chaired the re-formed local criminal justice board (LCJB), which was attended by the head of criminal justice. The Peninsula health and criminal justice group had not met since 2010 and was due to be re-formed in December 2013. These meetings needed to include improving provision for people detained under section 136 of the Mental Health Act, as too many were held in police cells rather than health care places of safety. This had become the practice under the current protocol between police and health services, as some hospitals had withdrawn from being places of safety and police cells were used instead, contrary to legislation. Devon and Cornwall police were being refused access to a service that would otherwise be available to the wider community (see main recommendation 2.28).

3.10 There was a strategic prosecution team performance meeting chaired by the chief Crown prosecutor and attended by the ACC custody lead. Local court user group meetings could have been better used to progress issues such as court cut-off times, where custody staff were just accepting the court staff’s decision to refuse detainees to the court, sometimes as early as 9.30am, when this should have been escalated to managers and challenged to ensure

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Section 136 of the Mental Health Act 1983 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.
detainees were not held unnecessarily in police cells. We were told that custody inspectors
did not attend these meetings.

3.11 We were told that the police used voluntary attendance rather than arrest and detention,
where appropriate, and management data supported this. The current year-to-date data
showed that voluntary attendance made up 20% of the total detainee throughput, which was
encouraging.

3.12 There was an independent custody visitors (ICV) coordinator in the PCC office. The ICV
scheme consisted of two panels and was active, with a regular schedule of visits. ICVs said
that they were generally admitted to custody suites quickly and were challenging. They had
not identified any particular trends or issues, and ad hoc issues were dealt with and
communicated effectively through panel meetings. There was regular and consistent police
representation at ICV meetings, and a good exchange of resources at training events.

Learning and development

3.13 All custody sergeants had undergone initial three-week custody-specific training before
taking on custody duties. The course was linked to the national custody officer learning
programme (NCOLP) of the College of Policing. The initial training was supplemented by a
one-week 'on the job' mentoring. DOs had a two-week initial custody course linked to the
NCOLP, adapted to their specific learning requirements and based on safer detention
principles. This training was followed by 10 'tutored' shifts in a custody suite. The initial
training programme was good.

3.14 Joint custody-specific refresher training for custody sergeants and DOs was built into the
shift system. There had also been a programme of refresher training for sergeants using the
'hydra' immersive training facility at Avon and Somerset police, which simulated custody
procedures and incidents.

3.15 A consolidated action plan for custody contained recommendations for developing and
improving custody provision in Devon and Cornwall. Senior police officers had taken the
recommendations on board, and activity was recorded to show the progress made. There
was also a comprehensive custody working practices document based on safer detention
principles, which was accessible on the custody intranet. The intranet site was also used to
communicate CJD briefings to staff on specific custody issues as required. A custody
newsletter also provided more general information on custody developments. We saw staff
using the intranet site and they were mostly aware of what information was available and
how to access it.

3.16 There was a comprehensive adverse incident process in which the custody sergeant
completed and forwarded a form on the custody intranet, with notification through the
custody inspector to the criminal justice strategic support team. The team provided a weekly
analysis of incidents to custody inspectors, and serious incidents were brought to the
immediate attention of the head of custody and senior management team. The analysis was
used to communicate learning points to staff through the CJD briefing document, and
informed refresher training where appropriate. The information was also sent to the crime
and justice health and safety committee.
3.17 There was a good corporate quality assurance process for custody sergeants to sample custody records. We were told that each custody inspector sampled a minimum of 10 custody records a month. A corporate template was used with a clear audit trail of feedback to staff. Custody inspectors also sampled records from other custody suites quarterly. The criminal justice strategic support team provided a monthly analysis of the quality assurance, identifying any trends and areas for improvement. The sampling sometimes focused on specific themes, for example rousing checks of intoxicated detainees, and also included the person escort record (PER) and cross-referencing to CCTV. Apart from the need to include sampling of staff handovers, the quality assurance process was comprehensive and thorough.

Housekeeping point

3.18 The force should implement quality assurance of staff shift handovers.
Section 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 Staff treated detainees in a caring, professional manner, using their first names or title and surname as appropriate. Detention officers (DOs) were generally not involved in the booking-in process, although they were responsible for lodging detainees in cells. All the detainees we spoke to said they had been well treated by staff. In our prisoner survey, 51% of respondents, against the comparator 35%, said they had been treated well by staff in the custody suite.

4.2 During booking-in, custody sergeants asked detainees if they had any dependants. Women detainees were asked if they were pregnant, told of the availability of sanitary products and asked if they wished to speak to a female member of staff. In our custody record analysis, entries in the Torquay records noted which female custody officers had been assigned to women detainees and if this changed during staff handovers. However, in one case at Camborne, a woman detainee asked to see a female officer but the detention log did not confirm that this took place. We were told that the availability of female staff was often a problem. For example, during a night visit at Barnstaple, we were told that there was only one female officer on duty in the whole North Devon area.

4.3 All custody suites had at least one copy of the Bible and Qur’an, and some held a limited number of other religious texts. Prayer mats and compasses were available, although they were occasionally stored loose on top of filing cabinets.

4.4 Most custody suites had access for detainees with mobility issues. Some had cells adapted for the needs of disabled detainees, and some walking aids were available, as were portable hearing loops. In our survey, 31% of respondents, against the comparator of 20%, considered themselves to have a disability.

4.5 All custody suites had an extra thick mattress to cater for the needs of older detainees or pregnant women.

4.6 Staff were aware of the need to ask transgender detainees what gender they considered themselves to be and that they should be dealt with in accordance with their preference.

4.7 Custody staff spoke to young people in an age-appropriate manner, but had not received any child protection awareness training. Staff told us that they were often reluctant to detain under-18-year-olds and, where possible, young people were ‘street-bailed’ to prevent them coming into custody or, if they did, were bailed rather than held for a lengthy period, if possible. We observed a 15-year-old under the influence of alcohol who was booked in at Camborne at 11.32pm, in the presence of his mother, and subsequently bailed at 2.29am to be interviewed at a later date. At Crownhill, we saw a young person booked in late at night who was detained for only a short time to allow his parents to collect him. At Torquay, we saw a custody sergeant who refused detention of a 16-year-old and instructed the police officer to deal with the matter in a non-custodial manner (see paragraph 5.1). Our custody record analysis included 10 young people aged under 17 (17%). Five were detained for under
six hours, four for up to 13 hours and one for just over 20 hours. Three were held overnight.

4.8 Staff in Cornwall reported the lack of local authority beds for young people required to be kept in custody overnight. Although staff in Devon said there had been instances when social services had been able to provide such beds, the distances involved sometimes negated their use. In our custody record analysis, one young person who was unable to return home was bailed to a care home and released into the care of social services.

4.9 All booking-in desks were in private rooms, which enabled detainees to disclose vulnerabilities and confidential information, which was good, although some desks were too high. While the private rooms were positive, there was the risk that the time that custody sergeants spent in them meant they became unfocused on events elsewhere in the custody suite. There was high reliance on the skills and experience of the DOs to keep an eye on developments in the suite.

4.10 Not all custody suites displayed notices advising detainees that CCTV cameras were installed and recording, and some notices were not always positioned clearly. Most cells had CCTV but detainees we interviewed had not been made aware of this. CCTV images of toilet areas were not obscured.

Recommendations

4.11 Staff should receive up-to-date awareness training on child protection and safeguarding.

4.12 Notices that CCTV cameras are in use should be clear and prominently displayed.

Housekeeping points

4.13 Religious artefacts should be stored respectfully.

4.14 CCTV images of toilet areas in cells should be obscured.

Safety

4.15 In our survey, 80% of respondents, against the comparator of 62%, said that they felt safe while in police custody. We observed custody sergeants conducting thorough risk assessments, and asking probing and supplementary questions where necessary, such as when self-harm or medication needs was disclosed. Our custody record analysis confirmed that risk assessments were detailed. We observed two separate cases (at Crownhill and Camborne) where the custody sergeant left the custody suite and spoke to violent detainees in the police vans to calm them down, making the assessment process easier.

4.16 Although most detainees were risk assessed on arrival into custody, we observed one case where this could not be completed due to the detainee’s lack of cooperation and level of intoxication. He was placed appropriately in a cell and strip searched due to threats he was making. The police made background checks on previous custody records and the police national computer (PNC) to gain all available information to manage the risks involved, before a full risk assessment when the detainee had further sobered. We found similar cases
in our record analysis, with detainees placed under appropriate observation in the interim period.

