Report on an inspection visit to police custody suites in Cumbria Constabulary

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by

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1. Introduction

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

At the time of the inspection, Cumbria Constabulary had four custody suites designated for the reception of detainees under the Police and Criminal Evidence Act (PACE) 1984: Carlisle, Workington, Barrow and Kendall. There were also five non-designated suites, including one at Millom that had closed shortly before the inspection. There was a total of 57 cells in designated suites operating 24 hours a day. An additional 16 cells were available in non-designated suites. In the course of the inspection, all suites were visited.

Strategic management was satisfactory and work was in hand to remedy a historical lack of attention to and investment in the custodial function. The Police Authority also took an active interest in this area, supported by an effective and innovative team of independent custody visitors. Trained custody staff were routinely used in all suites, but the number of vacancies was a concern. Partnership working was generally strong.

Relationships between staff and detainees were excellent. The needs of juveniles were adequately addressed, although there was insufficient awareness of child protection issues. The specific needs of women and detainees with disabilities were not well met. Suites were very clean, but the physical condition of some was poor and we found numerous ligature points. Showers were rarely offered, some toilets lacked privacy and toilet paper was not routinely supplied. Catering was adequate and some suites made good efforts to supply reading materials and facilitate visits.

Staff generally adhered to PACE and ensured detainees received their entitlements. The appropriate adult scheme operated well during the day, but less well at night, and was generally not applied to 17 year old children. The small number of immigration detainees were well treated, but the UK Border Agency was sometimes slow to collect them. The lack of video links and early court cut-off times meant that some detainees were held in custody longer than necessary. Complaint systems needed to be further improved. The management of forensic samples was among the best we have seen.

Healthcare provision was variable across the county and required considerable improvement. While medical rooms were excellent, medicine management and storage of clinical records were poor. There was a need for better oversight of the healthcare providers, and we were unconvinced that claimed response times were accurate. Services for substance abusers varied and services for those with mental health issues were poor.

This inspection of police custody suites in Cumbria provides an important degree of assurance to the public that, in most respects, detention is well managed. Nevertheless, custody is an area that has received little attention and investment in the past and this legacy needs to be addressed. In particular, healthcare provision requires review. We identify a number of areas

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

for improvement and hope that this assists the Chief Constable and the Police Authority to improve provision further.

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November 2009

2. Background and key findings

2.1 HM Inspectorates of Prisons and Constabulary are undertaking a programme of joint inspections of police custody suites, as part of the UK's international obligation to ensure regular independent inspection of places of detention. These inspections do not look only at the implementation of the Police and Criminal Evidence Act (PACE) codes (1984) and guidance on the safer detention and handling of persons in police custody (2006). They are also informed by *Expectations* about the appropriate treatment of detainees and conditions of detention, which have been developed by the two inspectorates to assist best custodial practice.

2.2 At the time of the inspection, Cumbria Constabulary had four custody suites designated under PACE for the reception of detainees: Carlisle in the north, Workington in the west and Barrow and Kendall in the south. These operated 24 hours a day and dealt with detainees arrested as a result of mainstream policing. There were four non-designated suites at Penrith, Whitehaven, Ulverston and Appleby. A fifth at Millom had been closed to detainees before the inspection. This inspection was mainly conducted in the four designated custody suites, but visits were made to all sites in the force area including Millom. A survey of prisoners at HMP Durham, who had formerly been detained at custody suites in the force area, was conducted by HM Inspectorate of Prisons researchers and a HM Inspectorate of Constabulary staff officer to obtain additional evidence (see appendix III).

2.3 The force cell capacity was 57, but this could be increased to 73 by opening non-designated suites. Carlisle had 24 cells, Workington 16, Barrow 10 and Kendal seven. Among the non-designated suites, Penrith had five cells, Appleby two, Whitehaven six and Ulverston three. Carlisle held approximately 6,700 detainees a year, with Workington holding 6,300 and Barrow and Kendall 5,700 between them. A total of 850 detainees a year were held in the non-designated suites, usually to cover specific events in the local areas concerned. Suites held a mixture of adults, juveniles and immigration detainees.

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

Strategic overview

2.5 There was a clear line management structure from the assistant chief constable to detention officers working in custody suites. All staff working in custody were permanent and designated suites were managed by a decentralised model within the three basic command units in the force. A well-attended custody forum met every six weeks to deal with the operational management of custody across the force. This group had a clear brief to manage any risks in the force custody facilities.

2.6 The force recognised that there has been historical underinvestment in the custody estate and there was a published estate strategy to address this.

2.7 The number of detention officers deployed under the staffing model used was a concern. There was good in-house training for new custody staff, but attendance at refresher training was disappointing.

2.8 We were told about some good partnership work, but there could have been more engagement with mental health services. The force felt well supported by the Police Authority,

which also oversaw an effective independent custody visitors' scheme that was undertaking some innovative and in-depth work.

2.9 Custody managers carried out regular dip sampling of custody records. Good practice information was disseminated by email, but was not reaching some front line staff.

2.10 A use of force form was completed and analysed for training purposes, but not for trends.

Treatment and conditions

2.11 Relationships between staff and detainees were excellent. The needs of juveniles under 17 were generally well met, but there was not enough awareness of child protection issues and little understanding of the different experience of women in custody. There had been few adaptations to make suites suitable for detainees with disabilities or mobility issues.

2.12 Thorough risk assessments were carried out and these were revised as circumstances changed. Staff routinely roused detainees when appropriate and varied the frequency of observations to make them less predictable. There were gaps in closed-circuit television coverage, but staff did not over rely on this. We found ligature points in all suites and few staff had received refresher training in safer custody. Regular fire evacuation drills were not taking place.

2.13 Cells and communal areas were very clean, even in the older and more run down custody suites, and this was supported by a zero tolerance approach to graffiti. The provision of bedding and clothing varied across the suites. There were hand washing facilities in many cells, but toilet paper was not always routinely provided. Showers were available and the main suites had exercise yards, but detainees were rarely offered use of either. Catering arrangements were adequate, but applied somewhat rigidly in some suites. Reading material was offered and some suites could facilitate supervised visits.

Individual rights

2.14 Custody sergeants authorised detention appropriately and actively considered alternatives. Custody suites were not usually used as a place of safety for children. Few immigration detainees were held, but despite improvements in waiting times to be collected by the UK Border Agency, there were still some unacceptable delays. Interpreting services were appropriately used and there was a good range of notices in languages other than English on display.

2.15 Someone concerned about the welfare of detainees was informed of their whereabouts, but free telephone calls were rarely offered. Not all detainees were asked about any dependants. Pre-release risk management assessments were included on NSPIS, but not always completed. There were good links to public protection units.

2.16 Staff mostly adhered to PACE and reviews were in accordance with this. Up-to-date copies of PACE were available at most suites. Detainees were not interviewed while under the influence of alcohol or drugs. The appropriate adult scheme operated well during the day, but less so out of hours. Appropriate adults were not routinely provided for 17 year olds.

2.17 Court cut-off times were sometimes too early, resulting in bed blocking and unnecessarily long periods in custody. There were no video link facilities.

2.18 Systems for dealing with complaints were generally robust, with good processes for analysing trends, including those with a racist element. However, detainees were not routinely given information on how to complain.

Healthcare

2.19 Healthcare was provided by Medacs and delivered by forensic medical examiners in the north and by nurses in the west and south. Medacs described the service as 'inherited' and there had been limited development of the provision for some considerable time. Healthcare professionals had an appraisal system, a good induction programme and refresher training, although some practice in the field differed.

2.20 The medical rooms in the designated suites were excellent. There was no clear medicines management policy, particularly on storage, checking and disposal. All suites contained waste and out-of-date medications.

2.21 Detainees were routinely asked when being booked in if they wanted to see a healthcare professional. Medacs said 99% of calls were responded to on time, but this was misleading as many responses inappropriately took place over the telephone. In the west and south, nurses were illegally prescribing medication over the telephone. Methadone was never given and symptomatic relief rarely provided.

2.22 There were no NSPIS terminals in medical rooms and some custody records contained limited or no information. Nurses took clinical records home, with no clear arrangements for their secure storage.

2.23 Substance misuse workers visited suites, some on a more formal basis than others, and carried out sweeps to identify relevant cases. They assessed need and offered support for alcohol and drug-related issues. Juveniles were less well served, falling outside the scope of the diversion service, which could only signpost them to relevant community initiatives. Needle exchange was not offered on release.

2.24 Services for detainees with mental health issues were scarce. Staff were unsure of the role of mental health crisis teams, which provided information and guidance on how to treat a person in detention, but were not set up to undertake assessments. There was a shortage of section 12-approved doctors in the south and west. There were examples where mental health service providers had not engaged positively with custody staff about the management of section 136 detainees.

3. Strategy

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

3.1 An assistant chief constable had portfolio responsibility for custody services supported by a Criminal Justice Department chief inspector. Responsibility for day-to-day management of custody suites and delivery of services had been devolved to basic command units and accountability rested with the commanders, who were chief superintendents. Trained custody staff were routinely used in all suites, but staffing levels were a concern. A comprehensive custody procedures manual drove working practice forward, although there were some gaps. The custody estate had suffered from a lack of investment resulting in some poor and unsafe infrastructure. There was a long-term rebuilding plan for custody suites. Apart from for mental health, partnership arrangements were generally strong.

3.2 An assistant chief constable (ACC) who had been in post since June 2009 had portfolio responsibility for custody services. Strategic priority was given to custody and there was clear direction of the development of custody within the context of the administration of criminal justice. A chief inspector at headquarters within the Partnerships and Criminal Justice Department (CJD) had oversight of custody provision in Cumbria Constabulary and was responsible for the strategic development of custody. The management of custody policies and procedures rested with the chief inspector, who was supported by an inspector and sergeant.

