



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

28 – 30 September 2009

by

HM Inspectorate of Prisons and

HM Inspectorate of Constabulary

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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 detention¹. The inspections look at force-wide strategies, treatment and conditions, individual rights and healthcare.

At the time of the inspection, Wiltshire Constabulary had three custody suites designated for the reception of detainees under the Police and Criminal Evidence Act 1984 (PACE): Swindon, Melksham and Salisbury. A fourth suite in Marlborough was designated for use in exceptional circumstances but was not currently in use. There were a total of 73 cells in the designated suites, operating 24 hours a day. In the course of the inspection, all three suites were visited.

There was sound strategic management, with clear lines of accountability and appropriate oversight committees. Day-to-day management was devolved to the two respective basic command units (BCUs). All custody staff were permanent but we had concerns about the use of detention officers (DOs) for booking in detainees, which we regard as a principal function of custody sergeants. The constabulary felt well supported by the police authority and, they in turn, were informed by an effective team of independent custody visitors. Partnership working was generally satisfactory, although links with mental health services required improvement.

Relationships between staff and detainees were observed to be good. The needs of juveniles were adequately addressed. The specific needs of women and people with disabilities were not well met. A number of cells had ligature points. Showers were rarely offered, some toilets lacked privacy and toilet paper was not routinely supplied. The quality of catering varied. Good efforts were made to supply reading materials, and it was notable that visits were sometimes facilitated.

Staff generally adhered to PACE and ensured detainees received their entitlements. There was a high standard of pre-release risk assessment for vulnerable and young detainees. The appropriate adult scheme operated well during the day but less well at night, and was generally not applied to 17 year olds and there were significant difficulties in provision for vulnerable adults. Complaint systems needed to be improved, as did the management of forensic samples.

Healthcare provision was reasonable. Medical rooms were generally well kept and clinical records were properly managed. However, medicine management by police staff was a concern. Services for substance misusers varied, but was particularly good in Swindon. Services for those with mental health issues also varied but generally required improvement.

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

This inspection of police custody suites in Wiltshire provides an important degree of assurance to the public that, in most respects, police detention is well managed. We identify a number of areas for improvement and hope that this assists the chief constable and the police authority to improve provision further.

Denis O'Connor
HM Chief Inspector of Constabulary

Anne Owers
HM Chief Inspector of Prisons

November 2009

2. Background and key findings

- 2.1 HM Inspectorates of Prisons and Constabulary have a programme of joint inspections of police custody suites, as part of the UK's international obligation to ensure regular independent inspection of places of detention. These inspections look beyond the implementation of the Police and Criminal Evidence Act 1984 (PACE) codes of practice and the guidance on safer detention and handling of persons in police custody, and focus on outcomes for detainees. They were informed by a set of 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 this unannounced inspection, Wiltshire Constabulary had three main custody suites designated under PACE for the reception of detainees: Swindon in the north of the county, Melksham in the middle, and Salisbury in the south. In addition, Marlborough was designated for use in exceptional circumstances, but it had not been opened for some time and its status as a designated suite was under review. The three main suites operated 24 hours a day and dealt with detainees arrested as a result of mainstream policing. There were custody facilities in several other police stations in the force area, but these had either been decommissioned or were not in use.
- 2.3 This inspection was largely conducted in the three main designated custody suites, but we visited all sites with custody facilities in the force area. A survey of prisoners at HMP Bristol, who had formerly been detained at custody suites in the force area, was conducted by HM Inspectorate of Prisons researchers (see Appendix III).
- 2.4 The force cell capacity was 73. The largest suite was Swindon with 40 cells, which had held 3,947 detainees in the previous six months. Melksham had 20 cells and had held 3,182 detainees during the same period, and Salisbury had 13 cells, which had held 2,182 detainees. Marlborough had three cells. Suites held a mixture of adults, juveniles and immigration detainees. Comments in this report refer to all suites, unless stated otherwise.

Strategic overview

- 2.5 There was a clear line management structure from the deputy chief constable (DCC) to detention officers (DOs) working in custody suites. All staff working in custody were permanent, and designated suites were managed through a decentralised model with day-to-day operational management falling to the two basic command units (BCUs) in the force. Custody issues were formally discussed at three forums - a strategic group attended by the deputy chief constable and other senior managers, a custody managers group chaired by the responsible chief inspector, and a users group in each BCU.
- 2.6 The force had an estates policy agreed by the police authority, but this did not outline plans for any significant upgrade of the facilities in the oldest suite at Salisbury.
- 2.7 The staffing model used was a concern (see paragraph 3.7). There was in-house training for new custody staff, and plans for refresher training.
- 2.8 We were told about some good partnership work, but there could have been more engagement with mental health services. Partner organisations only attended the user group meeting, so there was no ongoing formal mechanism for resolving issues at a strategic level.

The force felt well supported by the police authority, and the independent custody visitor (ICV) scheme functioned well.

- 2.9 Some management sampling of the quality of custody records took place, but not always reliably. Good practice information was disseminated to custody staff.
- 2.10 A use of force form was completed and analysed for training purposes, but not for trends.