4.17 In our custody record analysis, it was apparent that custody staff responded well to the potential risks posed by detainees, and regularly referred them for health care assessments – for example, 17 of 24 detainees who came into custody under the influence of alcohol or substances were referred to a health care professional; this did not always relate directly to intoxication but often to additional concerns on mental and physical health.

4.18 Staff understood the importance of the regular rousing of intoxicated detainees and obtaining an appropriate response. We observed good use of identification on cell doors to alert staff to detainees who were on rousing or who suffered from any allergies.

4.19 Thirty-minute staff checks on detainees were the practice in many custody suites. When we questioned this, we were told that this was the case even if detainees were placed on 60-minute visits. In our custody record analysis, the level of observation for detainees was generally appropriate and adhered to, but the quality of observation entries varied – some carefully detailed the detainee’s demeanour and response, while some merely stated ‘breathing noted’. Not all staff were clear on the levels of observation recommended by the College of Policing Authorised Professional Practice – Detention and Custody; for example, staff continually referred to constant observations (level three through CCTV) when they were describing close proximity watches (level four).

4.20 Cell keys were restricted to custody staff through the use of personal key tallies. This practice, together with the physical layout of most suites, including gated cell corridors, made it less likely that untrained staff gained access to detainees. Apart from Exeter, only custody staff routinely visited cells. If non-custody staff needed to visit cells, they were always accompanied by trained custody staff.

4.21 All custody sergeants and DOs carried anti-ligature knives. Cells were checked after use to identify if any unauthorised items had been left behind or damage caused.

4.22 We observed, and were told, of different practices when completing person escort records (PERs), a single document that shares risk information nationally between agencies and which accompanies detainees when they are transferred to court or elsewhere. While some custody suites printed off a national strategy for police information systems (NSPIS) copy of the detainee’s property sheet, and the record of any medication administered to accompany the PER, others printed off the full NSPIS medical assessment section, and others also printed off the full NSPIS risk assessment. All these were then filed loosely in the PERs, with the risk that information could be lost or misplaced during the transfer of the detainee.

4.23 The staff handovers we observed in all custody suites were very thorough, visually and audibly recorded and included all custody staff.

4.24 NSPIS incorporated a pre-release risk assessment (PRRA) prompt for custody staff to complete before closing the record. In our custody record analysis, PRRAs were completed for all detainees bailed or released directly from the suites, but the detail included varied, and in approximately one-quarter of cases it was unclear whether detainees’ vulnerabilities had been addressed effectively. Most of our concerns were about detainees being released late at night with no indication that they were able to travel home safely.
4.25 In one record, a female detainee came into custody under the influence of alcohol and disclosed that she was alcohol-dependent and took medication for depression. She had a history of self-harm and indicated that she felt like self-harming. Although she was in custody for almost nine and a half hours, there was no evidence that a health care professional had been contacted to assess her. On release, her PRRA was endorsed ‘no issues’ and there was no record of how she was getting home or whether any of her vulnerabilities had been considered. In another record, it was noted that a male detainee with a heart condition had been taken to hospital twice during his detention. His PRRA similarly showed ‘no issues’ and simply noted that he was making his own way home; it was unclear whether the detainee’s medical issues had been taken into consideration.

4.26 Despite the general lack of PRRA detail, we saw several custody records explaining how detainees were getting home, including officers taking them home and detainees given phone calls to arrange transport from family and friends. We also observed these practices as detainees were released across the custody suites.

4.27 The passing on of contact details for support organisations to vulnerable detainees varied. Most custody suites had a list of contact numbers or a supply of leaflets, but staff at only two suites (Torquay and Launceston) made us aware of the safeguarding directory on the force intranet. This contained links and contact details for many statutory partners and charitable and voluntary organisations, was tailored to cater for the different geographic areas across the force, and could be easily printed off to give to detainees.

Recommendation

4.28 Pre-release risk assessments should be detailed, meaningful and based on an assessment of detainees’ needs while in custody, and the custody record should reflect the position on release and any action needed.

Housekeeping points

4.29 All custody staff should be reminded of the levels of detainee observation set out the College of Policing Authorised Professional Practice – Detention and Custody.

4.30 Separate documentation should not be filed with the person escort records.

4.31 All custody staff should be reminded of the availability and content of the safeguarding directory on the force intranet.

Good practice

4.32 The issue and use of cell keys was restricted to custody staff through the introduction of personal key tallies, which reduced the likelihood of untrained staff accessing detainees in custody.
Use of force

4.33 Many detainees were not handcuffed on arrival into custody, which indicated that arresting officers used their judgement on whether this was necessary. Detainees who were handcuffed had them removed promptly, although at Crownhill we observed a compliant female who was handcuffed to the rear in the custody suite holding area, with no seating available, for almost 30 minutes waiting to be booked in. The handcuffs were removed when she was finally presented before a custody sergeant. This appeared to be common practice at Crownhill, as we witnessed several apparently compliant detainees waiting while handcuffed in the holding area, although not as long as 30 minutes.

4.34 The continued use of handcuffs could sometimes be justified, but we were further concerned by findings from our custody record analysis. Five of the 10 records sampled at Crownhill showed that detainees were handcuffed during the booking-in procedure. Only two stated that the reason was the detainee was violent or unpredictable, a third was because a strip search was likely, and no reason was given for the remaining two.

4.35 Elsewhere across the force, practice on the removal of handcuffs varied. Barnstaple and Launceston holding areas displayed a notice indicating that officers should not remove handcuffs until authorised by the custody sergeant, and custody staff confirmed this was their practice. However, at Torquay, Camborne and Newquay, arresting officers had discretion to remove handcuffs.

4.36 All custody suites had a supply of leg restraints and emergency response belts. Our custody record analysis revealed that a female detainee detained under section 136 of the Mental Health Act and placed on level three constant observation via CCTV was seen to self-harm. Officers entered the cell, handcuffed her ‘back to back’, and then applied leg restraints and emergency response belts to her arms. She remained on level three observations and calmed down through the night. Following a mental health assessment the next morning, she was released; it was not clear in the custody record when the restraints were removed.

4.37 The force had introduced a process for recording the use of force on arrest and in custody to identify trends, patterns and learning points. However, staff were confused about when such a form would be submitted, and some did not know it existed. We concluded that the use of force in custody was under-reported, with the potential to affect the current monitoring process.

4.38 We saw sergeants authorising the strip searching of detainees appropriately because of the nature of their alleged offences (such as possession of drugs). These searches were conducted in cells covered by CCTV, although staff switched off or covered the viewing screens while the searches took place. In our custody record analysis, 14 detainees (23%) were strip searched while in custody. The strip searching recorded was proportionate to risk, and in some cases it had been considered but did not take place as it was believed to be disproportionate.

4.39 Force data showed that disproportionately more strip searches were carried out at Plymouth Crownhill (including Plymouth Charles Cross) than the other custody suites. There were no reasons given why this was the case.
Recommendation

4.40 Handcuffs should be removed from detainees after their arrival in the custody suite, unless a risk assessment indicates this is necessary for the safety of staff and others.

Housekeeping points

4.41 All custody staff should be reminded of the force policy on the recording and submission of use of force forms.

4.42 Devon and Cornwall police should investigate why strip searches are disproportionately higher at Plymouth Crownhill (including Plymouth Charles Cross) than elsewhere.

Physical conditions

4.43 Custody suites, including non-designated suites, were mostly clean, bright and in good condition, with very little graffiti in cells, although there was graffiti in some exercise yards. Exeter, although clean, needed some refurbishment. We were informed of plans to permanently close this suite.

4.44 Most cells were warm and well ventilated, but staff told us they were unable to control the temperature in the custody suites as this was managed remotely. In our survey, responses to all the questions on detainees’ experience of the physical conditions were more positive than the comparator.

4.45 The cell call bells we tested were working, and we saw detainees advised of how to use them. In our survey, 40% of respondents, against the comparator of 24%, said that staff had explained the correct use of the cell call bell. We also saw that responses to cell call bells were prompt, helped by the internal cell intercoms in many suites.

4.46 Staff said there were good arrangements to facilitate repairs. Daily maintenance checks were carried out and recorded. Staff had access to cleaning materials, and we saw that mattresses and pillows were wiped down between use. Cleaning staff were vigilant in looking for and removing any in-cell graffiti, and in several cases we saw them respond promptly to out-of-hour calls for additional cleaning services – for example, we saw a cleaner attend a custody suite at 11.20pm.

4.47 We examined most cells that were unoccupied and found potential ligature points in many; we provided the force with details of these.