3.3 Day-to-day operational accountability was devolved to three basic command unit (BCU) commanders, who were chief superintendents covering the north, west and south constabulary areas. An operational chief inspector and an inspector custody manager were tasked with ensuring that custody suites delivered quality services in each BCU.

3.4 Strategic operations board meetings took place bi-monthly. They were supported by six-weekly force-wide custody forum meetings chaired by the chief inspector CJD and attended by representatives from a range of relevant police departments, external partners and the three custody site managers.

3.5 The force recognised that a lack of capital investment in the custody estate over a number of years had left a legacy of poor infrastructure at some suites and we found ligature points in all suites. The constabulary had been forced to invest a sizeable amount of money in replacing the custody suite at Carlisle after it was severely damaged by floods in 2005, building a facility to Home Office specifications. There was an ongoing programme of work to re-build the custody suite at Kendal in early 2010, with a proposal to carry out a similar project at Barrow in 2013-15. The Barrow work had been delayed due to funding constraints.

3.6 Cumbria has four designated custody suites operating under the control of the respective BCU commanders. The devolved model of custody suites was generally working well. This could be attributed to good leadership at all levels, which focused on delivering high standards within the custody environment. The responsible custody inspector in each BCU managed all police and criminal evidence (PACE) issues and reviews of detention when on duty. When they were not available, these duties fell to the BCU duty inspector.

3.7 The custody site managers had line management responsibilities for custody sergeants and detention officers. The police sergeants in the custody suites were posted into custody roles from their patrol teams, their postings varying in length but with a view to serving at least two years in post. There were 26.5 custody sergeants across the force supported by 37 detention officers, although there were two vacant detention officers posts and two were on restricted duties.

3.8 The staffing model and the vacancies carried were a concern. In some custody suites, such as Carlisle, staffing levels between 3am and 7am could comprise only one custody sergeant and one detention officer per team, in this case to cover 24 cells. The duties of detention officers included fingerprinting, photographing and DNA-testing every person brought into custody, all of which took away from their main custody duties of detainee welfare and safety. Staff reported feeling under pressure at busy times.

3.9 All custody sergeants had received specific custody training before their deployment into the custody suites. The availability of custody courses meant this was not always possible for detention officers, but those who had not yet been trained shadowed colleagues and did not work unaccompanied. Training was provided within four to six weeks of detention officers taking up position. The initial Detention Officer training comprises of 5 days SDHP, 5 days first aid at work, 5 days NSPIS, 1 day personal safety training (PST). Custody Sergeants new to the role receive 8 days custody/SDHP, 5 days NSPIS, 5 days first aid at work, 2 days (PST).

3.10 Staff were well trained and focused on the needs of detainees, but needed more training in recognising ligature points. A comprehensive custody procedures manual incorporated many issues contained within safer detention and handling of persons in police custody (SDHP) guidance and assisted staff in discharging their duties effectively.

3.11 There was evidence of good working relationships with partners across Cumbria. This was reinforced by the Police Authority, which was very positive about its relationship with the force, which it described as approachable and responsive. There were, however, some frustrations with the level of engagement with mental health services (see section on healthcare) and concerns over delays in the UK Border Agency dealing with immigration detainees, which led to cells being blocked and impacted on operational capacity (see section on individual rights). There were some future threats to the funding of the appropriate adult scheme for vulnerable adults.

3.12 Management was aware of the complaints process and a feedback loop from the Department for Professional Standards to area management teams within BCUs filtered down to custody site managers, allowing them to identify the number and type of complaint made.

3.13 The Police Authority lead for custody played a proactive role in custodial matters, which was seen to be supportive. There was a Police Authority lead for the independent custody visitors (ICV) scheme, which the force viewed as an important independent oversight mechanism. ICVs visited the four designated custody suites at least once a week and the non-designated custody suites on an ad hoc basis, specifically when they were used for local organised events. Feedback forms were submitted after every visit, with copies kept at the station for the attention of the officer-in-charge and forwarded to the local area coordinator and the central Police Authority scheme coordinator at police headquarters. Any issues raised were dealt with locally, but could be escalated by the scheme coordinator to the chief inspector CJD if required. Identified issues and actions taken to address them were recorded centrally and formally discussed at each BCU's quarterly meeting with members of the ICV, local custody site managers and staff.

3.14 The Barrow ICV members were piloting 'observational visits' where ICVs were prepared to sit and observe interactions between custody staff and detainees for several hours at a time. This had led to a greater understanding of the nature of the custody role and the challenges posed by it. The Police Authority was looking to extend this practice across the force area.

3.15 Although the central CJD provided policies and procedures for the guidance of BCUs, there were some policy gaps that needed to be underpinned by standard operating procedures (SOPs) to allow staff to deliver effective custody arrangements across the board. This included guidance on the use of Taser and incapacitant spray, as staff were unclear when these would be considered a justified and proportionate response within the custody environment.

3.16 Quality assurance checks were carried out by custody site managers, who were required to dip sample at least 20 random custody records a month for their respective areas. The details of these checks were submitted to the BCU chief inspector operations for monitoring purposes.

3.17 Good practice information was disseminated from the centre, but was not reaching some staff who were unaware of its content.

3.18 The use of force was routinely recorded in an officer's pocket notebook, on a detainee's custody record and through the submission of a use of force monitoring form. These forms were submitted to the force physical training instructor, who monitored the contents to identify any staff in need of additional training from a personal safety perspective. This information was not collated or analysed further, so the force could not identify patterns and monitor trends.

Recommendations

3.19 **The current staffing model in custody suites should be reviewed to ensure sufficient staff are on duty to provide an appropriate level of care to detainees.**

3.20 **The time detention officers are taken away from work ensuring the welfare and safety of detainees should be assessed and monitored to ensure these core duties can be effectively carried out.**

3.21 **Custody staff should be released to attend off-the-job refresher training.**

3.22 **The dissemination of good practice and lessons learned should be improved to ensure that all staff are fully briefed and up to date with current practices and knowledge.**

3.23 **Use of force should be monitored centrally to enable managers to identify patterns and monitor trends.**

3.24 **There should be a clear policy for staff outlining when the use of Tasers or incapacitant sprays is justifiable and proportionate within a custodial environment.**

Good practice

3.25 *The Barrow independent custody visitors (ICV) members were piloting 'observational visits' where ICVs were prepared to sit and observe interactions between custody staff and detainees for several hours at a time. This had led to a greater understanding of the nature of the custody role and the challenges posed by it.*

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.

4.1 Custody staff were professional and respectful towards detainees and generally met the needs of juveniles. However, there was limited recognition of the specific needs of female detainees or different religious needs and no formal arrangements for detainees with disabilities. Potential self-harm and suicide risks were thoroughly assessed and detainees were roused when necessary, but few staff had received refresher training in this area and not all carried ligature knives. There were multiple ligature points in cells. All suites were clean, but there was some damp and mould at Kendall. Health and safety walkthroughs were limited in scope. Not all toilets could be used in private and few detainees were offered a shower or outdoor exercise. Some visits were facilitated.

Respect

4.2 Transport to court was provided by G4S. The vans were cellular and those we saw were clean and well equipped. Custody staff were professional and friendly towards detainees, even when dealing with some extremely difficult situations and individuals. An ethos of care underpinned all interactions we observed and staff described their role as one of support and care for people in their charge. Interactions were particularly positive at Kendall. Detainees in all suites were addressed by their first names and said they had been treated respectfully and decently. The reception booking desk in some suites was high and in an open area that did not allow new arrivals much privacy. Closed-circuit television (CCTV) monitors were also visible in reception areas.

4.3 Staff at Barrow and Kendall said every effort was made to avoid detaining juveniles. Detention was used only as a last resort and children under 12 were not locked in a cell under any circumstances. This recognition of the unsuitability of custody for young people was less pronounced at Carlisle and Workington, although it was acknowledged that juveniles in custody needed additional support. In contrast, there was little recognition that women had a different experience of custody other than specified allocated cells in some suites and ensuring a female member of staff was on duty when women were held. Staff were aware of how to deal with transgender detainees, including identifying which gender they wanted to be treated as and which gender of staff they wished to be searched by, and one custody record we saw indicated that this had happened. Staff said they had not attended child protection awareness refresher training.

4.4 No cells had been adapted to meet the needs of detainees with disabilities. All cells at Carlisle contained low level plinths that were particularly unsuitable for detainees with mobility difficulties. Staff said they would manage each case individually, but there were no formal arrangements or policies. Equally, there was limited recognition of detainees' different religious needs. A bible was available and a Qur'an and prayer mat for Muslim detainees, but some staff said they would benefit from training to increase their understanding of the issues involved.

Safety

4.5 All detainees were assessed on arrival, covering any potential self-harm and suicide issues. The IT system also highlighted any individuals held previously with a known history of self-harm and suicide-related behaviour. An observational assessment was also completed, particularly on uncooperative detainees, and custody sergeants and detention officers were aware of visual warning indicators. Assessments were reviewed and revised as circumstances changed.

4.6 The initial risk assessment determined how often each detainee was observed. Staff routinely roused detainees when appropriate and varied the frequency of observations to make them less predictable. There were four levels of risk. Detainees subject to level three or four were given a mental health assessment by a healthcare professional and this would determine whether the mental health crisis team should be called. Some CCTV equipment was poor and there were gaps in coverage in some suites, but staff did not overly rely on it or life signs monitoring.