4.48 Staff were aware of fire evacuation procedures and drills, and, apart from Crownhill, there had been drills at all suites in the previous six to 12 months. There were sufficient sets of handcuffs in all suites to evacuate detainees safely if required. The fire alarm system at Camborne was not operating during the early part of our inspection.
Detainee care

4.49 All cells contained a mattress and a pillow. There were stocks of clean blankets, but these were not routinely offered. All cells had toilets but detainees had to request toilet paper. There were handwashing facilities on the cell corridors. Cotton towels and toiletries were available.

4.50 In our survey, 17% of respondents, against the comparator 9%, said that they had been offered a shower. At Torquay and Newquay, we observed showers being offered to detainees before they left for morning court, but during the inspection, we only saw one detainee ask for and receive a shower. One detainee at Camborne told us that he would have liked to have showered but did not realise this was available. In our survey, one respondent commented about Camborne: ‘They never give out showers even if you’re there for days’.

4.51 All showers were clean and had hot water. Most provided sufficient privacy except at Barnstaple, where the shower was at the end of a cell corridor and covered by a CCTV camera.

4.52 Replacement clothing was available, including flip-flops, paper suits, jogging bottoms, sweatshirts and T-shirts, but most were only in sizes from medium upwards. There was some replacement clothing for women detainees at Newquay and Barnstaple sourced from second-hand shops and stores, but this was inappropriately stored in a jumble in cardboard boxes. There was a small supply of unisex disposable underwear at most custody suites.

‘It was freezing cold and I wasn’t offered suitable clothing.’ Prisoner survey comment – Exeter

4.53 We saw several detainees who were issued with paper suits; they had to rip the waistband of the trousers to tie them at the waist to make them wearable. One male detainee had been issued with a long paper top that looked like a dress, which was inappropriate and degrading. The rationale for placing detainees in such clothing was not always recorded.

4.54 Rip-proof clothing for detainees at risk of self-harm was available at all suites but there was very little in small sizes. Staff told us the force catered for ‘one size fits all’, which in most cases was a large size. For example, we saw detainees being issued flip-flops that were far too large, which meant they had to walk around the custody suites in their bare or stocking feet.

‘Walking around the cells with no shoes is disgusting.’ Prisoner survey comment – Exeter

4.55 There was a reasonable variety of food in all the custody suites, which met most dietary requirements and was issued at recognised mealtimes. In our survey, 57% of respondents, against the comparator of 44%, said that the food and drink they received was suitable for their dietary requirements. Custody staff routinely offered drinks, and they told us that if a detainee was obviously hungry they would not restrict food to meal times and would supply double helpings if required. Our custody record analysis supported this information. All food preparation areas were clean, although the microwave ovens at several suites needed cleaning. In our survey, 94% of respondents, against the comparator 81%, said that they were offered something to eat, and 93%, against 84%, something to drink.

4.56 Exercise yards were clean, although some, such as Camborne, were small and dank, and some had graffiti. We observed the yards being used at some suites but this was in response to requests rather than actively offered to detainees.
Section 4. Treatment and conditions

4.57 English language newspapers, magazines and books, provided by staff, were available at all suites, although none were in an easy-read format and few were suitable for young people. Only Newquay had a selection of foreign language magazines (in Polish). Staff at Torquay showed us an email circulated in 2012 with hyperlinks to access newspapers in several foreign countries, which could be accessed and printed off. Staff at other suites did not know about these links. In our survey, 30% of respondents, against the comparator 14%, said they were offered something to read while in custody. In our custody record analysis, 26 detainees (43%) were offered reading materials.

4.58 Custody staff told us that they facilitated social visits on an individual basis, taking staffing levels into account. Many suites had very good closed-visit rooms.

Housekeeping points

4.59 Subject to risk assessment, toilet paper should be routinely provided in each cell.

4.60 Shoes and clothes should only be removed if supported by a risk assessment, and custody records should clearly record the reasons for placing detainees in alternative clothing.

4.61 Replacement clothing, including footwear, should be supplied in a range of sizes.

4.62 The stock of reading materials should be improved to cater for detainees who are non-English speakers or who have limited literacy.
Section 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 Most detainees were booked in promptly on their arrival at the custody suite. Custody sergeants asked arresting officers to give a full explanation of the circumstances of, and reasons for, the arrest before authorising detention. Some custody sergeants told us they never refused detention, whereas others said that they had occasionally refused to detain when they thought arrest was unnecessary. We observed a custody sergeant refuse detention of one arrested young person, and instructed the officer to deal with the matter in a different way.

5.2 We were told that voluntary attendance by suspects at police stations, as an alternative to arrest and detention, was encouraged, and its increased use had reduced the use of custody during the past year. That claim was supported by the force’s data, which showed a significant reduction in the number of detainees brought into custody. Many operational police officers we spoke to were well versed with this option. Officers had also received a briefing on code G of the Police and Criminal Evidence Act 1984 (PACE), the ‘necessity test’, which gives guidance on when an arrest is lawful – specifically the grounds to believe that it is necessary to arrest the person – and were aware of the need to be able to justify arrests. We saw posters explaining the code G ‘necessity test’ displayed in every booking-in area.

5.3 Investigations were mainly progressed without delay, and we observed custody staff contacting investigating officers to check on progress. Custody staff contacted solicitors promptly, and they often attended the suites out of office hours to ensure early interviews. However, we observed some delays. At Crownhill, for example, we saw the decision about whether or not to charge delayed by the ‘gatekeeping’ process (the confirmation by specially trained officers of the decision reached). It took two hours to reach a charging decision about a vulnerable female detainee who had admitted the charges against her. Some legal representatives told us that this was not uncommon.

5.4 The force had also introduced a scheme known as 'bail to fail' to reduce the times detainees were bailed from the police station for further enquiries; this aimed to conclude the investigation during the initial detention period. Custody sergeants' awareness of and support for this process was mixed: some were unaware of it, while others thought that it could unnecessarily delay a detainee's release. One custody sergeant told us: 'It is not unusual for people to be detained up to the wire, but then they usually get charged or NFAd [no further action]; they rarely get bailed'. Another stated: 'It’s a bail management issue, rather than what's best for the detainee'. In our survey, 79% of respondents, against the comparator of 69%, said they had been in custody over 24 hours. In our custody record analysis, only 10% of detainees had been held over 24 hours.

5.5 Custody sergeants and investigating officers worked well together to ensure that detainees bailed to return at a later date were not held unnecessarily in a cell. They coordinated the attendance of solicitors and, when necessary, appropriate adults (AAs) so that detainees could go straight into interview.
5.6 The number of immigration detainees were relatively low, and force data showed that significantly fewer immigration detainees had been held in the past year. Custody staff told us they were held on average for less than 24 hours before transfer by UK Border Force escort contractors to more suitable facilities.

5.7 Custody sergeants told us they would involve family members to act as AAs for young people or vulnerable adults whenever possible. Arrangements for the provision of AAs were complex and differed in the two counties, but mostly effective – with some notable exceptions. In Cornwall, local mental health services support workers occasionally acted as AAs for vulnerable adults. Custody staff told us that were often delays when they contacted the service before it accepted responsibility for supplying an AA, although after that an AA usually arrived within a reasonable time. AAs for young people were provided by a voluntary scheme in the day and paid sessional workers out of hours, facilitated through social services. In Devon, the local social services were contacted to provide AAs, who were volunteers, for vulnerable adults and young people.

5.8 In both counties, AAs rarely attended the custody suites after 10pm, and custody sergeants told us that whenever possible they would bail young people to avoid them waiting in the custody suite overnight. This was confirmed in our custody record analysis where we looked at the records of 10 young people; we found two instances where there was an unreasonably long wait for the AA to attend and the custody sergeant had released the young person, which was commendable. In both counties we observed AAs arriving promptly, mostly within an hour of being called. At Crownhill, a police community support officer involved in the arrest of a 16-year-old female arranged an AA immediately on her arrest, and the AA arrived at the custody suite within 15 minutes of the detainee’s arrival.

Recommendation

5.9 Appropriate adults to support young people aged 18 and under and vulnerable adults in custody should be available without undue delay, including out of hours.

Housekeeping points

5.10 Delays in gatekeeping decisions about charging should be reduced.

5.11 The 'bail to fail' scheme should be better explained to all staff and monitored to ensure that detainees are not detained longer than necessary.

Rights relating to PACE

5.12 The Criminal Defence Service poster advising detainee of the availability of legal advisers, in a range of languages, was displayed in or near the charge rooms at most suites. At all suites, interpreting service posters, and cards at the booking-in desks, enabled non-English speaking detainees to indicate their language, although at Barnstaple the posters were not easily visible. Custody sergeants told us that the professional telephone interpreting service could always obtain an interpreter, but police staff sometimes found it difficult to make themselves understood to the call centre staff.

5.13 At Newquay we were shown a Braille version of rights and entitlements information but staff in other suites were not aware this existed. The force had an excellent and very informative easy-read version of the information at most suites. Rights and entitlements information
could be printed from the intranet in a range of languages, and we saw a detainee given a version in Polish. There were hearing loops in all suites.

5.14 We observed detainees being told of their right to legal advice. Those who declined legal services were told they could change their mind at any time and were asked the reason why they did not want it. The detainee wanted someone informed of their arrest in a third of cases in our custody record analysis, but in three records it was not clear if the nominated person had been contacted.

5.15 Up-to-date PACE codes of practice C were available and were mostly shown to detainees. Several legal advisers confirmed that they had a good professional relationship with the custody staff and that the rights and entitlements of their clients were protected, but commented that there were often long delays in making charging decisions. We found legal advisers attending custody during unsocial hours, which helped minimise detainees’ time in custody.

5.16 Detainees could speak privately to legal advisers in cells through the use of a cordless telephone, or in consultation rooms in the custody suite. There were sufficient consultation and interview rooms to meet the average demands of each suite, and they were clean and in a reasonable condition.

5.17 Reviews of detention were usually conducted by criminal justice inspectors and many were by telephone, given the long distances between suites. Although operational inspectors were often available at the police station where the custody suite was based, we saw none undertake any reviews and were told that they rarely were expected to. This was a concern for some custody staff who said they would prefer more face-to-face reviews.

5.18 Each suite had a cordless telephone for the detainee to speak in private from their cell with the inspector conducting the review. Although a few reviews were very brief with very little recorded in the custody record, most of those we heard were of an excellent standard and recorded comprehensively. Inspectors prepared well by reading the risk assessment and detention log. They explained clearly the purpose of the review, reminded the detainee of their rights, and invited them to express any concerns and ask questions. However, custody records did not always make it clear when reviews were conducted by telephone, and in our custody record analysis, in half the cases where reviews took place when the detainee was sleeping, it was not recorded if the detainee had been told of it on waking. Most reviews were in time, but we found some that took place between 30 and 90 minutes late.

5.19 The force had good DNA management processes. Each suite had a fridge/freezer to store samples, which were collected almost daily, and we found no old samples. However, detention officers, who take the DNA from detainees, were not aware of the force’s DNA retention and disposal policy.

5.20 Custody staff told us of many occasions where local courts had refused to accept detainees early in the day. While in theory the usual cut-off time when the court would no longer accept detainees, was 2pm on weekdays and noon on Saturdays, many custody sergeants stated that these times were frequently not adhered to and that courts refused to accept detainees much earlier. For example, we were told that Bodmin magistrates’ court would sometimes refuse to accept detainees as early as 9.30am, and regularly at 11.30am. At Newquay, we saw a detainee ready for court at 1.55pm but the court would not accept him and he had to spend a night in police custody. We were told this was not uncommon, and that it was caused sometimes by the court list for the day being full or because there were no cells available at the court. We were also concerned to hear that the court had refused to accept female detainees on more than one occasion because there were no female court custody staff available to search them – this had been resolved temporarily by female police officers attending court to carry out duties (see main recommendation 2.29).
Section 5. Individual rights

5.21 There were video link facilities at Barnstaple and Torquay, but only Barnstaple operated a 'virtual court' (where a detainee can appear before the court on video, usually from the police custody suite) as part of a recent pilot.

Housekeeping points

5.22 There should be improved recording in detention logs to make clear if detainees have received the services and facilities to which they are entitled, such as inspector reviews and notifications of arrests.

5.23 Detention officers should be made aware of the force's DNA retention and disposal policy.

Rights relating to treatment

5.24 At most suites, custody sergeants told us that if a detainee wanted to complain about their treatment they were directed to an inspector who would normally speak with them or instruct a custody sergeant to initiate the complaints process. Inspectors confirmed that they would not expect a detainee to be told to go to the front desk to complain, although a few custody staff said that they would use this approach. Copies of the Independent Police Complaints Commission (IPCC) leaflet were available at most suites.

Housekeeping point

5.25 Detainees at all suites should be given information about how to make a complaint in line with the Independent Police Complaints Commission guidance and, unless there is a clear reason not to do so, complaints should be taken while they are still in police custody.
Section 6. Health care

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

Governance

6.1 Primary health care was provided by Serco Health, which employed nurses and forensic medical examiners (FMEs). Adult substance misuse services were provided by a range of local groups across the two counties. Detained children and young people could also be seen by The Children’s Society, YSMART and YZUP drug and alcohol services. A mental health criminal justice liaison and diversion service (CJLDS) was available to the force, as were mental health nurses during weekdays at most suites.

6.2 Serco Health worked well with frontline police staff, and services were managed effectively by a lead nurse based at the headquarters. The contract was monitored well and there was a multi-agency approach. There were reviews at quarterly meetings attended by the custody inspector, police officers, lead FME, independent doctor and the local provider lead. A health needs assessment had been completed in 2012 and was used to inform the delivery of services. It was difficult to assess how services changed as information was collected in a range of formats and there was no strategic overview of some elements, especially mental health. Custody staff were generally complimentary about the health care staff at the suites, but were less satisfied with the support and speed of response from some FMEs and community mental health teams. In our custody record analysis, we identified three detainees who we would have expected to see a health care practitioner and who did not. The force believed that the introduction of the CJLDS was improving mental health provision and diverting people from custody, but was insufficient to meet the demand.

6.3 The health care staff we observed were very professional, caring and courteous, and used language interpreting services when required. Detained women were usually seen by female health care staff, although it was more difficult to be seen by a woman doctor. Serco Health employed 21 FMEs and 39 nurses. In our survey, 45% of respondents were seen by a nurse, against the comparator of only 22%.

6.4 Serco Health and the lead chief inspectors had established clear lines of management and accountability. The health care provider had systems for checking staff’s professional credentials, and there were good opportunities for professional development. An induction programme allowed new staff to shadow more experienced staff. Mandatory training was well managed and there were opportunities for staff to receive regular clinical supervision. Detainee complaints about the level and quality of health care were rare.

6.5 The clinical rooms at all seven suites were clean, well equipped and in good order. The flooring at most suites needed deep cleaning or replacement. The sinks at Torquay, Barnstaple and Newquay were not suitable for a clinical environment. Examination couches were acceptable, apart from those in Barnstaple and Torquay, which had torn covers. All had examination lamps. The level of privacy for detainees varied and was more risk averse than we usually see. Detainees were seen with custody staff in the room or waiting outside the door. Rooms were used solely by health care staff and were secure, although staff at Plymouth Crownhill were unable to locate the key code for the door. There was no evidence of health screening or health promotion materials.
6.6 Medicines management was good with accurate records maintained, including for controlled drugs. All medicines were administered by health care staff or self-administered by detainees under supervision by custody staff. There were a good range of medicines that could be given using patient group directions (which authorise appropriate health care professionals to supply and administer prescription-only medicine). Stock was managed by the lead nurse manager and checked regularly by each nurse for their shift. There were very few discrepancies and we found very few medicines that were out of date. All clinical rooms had facilities to store heat-sensitive products, but fridge temperatures were not routinely recorded in all suites. The controlled drug cabinet at Crownhill did not comply with regulations as it did not lock with a key.

6.7 Although only 14% of respondents in our survey said that they were able to take their prescribed medication, we observed good measures to ensure that medications were continued. Each suite had lockers to secure medicines, and custody staff made efforts to retrieve medicines from the detainee's home or chemist when required, including methadone. In our custody record analysis, we found five detainees who required continuing medication and all had received appropriate treatment. Symptomatic relief was available for those withdrawing from drugs and alcohol.

6.8 There was an excellent range of accessible emergency resuscitation equipment in each suite. All the equipment sets were the same with the same layout, and included oxygen, suction apparatus and automated external defibrillators. There were also well-stocked first aid kits. Equipment was well maintained with good records of daily checks. There was first aid and resuscitation training for all staff.