4.7 Self-harm and suicide were covered in initial custody training, but few staff we spoke to had received refresher training. Not all staff carried anti-ligature knives, but these were available in all suites. Shift times overlapped, allowing custody sergeants enough time for a comprehensive handover briefing even when the suite was busy.

4.8 Custody staff were always informed in advance if any refractory detainees were due to arrive and good preparations were made to receive them, such as ensuring reception was clear. Staff tried to avoid cell sharing, but said this was not uncommon at Barrow and Kendall. This was done only following a risk assessment by the custody sergeant, but there was no formal process to notify senior management so frequency and reasons could not be monitored. It was therefore not possible to determine how often detainees shared cells.

4.9 We found multiple ligature points in cells and other detainee areas in all designated and non-designated suites visited, including the relatively new suite at Carlisle, which potentially presented significant risks for detainees. Staff could identify the more obvious physical environment safety issues, but there was a need for them to have specific training in identifying ligature points.

4.10 Use of the new prisoner escort record (PER) highlighting risks and vulnerabilities started on 1 September 2009. Staff said they had not received adequate training for this and some were unsure whether they were completing the PER adequately.

Use of force

4.11 Custody staff completed use of force forms and submitted them as required (see section on strategy). Staff said force was used only as a last resort and only in extreme circumstances. All those involved in using force had been trained in the approved techniques and received annual refresher training. Detainees subject to use of force were seen by a health professional only if they requested it themselves or had any visible injuries. Control and restraint equipment was in good order.

4.12 During our survey visit, prisoners complained to us about police use of force in custody, including use of Taser, but we could not fully follow this up as CCTV film of the custody desk area at Carlisle was not available between 10 June and 10 August 2009 due to technical problems.

4.13 In one incident at Workington, staff did not remove handcuffs from a compliant detainee for 10 minutes after arrival. Staff said this was basic command unit policy, but there did not appear to be any good reason for this and it was not happening elsewhere.

Physical conditions

4.14 All suites were very clean and, apart from three cells at Kendall, free of graffiti. Staff enforced a zero tolerance approach to graffiti and detainees were warned that they would be held responsible for any damage found after they had vacated a cell and that this could lead to prosecution. In our survey, former detainees at Cumbria were significantly more positive than the comparator[2] about the condition of cells.

4.15 Carlisle was a modern suite with two spurs of eight normal cells and one spur of four cells, two detention rooms and two terrorist cells. No cells were specifically for women and all contained low plinths that were particularly unsuitable for pregnant women. There was no policy on how detainees with mobility issues would be assisted. A shower on each spur offered limited privacy. Workington had 16 cells on three corridors, each of which had a shower. Two cells contained lower plinths for detainees under the influence of drugs or alcohol, two without en-suite toilets were used for juveniles, four on a separate corridor were for women and eight on another corridor were for men.

4.16 Barrow and Kendall were older suites. Barrow was in very good decorative order. It had two detention rooms for juveniles, one cell for women, seven general use cells and two showers. Some of the physical fabric in Kendall was in poor condition, with damp and mould in corridors a particular problem. It had seven cells, none of which were designated to specific groups, although staff said any juvenile or woman would be allocated a cell nearest the front desk. There was one shower.

4.17 All suites operated a no smoking policy, but smokers were not offered nicotine replacement therapy. However, we were told that staff at Barrow had bought some nicotine patches with petty cash for a heavy smoker experiencing significant withdrawal after he had signed a waiver. Fire evacuation procedures were clearly displayed and staff knew them well. Fire alarms were tested regularly, but staff said fire drills took place rarely and smoke detectors were not regularly tested. All cells were equipped with a cell bell system that was checked by staff every time a new detainee was located in a cell. Detainees were shown the bell and told how and why to use it. Staff responded to them promptly.

4.18 Staff were expected to carry out daily, weekly and monthly checks of their facilities to identify health and safety, maintenance and cleanliness issues. However, the basic command units used different checklists and a number of points included were not relevant. There was little evidence that these checks were well established in the north and west, but they had clearly been in place for some time in the south. A formal annual health and safety 'walkthrough' was also carried out by a health and safety assessor, administration manager and the custody manager if available. The records of these did not make clear whether all cells were physically checked. The walkthroughs were limited in their scope and effectiveness, and highlighted clear gaps in skills and knowledge when identifying health and safety issues and the appropriate steps to be taken to resolve them.

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

Personal comfort and hygiene

4.19 All detainees were provided with a mattress and blanket. Blankets were washed after each use and mattresses were wiped down with a disinfectant spray when cells were vacated, but, contrary to force policy, were routinely left in cells when not in use. Detainees at Barrow and Kendall were also given a pillow, but those at Workington were not and pillows were not routinely available at Carlisle because their material meant they had to be washed after use.

4.20 Suites were cleaned daily and a deep cleaning contractor was on 24-hour call to respond when cells were contaminated by body fluids such as vomit or urine. We saw staff at Kendall contacting the contractor after a detainee sleeping off alcohol intoxication had retched bile on the floor. They helped clean the detainee, moved him to a clean cell and closed the original cell until it had been deep cleaned. At Workington, we saw plinths being cleaned using the same mop as had been used on the floor.

4.21 The CCTV monitors of most cells with this coverage had the toilet area obscured, but some at Carlisle, Workington and Barrow did not. All cells at Carlisle and Workington and a few at Barrow contained hand washing facilities. At Kendall, sinks were located outside cells and we saw staff unlocking detainees to use them on request. All suites had supplies of soap and towels. Toilet paper had to be requested at Workington, but was supplied in all cells in the other suites. Women were not routinely given hygiene packs. Those we spoke to said staff had not asked if they required sanitary products and staff said they were given only on request.

4.22 Showers were very clean, but appeared little used even though staff said detainees who arrived dirty and those held over 24 hours were offered a shower. In our survey, only 5% of respondents said they had been offered a shower. One custody record indicated that a detainee held for 67 hours had requested but not been given a shower, while another recorded that one shower had been offered during 45 hours of detention. Showers could not be used in private. At Barrow, one shower was in clear view of a one of the cells and the second was outside the two detention rooms used for juveniles. At Kendall, the shower was in the finger printing and intoxyliser room and had only a stable door. Showers at Carlisle and Workington also had only stable doors, which were particularly unsuitable for female detainees.

4.23 Detainees who had their clothes removed on arrival in custody received different treatment depending on the custody suite. Those at Carlisle and Barrow were given paper suits, those at Workington were given light cotton tops and bottoms, which they said were not warm enough, and those at Kendall were routinely given tracksuits and plimsolls. Carlisle, Barrow and Workington also had supplies of tracksuits and plimsolls, but used these for detainees going to court or being released. Only Workington had supplies of underwear. Staff at Kendall commendably encouraged families to provide alternative clothing if needed.

Catering

4.24 Catering arrangements varied between suites, with staff at Carlisle and Workington offering detainees something to eat only at fixed meal times. Custody records also indicated that food was not always routinely or regularly offered, including one detainee held for 17 hours given nothing to eat and another held for 34 hours offered only one meal. Drinks were offered regularly. The only food available was microwave meals, the quality and calorific content of which were poor, and the range somewhat limited. Staff gave examples of where they had bought food from local supermarkets and takeaway restaurants for detainees held for longer periods or with specific diet requirements. Staff did not allow families and friends to bring in

food. The only exception to this was at Kendall, where staff allowed sealed items, such as ready meals and sandwiches, to be brought in. Staff had received food hygiene training, and food preparation areas were very clean.

Activities

4.25 All suites had outside exercise yards, but these were austere and had no seating. Staff said exercise was offered to detainees held over 24 hours and when enough staff were available, but there was little evidence that the yards were used. In our survey, only 4% of detainees said they had been offered outside exercise.

4.26 All suites also had reading material, but the quality varied and there was nothing specifically for juveniles or detainees with learning difficulties. Workington also had a range of newspapers in languages other than English. In our survey, significantly more detainees than the comparator said they had been offered something to read.

4.27 Carlisle had a purpose-built closed visits booth, which staff said was used occasionally, mainly for juveniles and long-staying detainees. Staff at Workington said an interview room was used to facilitate visits, but these rarely happened. Barrow had limited visit arrangements, with efforts made to accommodate visits for juveniles, but adults rarely having them. Staff at Kendall were more open to visits taking place, but only if the detainee had been held overnight and there were enough staff to facilitate them.

Recommendations

4.28 **Refresher training should be offered that incorporates the specific needs of female detainees, detainees with disabilities and those with differing religious needs.**

4.29 **Operational staff should receive child protection awareness training.**

4.30 **All female detainees should be offered a hygiene pack on arrival in custody.**

4.31 **There should be clear policies to meet the needs of detainees with disabilities or mobility issues while in custody.**

4.32 **Booking-in desks should be of an appropriate height and the reception area should allow adequate privacy for new arrivals.**

4.33 **Closed-circuit television monitors should be visible only to staff.**

4.34 **All cells should be fit for purpose and free of ligature points, and custody staff should be trained to identify potential ligature points.**

4.35 **All staff should carry anti-ligature knives.**

4.36 **Regular fire evacuation drills and smoke detector tests should be conducted.**

4.37 **The daily, weekly and monthly health and safety, maintenance and cleanliness checks should be reviewed and formalised across the custody estate. They should be fully recorded and monitored by custody site managers to ensure identified issues are progressed and actioned accordingly.**

4.38 **All custody staff should receive refresher self-harm and suicide training.**

4.39 **Handcuffs should be removed as soon after arrival in custody as is practical, subject to risk assessment.**

4.40 **Views of in-cell toilets covered by closed-circuit television should be obscured.**

4.41 **Detainees held overnight and those who are dirty should be offered a shower and shower areas should allow sufficient privacy, particularly for female detainees.**

4.42 **Detainees held overnight or for over eight hours should be offered outdoor exercise.**

4.43 **A change of underwear should be provided for all detainees when appropriate.**

4.44 **On an individual needs assessed basis, nicotine replacement should be available to smokers.**

4.45 **Pillows should be provided routinely to all detainees.**

4.46 **The calorific content of microwave meals should be improved. Meals should be offered to detainees on arrival and then when requested at meal times.**

Housekeeping point

4.47 Cleaning of plinths should be carried out using separate materials and cleaning implements.

Good practice

4.48 *Staff at Kendall allowed family and friends to bring in clean clothing and food in sealed containers for detainees.*

5. Individual rights

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

5.1 Custody sergeants checked that detention was appropriate. Custody suites were not usually used as a place of safety for children, but there were some unacceptable delays in dealing with immigration detainees. Language needs were well met. Detainees could have someone told of their whereabouts, but not all were asked about dependants. Staff mostly adhered to PACE. Support from appropriate adults was not reliable out of hours and not routinely provided for 17 year olds. There were no video links and some court cut-off times were too early. Not all detainees were told how to make a complaint. Pre-release risk assessments were not always completed.