Recommendation

6.9 Clinical examination rooms should comply with infection control standards.

Housekeeping points

6.10 Patient information leaflets and health promotion literature should be accessible in all the clinical rooms.

6.11 Heat-sensitive medicines should be stored correctly.

6.12 Controlled drugs at the Crownhill suite should be secured appropriately.

Good practice

6.13 The quality of resuscitation equipment and level of training set a standard that could be followed by all forces.

Patient care

6.14 A 24-hour service was available and one nurse was provided for a 12-hour shift at the suites. There was some cross-cover when staff attended more than one suite, and bank nurses were used when required. We were concerned that some nurses worked consecutive long 24-hour shifts, for example at Barnstaple. FMEs provided an on-call service for each shift.
6.15 Detainees were asked if they needed to see a health care professional or custody staff referred them if there were any concerns. If health care staff were to be involved, custody staff contacted the call centre to request attendance, even when a nurse was on site. The nurse then informed the call centre when the care incident was completed. Call-out and response times were recorded in the custody record. Response time targets were set at 45 and 90 minutes, depending on the distances travelled. The health care contract applied penalties when response times were not achieved. In our sample of records, there were minimal waiting times to see a health care professional. The average waiting time was approximately 19 minutes, with the longest wait approximately 67 minutes, which was at Launceston, and the shortest zero minutes, where the health care professional was already on site.

6.16 Custody staff told us that they were generally content with the availability of nursing staff, but most suites had times when there had been significant delays in accessing the FME and community mental health teams for crisis health assessments.

6.17 Nursing clinical records were maintained on paper and relevant entries made to custody records. Information was shared appropriately, and ensured that detainees were managed safely and cared for professionally. On completion of the nursing intervention, the records were sealed in an envelope and secured in locked cabinets in line with data protection requirements and Caldicott principles on the use and confidentiality of personal health information. At the Launceston suite, two health care records had not been secured and were loose in an unlocked desk drawer.

Recommendation

6.18 **Nursing staff should not be employed for long consecutive shifts to ensure that they remain safe to practice.**

Substance misuse

6.19 Substance misuse teams provided services in each suite during weekdays. Services varied from daily visits to three days a week. During the night and at weekends, detainees were either referred or given appointments or signposted to relevant services in the community. Drug workers saw detainees who met the criteria for drug testing, those who were under the influence of drugs or alcohol, and each county provided special services for the care and management of detained children and young people. There were good links with the mental health services and limited involvement with health care practitioners. In our survey, 69% of respondents said that they had a drug or alcohol problem, against the comparator of 52%, and of these only 16% said that they were given the opportunity to see a drug or alcohol support worker. Clean needles were available in all of the suites except Crownhill.

Recommendation

6.20 **All detainees should have the opportunity to access substance misuse services when required.**

Mental health

6.21 Mental health services were provided by each county’s NHS partnership trust. Each county had developed a CJLDS – Cornwall in the beginning of the 2013 and Devon in the previous...
month. There were two team leaders and mental health nurses in most suites, with cross-cover when required. Assessment, signposting and re-engagement were offered to all detainees on weekdays. The out-of-hours and weekend cover used emergency duty and community mental health teams when required, or a contact telephone number and generic email address for referral. We were informed that the out-of-hours response was slow and often resulted in people being detained for longer than necessary. The teams did not see detainees who had been detained under section 136 of the Mental Health Act.

6.22 Custody staff felt that the mental health nurses were a welcome addition. During the assessment of detainees, they provided information about previous contact with mental health services while identifying any associated risks. They could also meet detainees when required and provide supportive links to the community mental health services. Funding had been agreed to provide pre-arrest services in Cornwall, and the team leaders were aware that the services would benefit from an extension to the hours. The teams had good access to custody records and community electronic records via laptop computers. They also contributed to mental health awareness training for custody staff.

6.23 The management of section 136 detainees was unacceptably poor. The force employed a mental health liaison officer and there were monthly local meetings to review cases, but there had been no strategic oversight of the care and management of section 136 cases for over two years (see main recommendation 2.28); we were informed that the Peninsula strategic group was due to reconvene in December 2013. The force managed one of the largest number of section 136 detainees that we have seen, and the majority were detained in custody rather than using the NHS section 136 suites as places of safety. There were four section 136 suites in Devon and one in Cornwall; since January 2013, 604 section 136 detainees had been held in police custody while only 183 had been taken to the section 136 suites as places of safety. This was unacceptably high, considering that police custody should only be used in exceptional circumstances. We were told that the criteria for admission to a section 136 suite were overly restrictive, and that there were sometimes insufficient staff to supply the suites. Referrals could be made by custody nursing staff. All section 136 detainees were seen by an approved section 12 Mental Health Act doctor and an approved mental health practitioner.
Section 7. Summary of recommendations

Main recommendations

7.1 There should be urgent work at a strategic level by the police and health services to ensure that custody suites are only used as Mental Health Act 1983 section 136 places of safety in exceptional circumstances. (2.28)

7.2 Devon and Cornwall police should engage with HM Courts and Tribunals Service to ensure that early court cut-off times and the lack of court availability do not result in unnecessarily long stays in custody. (2.29)

Recommendations

Treatment and conditions

7.3 Staff should receive up-to-date awareness training on child protection and safeguarding. (4.11)

7.4 Notices that CCTV cameras are in use should be clear and prominently displayed. (4.12)

7.5 Pre-release risk assessments should be detailed, meaningful and based on an assessment of detainees' needs while in custody, and the custody record should reflect the position on release and any action needed. (4.28)

7.6 Handcuffs should be removed from detainees after their arrival in the custody suite, unless a risk assessment indicates this is necessary for the safety of staff and others. (4.40)

Individual rights

7.7 Appropriate adults to support young people aged 18 and under and vulnerable adults in custody should be available without undue delay, including out of hours. (5.9)

Health care

7.8 Clinical examination rooms should comply with infection control standards. (6.9)

7.9 Nursing staff should not be employed for long consecutive shifts to ensure that they remain safe to practice. (6.18)

7.10 All detainees should have the opportunity to access substance misuse services when required. (6.20)
Housekeeping points

Strategy

7.11 The force should implement quality assurance of staff shift handovers. (3.18)

Treatment and conditions

7.12 Religious artefacts should be stored respectfully. (4.13)
7.13 CCTV images of toilet areas in cells should be obscured. (4.14)
7.14 All custody staff should be reminded of the levels of detainee observation set out the College of Policing Authorised Professional Practice – Detention and Custody. (4.29)
7.15 Separate documentation should not be filed with the person escort records. (4.30)
7.16 All custody staff should be reminded of the availability and content of the safeguarding directory on the force intranet. (4.31)
7.17 All custody staff should be reminded of the force policy on the recording and submission of use of force forms. (4.41)
7.18 Devon and Cornwall police should investigate why strip searches are disproportionately higher at Plymouth Crownhill (including Plymouth Charles Cross) than elsewhere. (4.42)
7.19 Subject to risk assessment, toilet paper should be routinely provided in each cell. (4.59)
7.20 Shoes and clothes should only be removed if supported by a risk assessment, and custody records should clearly record the reasons for placing detainees in alternative clothing. (4.60)
7.21 Replacement clothing, including footwear, should be supplied in a range of sizes. (4.61)
7.22 The stock of reading materials should be improved to cater for detainees who are non-English speakers or who have limited literacy. (4.62)

Individual rights

7.23 Delays in gatekeeping decisions about charging should be reduced. (5.10)
7.24 The 'bail to fail' scheme should be better explained to all staff and monitored to ensure that detainees are not detained longer than necessary. (5.11)
7.25 There should be improved recording in detention logs to make clear if detainees have received the services and facilities to which they are entitled, such as inspector reviews and notifications of arrests. (5.22)
7.26 Detention officers should be made aware of the force's DNA retention and disposal policy. (5.23)
Detainees at all suites should be given information about how to make a complaint in line with the Independent Police Complaints Commission guidance and, unless there is a clear reason not to do so, complaints should be taken while they are still in police custody. (5.25)

7.28 Patient information leaflets and health promotion literature should be accessible in all the clinical rooms. (6.10)

7.29 Heat-sensitive medicines should be stored correctly. (6.11)

7.30 Controlled drugs at the Crownhill suite should be secured appropriately. (6.12)

There was a quarterly safer detention meeting, chaired by the head of custody and attended by inspectors, sergeants and detention officers, which discussed and shared good practice. (3.8)

The issue and use of cell keys was restricted to custody staff through the introduction of personal key tallies, which reduced the likelihood of untrained staff accessing detainees in custody. (4.32)

The quality of resuscitation equipment and level of training set a standard that could be followed by all forces. (6.13)
Section 8. Appendices

Appendix I: Inspection team

Elizabeth Tysoe  HMIP team leader
Gary Boughen    HMIP inspector
Peter Dunn      HMIP inspector
Paul Rowlands   HMIP inspector
Fiona Shearlaw  HMIP inspector
Paul Davies     HMIC lead staff officer
Mark Ewan       HMIC staff officer
Michael Bowen   HMIP health services inspector
Majella Pearce  HMIP health service inspector
Allan Brown     Care Quality Commission inspector
Rachel Murray   HMIP researcher
Laura Nettleingham HMIP researcher

Guests
Tina Yule       HM Inspectorate of Constabulary Scotland
Carol Dobson    HM Inspectorate of Constabulary Scotland
Appendix II: Summary of detainee questionnaires and interviews

Prisoner survey methodology
A voluntary, confidential and anonymous survey of the prisoner population at HMP Exeter, who had been through a police station in the Devon and Cornwall police force area 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 14 October 2013. A list of potential respondents to have passed through Barnstaple, Camborne, Exeter, Launceston, Newquay, Plymouth (Crown Hill) or Torquay police stations was created, listing all those who had arrived from Barnstaple, Bodmin, Exeter, Plymouth, Torquay and Truro magistrates’ courts, or Barnstaple, Exeter, Plymouth and Truro Crown courts within the past two months.

Selecting the sample
In total 143 respondents were approached. Forty-three reported being held in police stations outside Devon and Cornwall or outside the designated time period. On the day, the questionnaire was offered to 100 respondents; there were six refusals, five questionnaires returned blank and seven 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. One respondent was 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, 82 (82%) 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 of 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 69 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 overnight’ 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 those shown in the comparison data as the comparator data have been weighted for comparison purposes.
### Section 1: About you

**Q2** Which police station were you last held at?
Plymouth (25), Exeter (19), Camborne (13), Torquay (12), Newquay (6), Barnstaple (5), Launceston (1), Unknown (1)

**Q3** How old are you?

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>16 years or younger</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>17-21 years</td>
<td>6</td>
<td>7%</td>
</tr>
<tr>
<td>22-29 years</td>
<td>24</td>
<td>29%</td>
</tr>
<tr>
<td>30-39 years</td>
<td>33</td>
<td>40%</td>
</tr>
<tr>
<td>40-49 years</td>
<td>12</td>
<td>15%</td>
</tr>
<tr>
<td>50-59 years</td>
<td>5</td>
<td>6%</td>
</tr>
<tr>
<td>60 years or older</td>
<td>2</td>
<td>2%</td>
</tr>
</tbody>
</table>

**Q4** Are you:

<table>
<thead>
<tr>
<th>Gender</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>82</td>
<td>100%</td>
</tr>
<tr>
<td>Female</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Transgender/Transsexual</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>

**Q5** What is your ethnic origin?

<table>
<thead>
<tr>
<th>Ethnic Origin</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>White - British</td>
<td>74</td>
<td>90%</td>
</tr>
<tr>
<td>White - Irish</td>
<td>5</td>
<td>6%</td>
</tr>
<tr>
<td>White - other</td>
<td>2</td>
<td>2%</td>
</tr>
<tr>
<td>Black or black British - Caribbean</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Black or black British - African</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Black or black British - other</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Asian or Asian British - Indian</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Asian or Asian British - Pakistani</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Asian or Asian British - Bangladeshi</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Asian or Asian British - other</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Mixed heritage - white and black Caribbean</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Mixed heritage - white and black African</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Mixed heritage- white and Asian</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Mixed heritage - other</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Chinese</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Other ethnic group</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>8</td>
<td>10%</td>
</tr>
<tr>
<td>No</td>
<td>72</td>
<td>90%</td>
</tr>
</tbody>
</table>

**Q7** What, if any, is your religion?

<table>
<thead>
<tr>
<th>Religion</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>34</td>
<td>43%</td>
</tr>
<tr>
<td>Church of England</td>
<td>28</td>
<td>35%</td>
</tr>
<tr>
<td>Catholic</td>
<td>11</td>
<td>14%</td>
</tr>
<tr>
<td>Protestant</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Other Christian denomination</td>
<td>4</td>
<td>5%</td>
</tr>
<tr>
<td>Buddhist</td>
<td>2</td>
<td>3%</td>
</tr>
<tr>
<td>Hindu</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Jewish</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Muslim</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Sikh</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>
### Section 8 – Appendix II: Summary of detainee questionnaires and interviews

#### Q8  **How would you describe your sexual orientation?**
- Straight/heterosexual: 79 (99%)
- Gay/lesbian/homosexual: 0 (0%)
- Bisexual: 1 (1%)

#### Q9  **Do you consider yourself to have a disability?**
- Yes: 25 (31%)
- No: 56 (69%)

#### Q10  **Have you ever been held in police custody before?**
- Yes: 78 (95%)
- No: 4 (5%)

#### Section 2: Your experience of the police custody suite

#### Q11  **How long were you held at the police station?**
- Less than 24 hours: 16 (21%)
- More than 24 hours, but less than 48 hours (2 days): 38 (49%)
- More than 48 hours (2 days), but less than 72 hours (3 days): 14 (18%)
- 72 hours (3 days) or more: 10 (13%)

#### Q12  **Were you told your rights when you first arrived there?**
- Yes: 69 (84%)
- No: 4 (5%)
- Don't know/Can't remember: 9 (11%)

#### Q13  **Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')?**
- Yes: 61 (74%)
- No: 14 (17%)
- I don't know what this is/I don't remember: 7 (9%)

#### Q14  **If your clothes were taken away, what were you offered instead?**
- My clothes were not taken: 42 (55%)
- I was offered a tracksuit to wear: 15 (19%)
- I was offered an evidence/paper suit to wear: 13 (17%)
- I was only offered a blanket: 1 (1%)
- Nothing: 6 (8%)

#### Q15  **Could you use a toilet when you needed to?**
- Yes: 79 (96%)
- No: 3 (4%)
- Don't know: 0 (0%)

#### Q16  **If you used the toilet there, was toilet paper provided?**
- Yes: 46 (56%)
- No: 36 (44%)

#### Q17  **How would you rate the condition of your cell:**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Good</th>
<th>Neither</th>
<th>Bad</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleanliness</td>
<td>36 (44%)</td>
<td>30 (37%)</td>
<td>16 (20%)</td>
</tr>
<tr>
<td>Ventilation/air quality</td>
<td>27 (34%)</td>
<td>24 (30%)</td>
<td>28 (35%)</td>
</tr>
<tr>
<td>Temperature</td>
<td>23 (29%)</td>
<td>11 (14%)</td>
<td>46 (57%)</td>
</tr>
<tr>
<td>Lighting</td>
<td>43 (54%)</td>
<td>16 (20%)</td>
<td>20 (25%)</td>
</tr>
<tr>
<td>Question</td>
<td>Description</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
<td>-----</td>
<td>----</td>
</tr>
<tr>
<td>Q18</td>
<td>Was there any graffiti in your cell when you arrived?</td>
<td>Yes 40 (50%)</td>
<td>No 40 (50%)</td>
</tr>
<tr>
<td>Q19</td>
<td>Did staff explain to you the correct use of the cell bell?</td>
<td>Yes 32 (40%)</td>
<td>No 48 (60%)</td>
</tr>
<tr>
<td>Q20</td>
<td>Were you held overnight?</td>
<td>Yes 79 (96%)</td>
<td>No 3 (4%)</td>
</tr>
<tr>
<td>Q21</td>
<td>If you were held overnight, which items of bedding were you given? (Please tick all that apply to you.)</td>
<td>Not held overnight 3 (4%) Pillow 31 (39%) Blanket 70 (88%) Nothing 6 (8%)</td>
<td></td>
</tr>
<tr>
<td>Q22</td>
<td>If you were given items of bedding, were these clean?</td>
<td>Not held overnight / Did not get any bedding 9 (12%) Yes 47 (63%) No 19 (25%)</td>
<td></td>
</tr>
<tr>
<td>Q23</td>
<td>Were you offered a shower at the police station?</td>
<td>Yes 14 (17%) No 67 (83%)</td>
<td></td>
</tr>
<tr>
<td>Q24</td>
<td>Were you offered any period of outside exercise while there?</td>
<td>Yes 7 (9%) No 74 (91%)</td>
<td></td>
</tr>
<tr>
<td>Q25</td>
<td>Were you offered anything to:</td>
<td>Eat? Yes 76 (94%) No 5 (6%) Drink? Yes 72 (92%) No 6 (8%)</td>
<td></td>
</tr>
<tr>
<td>Q26</td>
<td>What was the food/drink like in the police custody suite?</td>
<td>Very good 0 (0%)</td>
<td>Good 11 (14%)</td>
</tr>
<tr>
<td>Q27</td>
<td>Was the food/drink you received suitable for your dietary requirements?</td>
<td>I did not have any food or drink 3 (4%) Yes 40 (55%) No 30 (41%)</td>
<td></td>
</tr>
<tr>
<td>Q28</td>
<td>If you smoke, were you offered anything to help you cope with not being able to smoke? (Please tick all that apply to you.)</td>
<td>I do not smoke 7 (9%)</td>
<td>I was allowed to smoke 0 (0%)</td>
</tr>
<tr>
<td>Q29</td>
<td>Were you offered anything to read?</td>
<td>Yes 24 (30%) No 56 (70%)</td>
<td></td>
</tr>
</tbody>
</table>
### Section 8 – Appendix II: Summary of detainee questionnaires and interviews