Rights relating to detention

5.2 Custody sergeants checked that arrest and detention were appropriate with the arresting officer and gave examples of where they had refused to accept detainees when this could not be clearly established. Custody sergeants and custody inspectors were prepared to challenge the proportionality of arrest and detention, particularly when involving children or juveniles. Where offences could be dealt with by other means, inspectors were intervening before detainees even arrived, thereby diverting children from custody suites. There was evidence that suites were not usually used as a formal place of safety for children and young people under section 46 of the Children Act (1989), although staff at Workington said they sometimes held children in cells until collected by social services.

5.3 Our custody record analysis showed that someone concerned about the welfare of detainees was informed of their whereabouts. However, only three out of 40 custody records said a free telephone call had been offered with no reasons given for this.

5.4 Only 16 immigration detainees had been held in the previous six months. They were usually dealt with by UK Border Agency (UKBA) officials within 24 hours, although staff said there had been delays of up to three days. Custody officers actively chased UKBA for updates on individual cases and used the standard operating procedure to escalate matters when necessary.

5.5 A professional telephone interpreting service was used when required during the booking in and risk assessment processes and to explain detainees' rights. However, custody sergeants could not demonstrate that the service was used during healthcare examinations and did not think it was used for healthcare assessments. Local interpreters from an agency could attend custody suites on request. Notices in several languages explaining detainees' rights and how the courts worked were displayed in front offices in custody suites. Spoken versions of detainees' rights were also available in a wide range of languages through a computer programme at Carlisle.

5.6 The NSPIS custody system prompted custody staff to ask detainees about any other issues they should know about, but custody records did not demonstrate that dependency issues were routinely recorded or actively addressed. Some, but not all, staff were aware of

dependency obligations of detainees. They said they would bail detainees with such obligations when possible and make arrangements to interview and process them at a later date. Failing that, they would inform social services or make alternative arrangements with family members.

5.7 Staff were generally aware of vulnerable detainees and the need to prepare pre-release risk management plans for then, although custody records indicated that assessments were not always carried out. We saw a custody officer, custody manager and healthcare professionals discussing a vulnerable detainee and the care plan that needed to be produced. However, there was no record of what had been done to ensure the safety of one 13 year old who had been released at 1am. There were good links between custody and basic command unit public protection units for supporting detainees bailed with relevant charges.

Rights relating to PACE

5.8 Reviews of detention were timely and appropriate. We observed a number of reviews held in person and remotely by telephone. The role of the reviewing officer was explained to detainees, who were spoken to directly or given the opportunity to speak to the reviewing officer by telephone. Any delays for operational reasons were endorsed on the custody record.

5.9 Apart from at Workington, all custody suites had up-to-date copies of PACE available for detainees to read. All suites also held copies of the guidance on the safer detention and handling of persons in police custody (SDHP), which custody sergeants readily referred to.

5.10 Local social services provided a good appropriate adult service, via the local Youth Offending Service, to detainees under the age of 17, although staff said this was less reliable out of hours when delays could occur or appropriate adults might not be available. Out-of-hours support could amount to no more than a telephone conversation with the duty social worker. Juveniles were not interviewed unless accompanied by an appropriate adult, but Cumbria continued to adhere to the PACE definition of a child instead of the Children Act definition, which meant those aged 17 were not provided with an appropriate adult unless otherwise deemed vulnerable.

5.11 Custody sergeants and inspectors were considerate and caring in their approach to juveniles in police custody and we witnessed some professional interactions between custody sergeants, juveniles and their parents. Custody officers used their own assessment and local knowledge, intelligence systems (Sleuth) and previous checks on the custody system to determine whether the appropriate adult was a suitable person.

5.12 A healthcare professional was called to assess any detainee thought to be unfit to be interviewed or detained due to drugs or alcohol. Interviews did not take place until the detainee had been declared fit. We saw custody officers and healthcare professionals discussing in detail with detainees their medical and welfare needs. Detainees brought in late at night were allowed at least eight hours of rest before being interviewed. We heard one sergeant checking with a healthcare professional that a detainee who had been unwell during the night had had enough rest and was now fit for interview.

5.13 The force did not have access to video links to the courts and detainees who were charged were promptly put before the courts. However, early cut-off times of noon for Kendal and 12.30pm for Barrow meant detainees sometimes remained in police custody longer than necessary. In one case we were told about, staff unsuccessfully tried to book a detainee into

court on Friday lunchtime, so the detainee spent the entire weekend in the custody suite before he could appear in court the following Monday.

5.14 Custody staff described good relations with defence solicitors and the interactions we saw were professional. Defence solicitors were give access to information on custody records, and they or the detainee could apply in writing for a copy of the record itself.

5.15 Systems to ensure the continuity of evidence and DNA were robust and the best we have seen. All fridges and freezers in custody suites, post rooms or CID offices had carbonated evidence and continuity logs in which officers and staff were required to record what was put in, when and by whom. This was then endorsed by the person picking up the sample or exhibit for onward transportation. However, one to two samples were left in fridges and freezers because they had not been entered in the appropriate log. Staff were not sure who was routinely responsible for monitoring the contents of the fridges and freezers.

Rights relating to treatment

5.16 Detainees arriving in custody were not told or given information about how to make a complaint. There was a clear force policy for dealing with complaints in custody, by which the duty inspector would take a complaint from a detainee once they had been discharged from custody, but before they left the police station. Complaints by detainees who remained in custody having been charged with an offence were taken while they were still in police custody. We heard inspectors carrying out reviews of detention explaining their rights to detainees and asking if they wanted to make any representations to the inspector reviewing their case, which included an explanation of how to make a complaint. Despite this, some custody staff at Carlisle still said they would refer complainants to the front desk of the police station on release.

5.17 Complaints, including racist complaints, were categorised on the force computer and trends identified and picked up by headquarters staff.

Recommendations

5.18 **Children detained under section 46 of the Children Act should not be held in police cells.**

5.19 **Unless there is a clear reason not to do so, detainees should be offered a free five-minute telephone call when they arrive in custody.**

5.20 **Managers should liaise with the UK Border Agency to ensure that immigration detainees are held in police custody for the shortest possible time.**

5.21 **A professional telephone interpreting service should be used as necessary when detainees are examined by healthcare professionals.**

5.22 **Custody staff should ensure that any detainee dependency issues are identified and, where possible, addressed.**

5.23 **Formal pre-release risk management planning for vulnerable detainees should be implemented consistently and any actions taken recorded on NSPIS.**

5.24 **Up-to-date PACE codes of practice should be readily available at Workington.**

5.25 Appropriate adults should be available 24 hours a day to support juveniles and vulnerable adults in custody.

5.26 Detainees aged 17 years should be provided with an appropriate adult.

5.27 The court service and the responsible assistant chief constable should work together to minimise delays in holding detainees who are to be produced at court, including the early introduction of video links.

5.28 The force should review and put in place a standard operating procedure and follow up mechanism that identifies and ensures that exhibits or forensic samples in fridges or freezers but not entered in log books are not overlooked.

5.29 Information about how to make a complaint should be given to all detainees during the booking in process in a format they understand and clearly displayed in the custody suites.

5.30 All staff in custody suites should be fully aware of the force policies for taking and dealing with complaints.

6. Healthcare

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

6.1 Cumbria Constabulary commissioned a private health service provider, Medacs, to provide health services to detainees. Medacs subcontracted the service provision in the north to a local GP practice and provided a nurse-only service in the south and west. Some clinical governance arrangements, particularly relating to medicines management and the storage of clinical records, were of great concern. Reported response times were dubious. Access to services for detainees with substance use problems differed across the county and services for detainees with mental health issues were poor. There was an urgent need to address shortfalls in healthcare provision.

Clinical governance

6.2 Primary health services for detainees were contracted to Medacs, who had inherited the contract in August 2007. They provided a nurse-only service in the south and west and subcontracted the service to a GP practice that had a longstanding arrangement with the custody suite in Carlisle. All the GPs were forensic medical examiners (FMEs). We saw nurses and doctors at work, but some calls were dealt with by telephone without the healthcare professional seeing the detainee (see paragraph 6.8). In our survey, detainees complained that they could not see a doctor. Most doctors were male, but they said a female detainee would be able to see a female doctor, although this might take several hours to organise. No one we spoke to could confirm that this was explained to female detainees.

6.3 Medacs had a comprehensive induction programme for new staff, and training for nurses and doctors was organised on a monthly rolling programme. One of the doctors undertook the nurses' appraisals and the doctors were subject to appraisal through their GP work. The monthly training was planned based on needs identified during the appraisal process. There was a lead nurse and a lead doctor for the county, although it was unclear exactly how the roles were defined. Discussions with Medacs managers and the police indicated that there was little monitoring of the day-to-day working of individual staff.

6.4 The clinical rooms in the four designated suites were all relatively spacious, clean and tidy. A separate clause in the cleaning contract stated how the rooms should be cleaned after forensic examinations, but nothing specific about day-to-day cleaning to meet infection control guidance. We found six bottles of out-of-date disinfectant and out-of-date forensic collection kits at Carlisle. The rooms in undesignated suites varied, with some sparse and others used for several things, including at Penrith where the room also housed the intoxalater. None of the rooms at undesignated suites were stocked and ready for immediate use. None of the sharps bins in any of the suites were dated and signed when first used and most clinical waste bins contained non-clinical waste. There was also some out of date stock, such as syringes. Access to the rooms in the designated suites varied. At Carlisle, the room was constantly left open. Staff seemed surprised when we asked for the key and could not find it. At Workington, the room key was attached to the keys for all the medicine cupboards, which was poor practice.

6.5 Medications were stored in a variety of places. Each designated suite had a medicine cupboard in the clinical room, the keys to which were usually held in the custody suite. There was also a medication cupboard by the custody desk, to which custody staff had access. All the cupboards held 'stock' medicines, although we could not find a stock list, patients' own medication that had been issued but not used and out of date medications. At Carlisle, detention officers put unwanted medications in a large, almost full pharmacy collection bucket that doctors knew nothing about and did not know who should empty it. There were medications dating back to 2005 at Penrith, with no record of stock held. At Workington, there were 17 different types of medications that were no longer needed, but had not been disposed of, all of which were immediately removed and destroyed in the correct way as soon as we pointed them out. However, no one actually knew who was responsible for the disposal of unwanted medications. Barrow, Kendal and Workington all contained a large number of drugs that had expired.

6.6 Only Workington had a defibrillator and oxygen and custody staff trained in their use. We were told this was because Workington had been the first site, but that a programme of training and the installation of defibrillators and oxygen to all custody suites was starting imminently. Not all Medacs staff were trained in resuscitation. There was a defibrillator at Millom, but no one knew how it had got there, it had not been checked and the pads were out of date. Suction equipment in each of the designated suites was still in its original packaging and not ready for use.

Patient care

6.7 Detainees were asked on arrival whether they wished to see a health professional. Custody staff contacted a central call centre to request a health professional. Medacs had set response times varying from one to two hours depending on the nature of the call. Custody staff did not know what the healthcare response times should have been and the police did not appear to challenge the monthly monitoring figures given to them at contract review meetings. Medacs stated that it met at least 99% of all calls within the designated response times, but we had considerable doubts about these claims.

6.8 We found evidence of doctors and nurses giving telephone advice, often within a few minutes of a call by custody staff. Medacs considered this to be a response to a call. In one case, a detainee had complained after his arrest of possible fractured ribs after a struggle with custody staff. A doctor had been called, had responded by telephone within three minutes and, according to a note in the custody record, advised custody staff to 'keep an eye' on the detainee and to contact the doctor again if he became short of breath. Staff contacted Medacs again some time after this and 122 minutes later the detainee was seen by a doctor. This was over eight hours after the original call. Another detainee had waited three hours to see a doctor. We also found evidence of call centre staff 'booking' an appointment for a healthcare professional to attend at a specific time, so avoiding the nurse or doctor breaching the contractual time limits. None of the health professionals were based in the custody suites.

6.9 There was a short list of medications that nurses could administer against patient group directions (PGDs), as none were nurse prescribers. Some medications were prescribed by doctors and nurses over the telephone for custody staff to administer. For nurses, this was in breach of their Nursing and Midwifery Code (2008) and Standards for Medicine Management (2007), which state that 'the administration of drugs via a PGD may not be delegated'. The Medacs book of clinical protocols, which condoned the practice of over-the-phone prescribing for doctors and nurses for paracetamol, GTN (angina) spray and asthma inhalers, made no mention of the Code.

6.10 In one case, custody staff contacted a doctor to prescribe anti-epileptic medications that police had retrieved from a detainee's home. The detainee had been seen earlier by a doctor, who had noted that the detainee usually took night sedation and an anti-psychotic medication, neither of which were prescribed at the time owing to the detainee's clinical state. The doctor prescribed the anti-epileptic medication over the telephone to the detention officer, but at no time was he made aware of the detainee's previous consultation with a doctor. The custody sergeant did not feel that he was in a position to challenge the doctor's actions.

6.11 Detainees with drug or alcohol addictions were not well served by Medacs staff. Health professionals had a 'no methadone' policy, the only exception being a pregnant woman who was a methadone user. Detainees had to wait at least six hours before getting any symptomatic relief and those suffering opiate withdrawal were given dihydrocodiene (DF118) only if considered to be in severe withdrawal. One prisoner told us he believed he had been forced to go into withdrawal.

6.12 None of the clinical rooms had a computer terminal, so healthcare staff had to add relevant consultation information for the police to the NSPIS record on any computer they could use. They then kept their original clinical records and took them away for storage. The doctors kept their records at their surgery, where there were reasonable storage facilities, but the nurses took them home, as suggested in the Medacs staff induction handbook. This was clearly in breach of Caldicott guidelines and Information Governance Guidance on legal and professional obligations (2007).

6.13 Staff we spoke to had differing views on whether they would provide a detainee with a copy of their clinical records and there was no clear policy.

Substance use

6.14 Substance use services were provided by the voluntary organisation Crime Reduction Initiative (CRI). A worker attended the Carlisle suite every weekday morning and evening, but attendance was less at other suites. In Kendal, a worker visited only once or twice a week. The workers saw adults with drug or alcohol addiction and undertook initial assessments in custody if possible, but were not contracted to deal with juveniles who they could only signpost to alternative specialist services. When they were not available, custody staff referred detainees to the service through a 24-hour manned telephone line, completed the relevant paperwork and faxed it to the team.

6.15 In our survey, 73% of respondents, significantly more than the comparator of 57%, said they had drug or alcohol problems. Records indicated that 598 referrals had been made to the pilot Cumbria alcohol arrest referral scheme (CAARS) in the year to the end of June 2009. Of these, only 47 were voluntary referrals by custody staff compared to 118 voluntary referrals by substance use workers. The vast majority were as a result of conditional bail instructions. Just over a third of all referrals were from Workington, while only 13% were from Kendal. Voluntary referrals by custody staff had the lowest rate of subsequent attendance, while conditional caution had the best.

6.16 For those with drug problems, the data were not divided between custody suites. Annual performance targets were set by the drug intervention programme, which included 35 custody suite contacts a month. Records indicated that in the year from June 2008 to May 2009, this target had been met or exceeded in only two months and that in other months fewer than 20 contacts had been made.

6.17 Drug workers initially saw clients, then took them onto their caseloads, which provided continuity of care. In our analysis of custody records, only one detainee was recorded as having seen a substance misuse worker. Detainees were not offered clean needles or other 'works' on release from custody, even though we found a large crate of needle exchange packs in the clinical room cupboard at Workington.

Mental health

6.18 Mental health services for detainees in custody were poor despite a county-wide 'mentally disordered offenders protocol' signed by the chief constable, director of social services and chief executives of health organisations. There were mental health crisis teams, but they had limited criteria for referral.

6.19 If a detainee presented with mental health issues, custody staff first had to contact Medacs staff to see them. In the north, they were assessed by FMEs and referred if necessary to the local mental health service, with which they had a good relationship. However, the process was less well defined for detainees in the south and west, where nurses undertook what was described to us by managers as a 'mental health status' and then referred the detainee either to the crisis team (which, given their criteria for referral, was not always appropriate) or to a local GP with relevant experience, who was then paid by Medacs for his/her services. Custody staff described delays in getting detainees with mental health problems seen and treated appropriately.

6.20 Police officers could use section 136 suites at local hospitals throughout the county, but described problems in accessing them. The police did not collate any figures on the number of referrals to the 136 suites.

Recommendations

6.21 **There should be an urgent review of the provision of health services to ensure that the physical, mental and substance use needs of detainees are met in good time by competent healthcare professionals.**

6.22 **The contract for health service provision should be robustly managed by the constabulary and performance data challenged when appropriate.**

6.23 **Nursing staff should ensure that they adhere to their Nursing and Midwifery Code and remember that they are personally accountable for actions and omissions in their practice and should always be able to justify their decisions.**

6.24 **Female detainees should be told that they can see a female doctor on request.**

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

6.26 **There should be safe pharmaceutical management and use. All medications should be stored safely and securely and disposed of safely if not consumed.**

6.27 **Resuscitation equipment should be available and ready for use in every custody suite and all staff trained in its use.**

6.28 Healthcare professionals should attend in person within the agreed response times when detainees request to see them or custody staff assess that their services are required.

6.29 Health professionals should not provide prescriptions for medications over the telephone for non-health professionals to administer.

6.30 Detainees should be able to continue with prescribed medications for any clinical condition and to receive medications to provide relief for drug and alcohol withdrawal symptoms if needed.

6.31 All clinical records should be stored in line with Caldicott guidelines, the Data Protection Act and other relevant legislation.

6.32 Access to services for detainees with substance use issues should be consistent across the county and adequate services for juveniles provided.

6.33 Injecting drug users who are released into the community should be offered clean needles by drugs workers.

6.34 There should be a liaison and/or diversion scheme that enables detainees with mental health problems to be identified and diverted into appropriate mental health services or referred on to prison health services.