**Q30** Was someone informed of your arrest?
- Yes: 28 (35%)
- No: 24 (30%)
- I don’t know: 7 (9%)
- I didn’t want to inform anyone: 20 (25%)

**Q31** Were you offered a free telephone call?
- Yes: 30 (38%)
- No: 49 (62%)

**Q32** If you were denied a free phone call, was a reason for this offered?
- My telephone call was not denied: 44 (56%)
- Yes: 3 (4%)
- No: 31 (40%)

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

<table>
<thead>
<tr>
<th>Concern</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who was taking care of your children</td>
<td>7 (10%)</td>
<td>64 (90%)</td>
</tr>
<tr>
<td>Contacting your partner, relative or friend</td>
<td>30 (39%)</td>
<td>46 (61%)</td>
</tr>
<tr>
<td>Contacting your employer</td>
<td>8 (11%)</td>
<td>64 (89%)</td>
</tr>
<tr>
<td>Where you were going once released</td>
<td>22 (32%)</td>
<td>46 (68%)</td>
</tr>
</tbody>
</table>

**Q34** Were you offered free legal advice?
- Yes: 74 (94%)
- No: 5 (6%)

**Q35** Did you accept the offer of free legal advice?
- Was not offered free legal advice: 5 (6%)
- Yes: 54 (70%)
- No: 18 (23%)

**Q36** Were you interviewed by police about your case?
- Yes: 65 (80%)
- No: 16 (20%)

**Q37** Was a solicitor present when you were interviewed?
- Did not ask for a solicitor / Was not interviewed: 21 (26%)
- Yes: 50 (62%)
- No: 10 (12%)

**Q38** Was an appropriate adult present when you were interviewed?
- Did not need an appropriate adult / Was not interviewed: 54 (69%)
- Yes: 10 (13%)
- No: 14 (18%)

**Q39** Was an interpreter present when you were interviewed?
- Did not need an interpreter / Was not interviewed: 60 (76%)
- Yes: 1 (1%)
- No: 18 (23%)

### Section 3: Safety

**Q41** Did you feel safe there?
- Yes: 61 (80%)
- No: 15 (20%)
Q42  Did a member of staff victimise (insulted or assaulted) you there?
   Yes 21 (26%)
   No 60 (74%)

Q43  If you were victimised by staff, what did the incident involve? (Please tick all that apply to you.)
   I have not been victimised 60 (75%)
   Insulting remarks (about you, your family or friends) 12 (15%)
   Physical abuse (being hit, kicked or assaulted) 5 (6%)
   Sexual abuse 0 (0%)
   Your race or ethnic origin 1 (1%)
   Drugs 11 (14%)

Q44  Were your handcuffs removed on arrival at the police station?
   Yes 59 (73%)
   No 14 (17%)
   I wasn’t handcuffed 8 (10%)

Q45  Were you restrained while in the police custody suite?
   Yes 12 (15%)
   No 68 (85%)

Q46  Were you injured while in police custody, in a way that was not your fault?
   Yes 13 (16%)
   No 67 (84%)

Q47  Were you told how to make a complaint about your treatment if you needed to?
   Yes 14 (18%)
   No 65 (82%)

Q48  How were you treated by staff in the police custody suite?
   Very well 7 (9%)
   Well 34 (43%)
   Neither 22 (28%)
   Badly 8 (10%)
   Very badly 9 (11%)
   Don’t remember 0 (0%)

Section 4: Health care

Q50  Did someone explain your entitlements to see a health care professional, if you needed to?
   Yes 32 (43%)
   No 40 (53%)
   Don’t know 3 (4%)

Q51  Were you seen by the following health care professionals during your time there?
   Doctor 19 (29%)
   Nurse 30 (44%)
   Paramedic 4 (8%)

Q52  Were you able to see a health care professional of your own gender?
   Yes 14 (19%)
   No 38 (51%)
   Don’t know 22 (30%)
Section 8 – Appendix II: Summary of detainee questionnaires and interviews

Q53  Did you need to take any prescribed medication when you were in police custody?
     Yes                        38 (50%)
     No                         38 (50%)

Q54  Were you able to continue taking your prescribed medication while there?
     Not taking medication       38 (51%)
     Yes                        5 (7%)
     No                         31 (42%)

Q55  Did you have any drug or alcohol problems?
     Yes                        52 (68%)
     No                         24 (32%)

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
     Yes                        24 (32%)
     No                         43 (57%)

Q57  Were you offered relief or medication for your immediate withdrawal symptoms?
     I didn't have any drug/alcohol problems
     Yes                        12 (16%)
     No                         37 (51%)

Q58  Please rate the quality of your health care while in police custody:
     I was not seen by health care
     Very good                  33 (43%)
     Good                       11 (14%)
     Neither                    9 (12%)
     Bad                        10 (13%)
     Very bad                   11 (14%)

Q59  Did you have any specific physical health care needs?
     Yes                        25 (33%)
     No                         51 (67%)

Q60  Did you have any specific mental health care needs?
     Yes                        25 (33%)
     No                         51 (67%)

Q61  If you had any mental healthcare needs, were you seen by a mental health nurse / psychiatrist?
     I didn't have any mental health care needs
     Yes                        6 (8%)
     No                         17 (23%)
     Yes                        51 (69%)
     No                         51 (69%)
### Prisoner survey responses for Devon and Cornwall Police 2013

**Key to tables**
- 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
<table>
<thead>
<tr>
<th></th>
<th>Devon and Cornwall Police</th>
<th>Police custody comparator</th>
</tr>
</thead>
<tbody>
<tr>
<td>82</td>
<td>2618</td>
<td></td>
</tr>
</tbody>
</table>

#### SECTION 1: General information

<table>
<thead>
<tr>
<th>Question</th>
<th>Devon and Cornwall Police</th>
<th>Police custody comparator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you under 21 years of age?</td>
<td>7%</td>
<td>10%</td>
</tr>
<tr>
<td>Are you transgender/transsexual?</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Are you from a minority ethnic group? (Including all those who did not tick white British, white Irish or white other categories)</td>
<td>1%</td>
<td>29%</td>
</tr>
<tr>
<td>Are you a foreign national?</td>
<td>10%</td>
<td>16%</td>
</tr>
<tr>
<td>Are you Muslim?</td>
<td>0%</td>
<td>10%</td>
</tr>
<tr>
<td>Are you homosexual/gay or bisexual?</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>Do you consider yourself to have a disability?</td>
<td>31%</td>
<td>20%</td>
</tr>
<tr>
<td>Have you been in police custody before?</td>
<td>95%</td>
<td>92%</td>
</tr>
</tbody>
</table>

#### SECTION 2: Your experience of this custody suite

<table>
<thead>
<tr>
<th>Question</th>
<th>Devon and Cornwall Police</th>
<th>Police custody comparator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were you held at the police station for over 24 hours?</td>
<td>73%</td>
<td>69%</td>
</tr>
<tr>
<td>Were you told your rights when you first arrived?</td>
<td>64%</td>
<td>79%</td>
</tr>
<tr>
<td>Were you told about PACE?</td>
<td>74%</td>
<td>52%</td>
</tr>
<tr>
<td>Were you given a tracksuit to wear?</td>
<td>43%</td>
<td>42%</td>
</tr>
<tr>
<td>Could you use a toilet when you needed to?</td>
<td>96%</td>
<td>91%</td>
</tr>
<tr>
<td>If you used the toilet, was toilet paper provided?</td>
<td>56%</td>
<td>47%</td>
</tr>
<tr>
<td>Would you rate the condition of your cell, as 'good' for:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleanliness?</td>
<td>44%</td>
<td>34%</td>
</tr>
<tr>
<td>Ventilation/air quality?</td>
<td>34%</td>
<td>23%</td>
</tr>
<tr>
<td>Temperature?</td>
<td>29%</td>
<td>17%</td>
</tr>
<tr>
<td>Lighting?</td>
<td>54%</td>
<td>44%</td>
</tr>
<tr>
<td>Was there any graffiti in your cell when you arrived?</td>
<td>50%</td>
<td>53%</td>
</tr>
<tr>
<td>Did staff explain the correct use of the cell bell?</td>
<td>40%</td>
<td>24%</td>
</tr>
<tr>
<td>Were you held overnight?</td>
<td>96%</td>
<td>92%</td>
</tr>
<tr>
<td>Were you given any items of bedding?</td>
<td>93%</td>
<td>87%</td>
</tr>
<tr>
<td>Were these clean?</td>
<td>71%</td>
<td>61%</td>
</tr>
<tr>
<td>Were you offered a shower?</td>
<td>17%</td>
<td>9%</td>
</tr>
</tbody>
</table>
### Key to tables