Housekeeping points

6.35 The forensic medical examiner rooms should be locked when not in use.

6.36 Sharps bins should be dated and signed when first used.

6.37 There should be regular checks of all stocks to ensure that they are not out of date.

7. Summary of recommendations

Strategy

7.1 The current staffing model in custody suites should be reviewed to ensure sufficient staff are on duty to provide an appropriate level of care to detainees. (3.19)

7.2 The time detention officers are taken away from work ensuring the welfare and safety of detainees should be assessed and monitored to ensure these core duties can be effectively carried out. (3.20)

7.3 Custody staff should be released to attend off-the-job refresher training. (3.21)

7.4 The dissemination of good practice and lessons learned should be improved to ensure that all staff are fully briefed and up to date with current practices and knowledge. (3.22)

7.5 Use of force should be monitored centrally to enable managers to identify patterns and monitor trends. (3.23)

7.6 There should be a clear policy for staff outlining when the use of Tasers or incapacitant sprays is justifiable and proportionate within a custodial environment. (3.24)

Treatment and conditions

7.7 Refresher training should be offered that incorporates the specific needs of female detainees, detainees with disabilities and those with differing religious needs. (4.28)

7.8 Operational staff should receive child protection awareness training. (4.29)

7.9 All female detainees should be offered a hygiene pack on arrival in custody. (4.30)

7.10 There should be clear policies to meet the needs of detainees with disabilities or mobility issues while in custody. (4.31)

7.11 Booking-in desks should be of an appropriate height and the reception area should allow adequate privacy for new arrivals. (4.32)

7.12 Closed-circuit television monitors should be visible only to staff. (4.33)

7.13 All cells should be fit for purpose and free of ligature points, and custody staff should be trained to identify potential ligature points. (4.34)

7.14 All staff should carry anti-ligature knives. (4.35)

7.15 Regular fire evacuation drills and smoke detector tests should be conducted. (4.36)

7.16 The daily, weekly and monthly health and safety, maintenance and cleanliness checks should be reviewed and formalised across the custody estate. They should be fully recorded and

monitored by custody site managers to ensure identified issues are progressed and actioned accordingly. (4.37)

7.17 All custody staff should receive refresher self-harm and suicide training. (4.38)

7.18 Handcuffs should be removed as soon after arrival in custody as is practical, subject to risk assessment. (4.39)

7.19 Views of in-cell toilets covered by closed-circuit television should be obscured. (4.40)

7.20 Detainees held overnight and those who are dirty should be offered a shower and shower areas should allow sufficient privacy, particularly for female detainees. (4.41)

7.21 Detainees held overnight or for over eight hours should be offered outdoor exercise. (4.42)

7.22 A change of underwear should be provided for all detainees when appropriate. (4.43)

7.23 On an individual needs assessed basis, nicotine replacement should be available to smokers. (4.44)

7.24 Pillows should be provided routinely to all detainees. (4.45)

7.25 The calorific content of microwave meals should be improved. Meals should be offered to detainees on arrival and then when requested at meal times. (4.46)

Individual rights

7.26 Children detained under section 46 of the Children Act should not be held in police cells. (5.18)

7.27 Unless there is a clear reason not to do so, detainees should be offered a free five-minute telephone call when they arrive in custody. (5.19)

7.28 Managers should liaise with the UK Border Agency to ensure that immigration detainees are held in police custody for the shortest possible time. (5.20)

7.29 A professional telephone interpreting service should be used as necessary when detainees are examined by healthcare professionals. (5.21)

7.30 Custody staff should ensure that any detainee dependency issues are identified and, where possible, addressed. (5.22)

7.31 Formal pre-release risk management planning for vulnerable detainees should be implemented consistently and any actions taken recorded on NSPIS. (5.23)

7.32 Up-to-date PACE codes of practice should be readily available at Workington. (5.24)

7.33 Appropriate adults should be available 24 hours a day to support juveniles and vulnerable adults in custody. (5.25)

7.34 Detainees aged 17 years should be provided with an appropriate adult. (5.26)

7.35 The court service and the responsible assistant chief constable should work together to minimise delays in holding detainees who are to be produced at court, including the early introduction of video links. (5.27)

7.36 The force should review and put in place a standard operating procedure and follow up mechanism that identifies and ensures that exhibits or forensic samples in fridges or freezers but not entered in log books are not overlooked. (5.28)

7.37 Information about how to make a complaint should be given to all detainees during the booking in process in a format they understand and clearly displayed in the custody suites. (5.29)

7.38 All staff in custody suites should be fully aware of the force policies for taking and dealing with complaints. (5.30)

Healthcare

7.39 There should be an urgent review of the provision of health services to ensure that the physical, mental and substance use needs of detainees are met in good time by competent healthcare professionals. (6.21)

7.40 The contract for health service provision should be robustly managed by the constabulary and performance data challenged when appropriate. (6.22)

7.41 Nursing staff should ensure that they adhere to their Nursing and Midwifery Code and remember that they are personally accountable for actions and omissions in their practice and should always be able to justify their decisions. (6.23)

7.42 Female detainees should be told that they can see a female doctor on request. (6.24)

7.43 There should be clear infection control procedures, including cleaning schedules that should be adhered to and monitored. (6.25)

7.44 There should be safe pharmaceutical management and use. All medications should be stored safely and securely and disposed of safely if not consumed. (6.26)

7.45 Resuscitation equipment should be available and ready for use in every custody suite and all staff trained in its use. (6.27)

7.46 Healthcare professionals should attend in person within the agreed response times when detainees request to see them or custody staff assess that their services are required. (6.28)

7.47 Health professionals should not provide prescriptions for medications over the telephone for non-health professionals to administer. (6.29)

7.48 Detainees should be able to continue with prescribed medications for any clinical condition and to receive medications to provide relief for drug and alcohol withdrawal symptoms if needed. (6.30)

7.49 All clinical records should be stored in line with Caldicott guidelines, the Data Protection Act and other relevant legislation. (6.31)

7.50 Access to services for detainees with substance use issues should be consistent across the county and adequate services for juveniles provided. (6.32)

7.51 Injecting drug users who are released into the community should be offered clean needles by drugs workers. (6.33)

7.52 There should be a liaison and/or diversion scheme that enables detainees with mental health problems to be identified and diverted into appropriate mental health services or referred on to prison health services. (6.34)

Housekeeping points

Treatment and conditions

7.53 Cleaning of plinths should be carried out using separate materials and cleaning implements. (4.47)

Healthcare

7.54 The forensic medical examiner rooms should be locked when not in use. (6.35)

7.55 Sharps bins should be dated and signed when first used. (6.36)

7.56 There should be regular checks of all stocks to ensure that they are not out of date. (6.37)

Good practice

Strategy

7.57 The Barrow independent custody visitors (ICV) members were piloting 'observational visits' where ICVs were prepared to sit and observe interactions between custody staff and detainees for several hours at a time. This had led to a greater understanding of the nature of the custody role and the challenges posed by it. (3.25)

Treatment and conditions

7.58 Staff at Kendall allowed family and friends to bring in clean clothing and food in sealed containers for detainees. (4.48)

Appendix I : Inspection team

Peter Todd	– Assistant Chief Inspector of Constabulary
Sean Sullivan	– HMIP team leader
Martin Owens	– HMIP inspector
Andrew Rooke	– HMIP inspector
Paddy Craig	– HMIC inspector
Fiona Shearlaw	– HMIC inspector
Elizabeth Tysoe	– HMIP healthcare inspector
Steve Quinn	– CQC healthcare inspector
Catherine Nichols	– HMIP researcher

Appendix II : Custody Record Analysis

Background

As part of the inspection of Cumbria police custody cells, a sample of the custody records of detainees held between 24 August and 30 August 2009 were analysed. Custody records were held electronically on NSPIS. A total sample of 40 records were analysed from across the Cumbria area:

Custody suite	Number of records analysed
Kendal	8
Carlisle	12
Workington	12
Barrow	8
TOTAL	40

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

Demographic information

- Thirteen (33%) of the detainees were female and 27 were male.
- Seven people (18%) under the age of 17 were included in the sample, the youngest was 12 years old.
- All but one person was of White origin and the exception was Mixed White and Asian Heritage. Within the White detainees, there was one White Irish person and two from White backgrounds other than British and Irish.
- Fourteen (35%) detainees had been held overnight, including those who had arrived during the night and were not released until the morning. Four (10%) had been held for more than 24 hours, all of whom were to attend court and three of them over a weekend. The longest period noted was 67 hours. One was released before attending court as a CPS decision on a breach of bail could not be made in good time so he was granted bail.

Removal of clothing

Six (15%) detainees had had clothing removed:

- One man had is clothing forcibly removed and was left without replacement clothes for nine hours in his cell as he was drunk and violent on arrival so no risk assessment could be completed.
- Another had clothing removed because no assessment of risk could be made. On this occasion, there were no self-harm suits available, so he was left in his underpants and given a blanket. He tied the blanket around his neck, which was subsequently removed along with his underpants. Some self-harm shorts were then found, but the detainee refused to wear them and went on to tie them around his neck. The shorts were then removed too. In total, he was naked in his cell for seven hours.
- One man was left in a T-shirt and replacement underwear, as his had cords, for six hours. This was because he attempted suicide three years previously and no self-harm clothing was available.
- One woman was given a replacement top as hers had wire around the neck. Another woman was placed in a paper suit as she had a history of self-harm, although the officers

offered the chance to wear trousers during her interview. Finally, one man was also placed in a suicide suit due to previous self-harm/suicide attempts.

There was discretion in the removal of clothing, allowing one woman to keep her clothes, but under constant supervision. She attempted to kill herself by jumping off a bridge and stated in custody that she was going to kill herself when she got home.

Young people

- For all seven of the young people in our sample, appropriate adults had been requested. Six were interviewed in the presence of the appropriate adult, one was not interviewed and all had appropriate adults present for the reading of their rights.
- One young girl aged 13 was released at 1.04am and there was no pre-release risk assessment or consideration noted of where she was going. She had been arrested for kicking a car, which caused damage.
- One young boy aged 12 was arrested for picking things out of a skip. He was not placed in a cell as it was his first time in custody. He had been given street bail in order to arrange an appropriate adult for interview.
- One young boy aged 13, who was in the care of Newham social services, had a prolonged wait as social services insisted on a solicitor being called and then there was confusion and difficulty finding an appropriate adult.

Interpreters

One (3%) detainee in the sample could not understand English and required an interpreter. It was a pre-planned attendance at the station from prison so an interpreter was ready at the station throughout the process. The detainee was also a foreign national and was informed of his foreign national rights with the interpreter present.

There were no immigration detainees in the sample.

Inspector reviews

Inspector reviews were held in line with requirements. A few reviews were conducted at a delayed time or without the involvement of the detainee due to other operational commitments. It was unclear what the nature of the operational reasons were as one record stated operational reasons and a later entry suggested it was so as not to disturb her period of rest. The time was 1.52pm and the detainee had been awake before the review intermittently, and seven minutes after the review was visited and spoken to. It was not until 2.48pm that was she informed of the review, when she was taken out for interview.

One review was made on the wrong detainee's record.

Services

- Three detainees asked to make a telephone call and were granted that call and another three detainees were offered the opportunity to make a call and accepted. The remaining 34 (85%) detainees were not offered, and did not ask for, the opportunity to make a call.
- Twenty-one (53%) detainees had legal representation. Two of these had significant waiting periods for their representation to arrive. One waited an hour and another over two

hours, as the solicitor was coming from Lancaster. One other detainee had their interview postponed as the legal representation could not make the time of interview.

- Two interviews were delayed because no interview rooms were available.
- No detainees shared a cell while in custody.
- Ten (25%) detainees had requested to see the FHCP. Seven of these detainees had seen the FME.
  - Three detainee left custody before a FHCP had arrived: one had blood pressure problems, one had been sprayed with PAVA and had vomited, and one had respiratory problems.
  - The longest wait was one hour, but several consultations happened over the telephone rather than in person. This was the case even when the prescribing of medicines was necessary. Sometime the prescriber was detailed as a doctor, sometimes a nurse.
- One detainee saw an independent alcohol worker and no one was recorded as seeing a drugs worker. It was not recorded that any detainees requested to see a drugs or alcohol worker.
- Twenty-nine (73%) detainees were recorded as not having a meal throughout their time in custody. Eleven (28%) detainees had eaten at least one meal in custody. Seven had refused a meal, but of those who were not offered a meal at all, seven were in custody six hours or more, the longest being 17 hours.
  - One man was in custody for 34 hours having only been offered one meal, which he declined.
  - Long periods between meals for some were as a result of declining the meals on offer. Five detainees refused more than one meal.
- Two (5%) detainees had received a shower.
  - One detainee had vomited over the mattress and on the floor, and was lying in it. In response, a blanket was given to him to place on the mattress. The detainee was allowed a shower over 19 hours later. There was no evidence that he was moved cells or that his cell was cleaned.
  - One detainee was offered a shower by the custody staff. This man was in custody for 45 hours.
  - One detainee asked for a shower, but was not given one. He was in custody for 67 hours. The detainee first requested a shower at 9.05pm and was told he could have a shower at 5pm the following day. The same message was given for clean clothes. When this time came, he was told staff were too busy. Use of washing facilities was allowed, but no shower and clean clothes were given.
- One detainee had received outside exercise, but this was because he was feeling 'queasy' and it was on request from the FHCP.
- Seven detainees had been provided with reading materials.

Additional points of note

- Two detainees were given visits from their family: one in a visits room, the other in the exercise yard under supervision.
- Two custody records ended ambiguously, making it unclear when the detainee left or what the outcome was.
- There were two cases of detainees coming in who were suffering the effect of PAVA spray. One of these detainees was pregnant and had been cross-contaminated. She saw a nurse who was at the station, but when a doctor was requested there was no reply from Medacs. When Medacs was contacted 15 minutes later, they informed the station that someone would call back. No other contact with Medacs was then recorded and neither was a visit by a doctor. Medacs could not be contacted for the second person sprayed with PAVA and he left without seeing an FCHP.

- At least one custody record has been overwritten with a new entry for the same person, due to an error in the software.
- Regular reviews of risk levels posed were taking place and the level of observations changed in accordance.
- Contact with family, keeping them up to date on action taken and requests were carried out by staff, which was very positive (e.g. passing on messages to one detainee's father so that he could set his house alarm).
- One detainee was turned away at the desk because there was no power of arrest. One other detainee's charges were later dropped because her actions were attempts to commit suicide rather than criminal actions.
- Outstanding warrants were routinely checked, as was STAN, the firearms database.

Appendix III : Summary of detainee questionnaires and interviews

Prisoner survey methodology

A voluntary, confidential and anonymous survey of the prisoner population, who had been through a police station in Cumbria, 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 9 September 2009. A list of potential respondents to have passed through Durranhill/Carlisle, Workington, Kendal, Whitehaven and Barrow-in-Furness police stations was created, listing all those who had arrived from Kendal, Carlisle, Workington, Penrith and Barrow-in-Furness Magistrates court within the past month.

Selecting the sample

In total, 47 respondents were approached. Two respondents reported either being held in police stations outside Cumbria or having been in a Cumbrian station longer than two months ago. On the day, the questionnaire was offered to 45 respondents; there was one refusal and one non-return. All of those sampled had been in custody within the last two months.

Completion of the questionnaire was voluntary. No interviews were carried as none of the respondents had literacy difficulties.

Methodology

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

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

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

Respondents were not asked to put their names on their questionnaire.

Response rates

In total, 43 (96%) respondents completed and returned their questionnaires.

Comparisons

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

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

The current survey responses were analysed against comparator figures for all prisoners surveyed in other police areas. This comparator is based on all responses from prisoner surveys carried out in 13 police areas since April 2008.

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

Summary

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

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

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

Police Custody Survey

Section 1: About You

Q2 What police station were you last held at?

Kendal – 1; Workington - 15; Carlisle - 26; Not recorded - 1

Q3 What type of detainee were you?

Police detainee	93%
Prison lock-out (i.e. you were in custody in a prison before coming here)	0%
Immigration detainee	0%
I don't know	7%

Q4 How old are you?

16 years or younger	0%	*40-49 years*	16%
17-21 years	0%	*50-59 years*	5%
22-29 years	35%	*60 years or older*	0%
30-39 years	44%		

Q5 Are you:

Male	100%
Female	0%
Transgender/Transexual	0%

Q6 What is your ethnic origin?

White - British	95%
White - Irish	0%
White - Other	0%
Black or Black British - Caribbean	0%
Black or Black British - African	0%
Black or Black British - Other	0%
Asian or Asian British - Indian	2%
Asian or Asian British - Pakistani	0%
Asian or Asian British - Bangladeshi	2%
Asian or Asian British - Other	0%
Mixed Race - White and Black Caribbean	0%
Mixed Race - White and Black African	0%
Mixed Race - White and Asian	0%
Mixed Race - Other	0%
Chinese	0%
Other ethnic group	0%

Please specify:

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

Yes	8%
No	92%

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

None	33%
Church of England	42%

	Catholic	19%
	Protestant	2%
	Other Christian denomination	2%
	Buddhist	0%
	Hindu	0%
	Jewish	0%
	Muslim	2%
	Sikh	0%

Q9 **How would you describe your sexual orientation?**

Straight / Heterosexual	98%
Gay / Lesbian / Homosexual	2%
Bisexual	0%

Q10 **Do you consider yourself to have a disability?**

Yes	26%
No	71%
Don't know	2%

Q11 **Have you ever been held in police custody before?**

Yes	98%
No	2%

Section 2: Your experience of this custody suite

If you were a *'prison-lock out'* **some** of the following questions may not apply to you. If a question does not apply to you, please leave it blank.

Q12 **How long were you held at the police station?**

1 hour or less	0%
More than 1 hour, but less than 6 hours	3%
More than 6 hours, but less than 12 hours	5%
More than 12 hours, but less than 24 hours	20%
More than 24 hours, but less than 48 hours (2 days)	43%
More than 48 hours (2 days), but less than 72 hours (3 days)	28%
72 hours (3 days) or more	3%

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

Yes	71%
No	20%
Don't know/Can't remember	10%

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

Yes	37%
No	51%
I don't know what this is/I don't remember	12%

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

My clothes were not taken	65%
I was offered a tracksuit to wear	14%

I was offered an evidence suit to wear 14%
I was offered a blanket 8%

Q16 Could you use a toilet when you needed to?

Yes 93%
No 7%
Don't Know 0%

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

	Yes	*No*
Toilet paper	49%	51%

Q18 Did you share a cell at the police station?

Yes 0%
No 100%

Q19 How would you rate the condition of your cell:

	Good	*Neither*	*Bad*
Cleanliness	61%	27%	12%
Ventilation / Air Quality	36%	23%	41%
Temperature	28%	26%	46%
Lighting	60%	15%	25%

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

Yes 24%
No 76%

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

Yes 21%
No 79%

Q22 Were you held overnight?

Yes 95%
No 5%

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

Not held overnight 4%
Pillow 24%
Blanket 58%
Nothing 15%

Q24 Were you offered a shower at the police station?