- **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**

<table>
<thead>
<tr>
<th>Question</th>
<th>Devon and Cornwall Police</th>
<th>Police Custody</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>24</strong> Were you offered a period of outside exercise?</td>
<td>9%</td>
<td>6%</td>
<td></td>
</tr>
<tr>
<td><strong>25a</strong> Were you offered anything to eat?</td>
<td>94%</td>
<td>81%</td>
<td></td>
</tr>
<tr>
<td><strong>25b</strong> Were you offered anything to drink?</td>
<td>93%</td>
<td>84%</td>
<td></td>
</tr>
<tr>
<td>For those who had food/drink:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>26</strong> Was the quality of the food and drink you received good/very good?</td>
<td>14%</td>
<td>13%</td>
<td></td>
</tr>
<tr>
<td><strong>27</strong> Was the food/drink you received suitable for your dietary requirements?</td>
<td>57%</td>
<td>44%</td>
<td></td>
</tr>
<tr>
<td>For those who smoke:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>28</strong> Were you offered anything to help you cope with not being able to smoke?</td>
<td>1%</td>
<td>6%</td>
<td></td>
</tr>
<tr>
<td><strong>29</strong> Were you offered anything to read?</td>
<td>38%</td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td><strong>30</strong> Was someone informed of your arrest?</td>
<td>35%</td>
<td>44%</td>
<td></td>
</tr>
<tr>
<td><strong>31</strong> Were you offered a free telephone call?</td>
<td>38%</td>
<td>49%</td>
<td></td>
</tr>
<tr>
<td>If you were denied a free telephone call:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>32</strong> Was a reason given?</td>
<td>10%</td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td><strong>33</strong> Did you have any concerns about:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>33a</strong> Who was taking care of your children?</td>
<td>10%</td>
<td>13%</td>
<td></td>
</tr>
<tr>
<td><strong>33b</strong> Contacting your partner, relative or friend?</td>
<td>40%</td>
<td>52%</td>
<td></td>
</tr>
<tr>
<td><strong>33c</strong> Contacting your employer?</td>
<td>11%</td>
<td>18%</td>
<td></td>
</tr>
<tr>
<td><strong>33d</strong> Where you were going once released?</td>
<td>33%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td><strong>34</strong> Were you offered free legal advice?</td>
<td>94%</td>
<td>88%</td>
<td></td>
</tr>
<tr>
<td>For those who were offered free legal advice:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>35</strong> Did you accept the offer of free legal advice?</td>
<td>75%</td>
<td>72%</td>
<td></td>
</tr>
<tr>
<td>For those who were interviewed and needed them:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>37</strong> Was a solicitor present when you were interviewed?</td>
<td>84%</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td><strong>38</strong> Was an appropriate adult present when you were interviewed?</td>
<td>41%</td>
<td>29%</td>
<td></td>
</tr>
<tr>
<td><strong>39</strong> Was an interpreter present when you were interviewed?</td>
<td>4%</td>
<td>11%</td>
<td></td>
</tr>
</tbody>
</table>

### SECTION 3: Safety

<table>
<thead>
<tr>
<th>Question</th>
<th>Devon and Cornwall Police</th>
<th>Police Custody</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>41</strong> Did you feel safe?</td>
<td>80%</td>
<td>62%</td>
<td></td>
</tr>
<tr>
<td><strong>42</strong> Has another detainee or a member of staff victimised you?</td>
<td>26%</td>
<td>36%</td>
<td></td>
</tr>
<tr>
<td><strong>43</strong> If you have felt victimised, what did the incident involve?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>43a</strong> Insulting remarks (about you, your family or friends)</td>
<td>15%</td>
<td>18%</td>
<td></td>
</tr>
<tr>
<td><strong>43b</strong> Physical abuse (being hit, kicked or assaulted)</td>
<td>6%</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td><strong>43c</strong> Sexual abuse</td>
<td>0%</td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td><strong>43d</strong> Your race or ethnic origin</td>
<td>1%</td>
<td>5%</td>
<td></td>
</tr>
</tbody>
</table>
### Key to tables

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- Percentages which are not highlighted show there is no significant difference

#### Police custody

<table>
<thead>
<tr>
<th>Police custody suite</th>
<th>Devon and Cornwall Police</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drugs</td>
<td>13% 11%</td>
</tr>
<tr>
<td>Because of your crime</td>
<td>9% 13%</td>
</tr>
<tr>
<td>Because of your sexuality</td>
<td>0% 1%</td>
</tr>
<tr>
<td>Because you have a disability</td>
<td>2% 3%</td>
</tr>
<tr>
<td>Because of your religion/religious beliefs</td>
<td>1% 2%</td>
</tr>
<tr>
<td>Because you are from a different part of the country than others</td>
<td>2% 3%</td>
</tr>
</tbody>
</table>

#### Police custody suite

<table>
<thead>
<tr>
<th>Police custody suite</th>
<th>Devon and Cornwall Police</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were your handcuffs removed on arrival at the police station?</td>
<td>81% 73%</td>
</tr>
<tr>
<td>Were you restrained while in the police custody suite?</td>
<td>15% 19%</td>
</tr>
<tr>
<td>Were you injured whilst in police custody, in a way that was not your fault?</td>
<td>16% 23%</td>
</tr>
<tr>
<td>Were you told how to make a complaint about your treatment?</td>
<td>18% 13%</td>
</tr>
<tr>
<td>Were you treated well/very well by staff in the police custody suite?</td>
<td>51% 35%</td>
</tr>
</tbody>
</table>

### SECTION 4: Health care

<table>
<thead>
<tr>
<th>Police custody suite</th>
<th>Devon and Cornwall Police</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did someone explain your entitlements to see a health care professional, if you needed to?</td>
<td>43% 34%</td>
</tr>
<tr>
<td>Were you seen by the following health care professionals during your time in police custody?</td>
<td>29% 42%</td>
</tr>
<tr>
<td>Doctor</td>
<td>29% 42%</td>
</tr>
<tr>
<td>Nurse</td>
<td>45% 22%</td>
</tr>
<tr>
<td>Percentage seen by either a doctor or a nurse</td>
<td>52% 50%</td>
</tr>
<tr>
<td>Paramedic</td>
<td>8% 4%</td>
</tr>
<tr>
<td>Were you able to see a health care professional of your own gender?</td>
<td>19% 25%</td>
</tr>
<tr>
<td>Did you need to take any prescribed medication when you were in police custody?</td>
<td>50% 43%</td>
</tr>
</tbody>
</table>

**For those who were on medication:**

<table>
<thead>
<tr>
<th>Police custody suite</th>
<th>Devon and Cornwall Police</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were you able to continue taking your medication while in police custody?</td>
<td>14% 32%</td>
</tr>
<tr>
<td>Did you have any drug or alcohol problems?</td>
<td>69% 52%</td>
</tr>
</tbody>
</table>

**For those who had drug or alcohol problems:**

<table>
<thead>
<tr>
<th>Police custody suite</th>
<th>Devon and Cornwall Police</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you see, or were offered the chance to see a drug or alcohol support worker?</td>
<td>16% 41%</td>
</tr>
<tr>
<td>Were you offered relief or medication for your immediate withdrawal symptoms?</td>
<td>25% 25%</td>
</tr>
</tbody>
</table>

**For those who were seen by health care:**

<table>
<thead>
<tr>
<th>Police custody suite</th>
<th>Devon and Cornwall Police</th>
</tr>
</thead>
<tbody>
<tr>
<td>Would you rate the quality as good/very good?</td>
<td>30% 31%</td>
</tr>
<tr>
<td>Did you have any specific physical health care needs?</td>
<td>33% 32%</td>
</tr>
<tr>
<td>Did you have any specific mental health care needs?</td>
<td>33% 25%</td>
</tr>
</tbody>
</table>

**For those who had any mental health care needs:**

<table>
<thead>
<tr>
<th>Police custody suite</th>
<th>Devon and Cornwall Police</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were you seen by a mental health nurse/psychiatrist?</td>
<td>25% 12%</td>
</tr>
</tbody>
</table>