Yes 14%
No 86%

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

Yes 5%
No 95%

Q26 Were you offered anything to:

	Yes	*No*
Eat?	90%	10%

Drink?	92%	8%

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

- ***I did not have any food or drink.*** ... 5%
- *Yes* ... 46%
- *No* ... 49%

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

- ***I do not smoke*** ... 14%
- *I was allowed to smoke* ... 7%
- *I was not offered anything to cope with not smoking* ... 79%
- *I was offered nicotine gum* ... 0%
- *I was offered nicotine patches* ... 0%
- *I was offered nicotine lozenges* ... 0%

Q29 Were you offered anything to read?

- *Yes* ... 29%
- *No* ... 71%

Q30 Was someone informed of your arrest?

- *Yes* ... 41%
- *No* ... 39%
- *I don't know* ... 10%
- *I didn't want to inform anyone* ... 10%

Q31 Were you offered a free telephone call?

- *Yes* ... 38%
- *No* ... 62%

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

- ***My phone call was not denied*** ... 43%
- *Yes* ... 5%
- *No* ... 52%

Q33 Did you have any concerns about the following, whilst you were in police custody:

	Yes	*No*
Who was taking care of your children	7%	93%
Contacting your partner, relative or friend	61%	39%
Contacting your employer	14%	86%
Where you were going once released	36%	64%

Q34 Were you interviewed by police officials about your case?

- *Yes* ... 76%
- *No* ... 24% If No, go to Q36

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

	Yes	*No*	*Not needed*
Solicitor	56%	38%	6%
Appropriate Adult	17%	30%	52%
Interpreter	0%	33%	67%

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

I did not requested a solicitor	40%
2 hours or less	8%
Over 2 hours but less than 4 hours	13%
4 hours or more	40%

Q37 Were you officially charged?

Yes	76%
No	24%
Don't Know	0%

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

I have not been charged yet	24%
1 hour or less	2%
More than 1 hour, but less than 6 hours	2%
More than 6 hours, but less than 12 hours	10%
12 hours or more	62%

Section 3: Safety

Q40 Did you feel safe there?

Yes	69%
No	31%

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

Yes	34%
No	66%

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

I have not been victimised	51%	*Because of your crime*	4%
Insulting remarks (about you, your family or friends)	11%	*Because of your sexuality*	0%
Physical abuse (being hit, kicked or assaulted)	9%	*Because you have a disability*	4%
Sexual abuse	4%	*Because of your religion/religious beliefs*	0%
Your race or ethnic origin	2%	*Because you are from a different part of the country than others*	4%
Drugs	11%		

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

Yes	49%
No	51%

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

Yes	17%
No	83%

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

Yes	14%
No	86%

Section 4: Healthcare

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

Yes	56%
No	44%

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

Not taking medication	45%
Yes	20%
No	35%

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

Yes	41%
No	49%
Don't know	10%

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

	Yes	*No*
Doctor	46%	54%
Nurse	27%	73%
Paramedic	4%	96%
Psychiatrist	4%	96%

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

Yes	28%
No	46%
Don't know	26%

Q52 Did you have any drug or alcohol problems?

Yes	73%
No	27%

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

I didn't have any drug/alcohol problems	28%
Yes	38%
No	35%

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

I didn't have any drug/alcohol problems	27%
Yes	34%
No	39%

Q55 Please rate the quality of your healthcare whilst in police custody:

	I was not seen by health -care	*Very Good*	*Good*	*Neither*	*Bad*	*Very Bad*
Quality of Healthcare	39%	2%	12%	12%	20%	15%

Q56 Did you have any specific physical healthcare needs?

No	66%

Yes 34%

Please specify: *Damaged spine which has cause irreversible nerve damage/ pain in my right leg*
High frequency deafness

Q57 Did you have any specific mental healthcare needs?

No 70%

Yes 30%

Please specify: *Depression & anxiety*
Reactive attachment disorder

Prisoner Survey Responses for Cumbria Police Custody 2009

Prisoner Survey Responses (Missing data has been excluded for each question) Please note: Where there are apparently large differences, which are not indicated as statistically significant, this is likely to be due to chance.

Key to tables

		Cumbria 2009	Police custody comparator
(green)	Any percent highlighted in green is significantly better		
(blue)	Any percent highlighted in blue is significantly worse		
(orange)	Any percent 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		43	462
SECTION 1: General Information			
2	Are you a Police detainee?	94%	86%
3	Are you under 21 years of age?	0%	10%
4	Are you Transgender/Transsexual?	0%	1%
5	Are you from a minority ethnic group? (including all those who did not tick White British, White Irish or White other categories)	4%	41%
6	Are you a foreign national?	7%	16%
7	Are you Muslim?	2%	14%
8	Are you homosexual/gay or bisexual?	2%	1%
9	Do you consider yourself to have a disability?	27%	17%
10	Have you been in police custody before?	98%	90%
SECTION 2: Your experience of this custody suite			
For the most recent journey you have made either to or from court or between prisons:			
11	Were you held at the police station for over 24hours?	72%	64%
12	Were you given information about your arrest and entitlements when you arrived?	71%	73%
13	Were you told about PACE?	36%	55%
14	If your clothes were taken away, were you given a tracksuit to wear?	40%	41%
15	Could you use a toilet when you needed to?	94%	88%
16	If you did use the toilet, was toilet paper provided?	49%	54%
17	Did you share a cell at the station?	0%	4%
18	Would you rate the condition of your cell, as 'good' for:		
18a	Cleanliness?	60%	25%
18b	Ventilation/air quality?	36%	18%
18c	Temperature?	29%	13%
18d	Lighting?	60%	42%
19	Was there any graffiti in your cell when you arrived?	25%	60%
20	Did staff explain the correct use of the cell bell?	21%	21%
21	Were you held overnight?	96%	90%
22	If you were held overnight, were you giveno clean items of bedding?	19%	33%
23	Were you offered a shower?	14%	7%

Key to tables

		Cumbria 2009	Police custody comparator
	Any percent highlighted in green is significantly better		
	Any percent highlighted in blue is significantly worse		
	Any percent highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
24	Were you offered a period of outside exercise?	**4%**	**5%**

Key to tables

		Cumbria 2009	Police custody comparator
(green)	Any percent highlighted in green is significantly better		
(blue)	Any percent highlighted in blue is significantly worse		
(orange)	Any percent highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
25a	Were you offered anything to eat?	90%	78%
25b	Were you offered anything to drink?	93%	82%
26	Was the food/drink you received suitable for your dietary requirements?	49%	39%
27	For those who smoke: were you offered **nothing** to help you cope with the ban there?	79%	76%
28	Were you offered anything to read?	29%	11%
29	Was someone informed of your arrest?	42%	42%
30	Were you offered a free telephone call?	39%	51%
31	If you were denied a free call, was a reason given?	7%	18%
32	Did you have ay concerns about:		
32a	Who was taking care of your children?	6%	18%
32b	Contacting your partner, relative or friend?	61%	53%
32c	Contacting your employer?	15%	23%
32d	Where you were going once released?	36%	36%
34	If you were interviewed were the following people present:		
34a	Solicitor	57%	76%
34b	Appropriate adult	19%	7%
34c	Interpreter	0%	10%
35	Did you wait over 4 hours for your solicitor?	68%	64%
37	Were you held 12 hours or more in custody after being charged?	81%	64%
SECTION 3: Safety			
39	Did you feel unsafe?	31%	42%
40	Has another detainee or a member of staff victimised you?	34%	45%
41	If you have felt victimised, what did the incident involve?		
41a	Insulting remarks (about you, your family or friends)	15%	27%
41b	Physical abuse (being hit, kicked or assaulted)	13%	16%
41c	Sexual abuse	4%	2%
41d	Your race or ethnic origin	2%	6%
41e	Drugs	15%	16%
41f	Because of your crime	4%	21%
41g	Because of your sexuality	0%	1%
41h	Because you have a disability	4%	3%
41i	Because of your religion/religious beliefs	0%	4%
41j	Because you are from a different part of the country than others	4%	5%

Key to tables

		Cumbria 2009	Police custody comparator
	Any percent highlighted in green is significantly better		
	Any percent highlighted in blue is significantly worse		
	Any percent highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
42	Were you handcuffed or restrained whilst in the police custody suite?	**49%**	**48%**
43	Were you injured whilst in police custody, in a way that you feel is not your fault?	**17%**	**28%**
44	Were you told how to make a complaint about your treatment?	**14%**	**13%**
SECTION 4: Healthcare			
46	Were you on any medication?	**56%**	**44%**
47	For those who were on medication: were you able to continue taking your medication?	**36%**	**40%**
48	Did someone explain your entitlement to see a healthcare professional, if you needed to?	**42%**	**36%**
49	Were you seen by the following healthcare professionals during your time in police custody:		
49a	Doctor	**46%**	**51%**
49b	Nurse	**26%**	**17%**
49c	Paramedic	**3%**	**2%**
49d	Psychiatrist	**4%**	**3%**
50	Were you able to see a healthcare professional of your own gender?	**29%**	**28%**
51	Did you have any drug or alcohol problems?	**73%**	**57%**
For those who had drug or alcohol problems:			
52	Did you see, or were offered the chance to see a drug or alcohol support worker?	**52%**	**41%**
53	Were you offered relief medication for your immediate symptoms?	**46%**	**35%**
54	For those who had been seen by healthcare, would you rate the quality as good/very good?	**24%**	**31%**
55	Do you have any specific physical healthcare needs?	**34%**	**35%**
56	Do you have any specific mental healthcare needs?	**30%**	**24%**