Treatment and conditions

- 2.11 We observed good relationships between staff and detainees, but there was a lack of privacy in booking areas and some front desks were extremely high and intimidating.
- 2.12 Juveniles were routinely placed on at least 30-minute observations and we saw examples of young or vulnerable detainees being held in interview rooms rather than cells. Staff were undertaking an e-learning child protection awareness training package.
- 2.13 There was little difference in the approach to dealing with women detainees. Staff received training about working with vulnerable and juvenile detainees in the initial custody module.
- 2.14 Initial risk assessments were generally compiled by detention officers under supervision of the custody sergeants who made the decision about risk levels. We saw some good examples of in-depth questions asked to assist these decisions. Staff routinely roused detainees when appropriate, and carried anti-ligature knives. Fire evacuation arrangements were good.
- 2.15 There were few cells or custody areas covered by CCTV, and the quality of the systems at Melksham and Salisbury were poor. Toilets in cells with CCTV were not obscured for detainee privacy.
- 2.16 We found ligature points in all suites, and some daily and weekly health and safety checks were not being done.
- 2.17 Standards of cleanliness in the main custody suites varied from good to adequate, but there was little graffiti.
- 2.18 Access for detainees with disabilities in Swindon and Melksham was good, but there were no specially adapted cells. This was a particular issue at Swindon, where all cells had low-level plinths.
- 2.19 Mattresses, pillows and blankets were routinely provided. Showers and outside exercise yards were available but rarely offered. Paper suits were usually provided for detainees when their clothes were taken, but tracksuits were available for those being released or going to court.
- 2.20 The quality and variety of food varied from suite to suite. Reading materials were routinely offered and visits sometimes facilitated.

Individual rights

- 2.21 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, there were still sometimes unacceptable

delays in waiting times to be collected by the UK Border Agency. Interpreting services were used appropriately.

- 2.22 Police contacted someone on behalf of a detainee to inform them of their whereabouts, but free telephone calls were rarely offered. Not all detainees were asked about any dependants. There were high standard pre-release risk management assessments for vulnerable and young detainees.
- 2.23 Staff mostly adhered to the Police and Criminal Evidence Act (PACE) and reviews were in accordance with this. Up-to-date copies of PACE were available in all suites. Detainees were not interviewed while under the influence of alcohol or drugs. The appropriate adult scheme for juveniles operated well during the day, but less so out of hours. Appropriate adults were not routinely provided for 17 year olds, and there were significant difficulties in provision for vulnerable adults.
- 2.24 Court cut-off times were generally reasonable, but there were no video-link facilities. The duty solicitor scheme worked well.
- 2.25 Systems for dealing with complaints were confused, and neither staff nor detainees were clear of the process.

Healthcare

- 2.26 Healthcare was delivered by G4S-employed forensic medical examiners and nurses providing 24-hour coverage. Healthcare professionals had an appraisal system, a good induction programme and refresher training.
- 2.27 The medical rooms in the designated suites were mostly good. The management of medicines by G4S was adequate. We were concerned about management of stocks by police staff in custody suites. Clinical records were scanned on to Niche (the electronic custody system) and the management of paper records was good.
- 2.28 When they were booked in, detainees were routinely asked if they wanted to see a healthcare professional. Average waiting times were usually within the hour, and we observed some good quality care being provided. Methadone was rarely given, but alternative opiate substitutes were provided.
- 2.29 Substance misuse services varied between a good proactive service in Swindon and less provision in the rest of the county. Drugs workers visited the suites and carried out initial assessments, but they could only provide signposting services to detainees with alcohol problems and juveniles. Needle exchange was offered on release from Swindon but not the other suites.
- 2.30 Services for detainees with mental health needs also varied between Swindon and the rest of the county. Section 136 suites were available, but there were examples where mental health service providers had not engaged positively with custody staff about the management of detainees needing this level of support. There were difficulties in accessing mental health assessments, and no mental health diversion scheme.

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 There was evidence of a strategic priority being given to custody and clear strategic direction for its development. The deputy chief constable had recently taken over responsibility for custody services, and a chief inspector had oversight of provision and was responsible for the strategic development of custody. Operational accountability was devolved to two basic command unit (BCU) commanders who were chief superintendents, and the BCU detective chief inspectors were tasked with ensuring quality services. Each BCU had a dedicated inspector as a custody manager. Six-weekly strategic custody management group meetings were supported by monthly meetings of custody managers and custody users.
- 3.2 The deputy chief constable was the senior portfolio holder for custody issues in Wiltshire Constabulary and had recently taken over this responsibility. There had been a large investment in the custody estate at Melksham (in 2002) and Swindon (2004). Proposed works to upgrade Salisbury, which was built in the 1930s, were minor, amounting to installation of a second booking-in terminal. Although Salisbury was an older custody suite with inherent design faults, we could find no evidence of a long-term strategic plan for its continued development.
- 3.3 A chief inspector based in the justice department (JD) at headquarters (HQ) had oversight of custody provision in Wiltshire 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. Operational accountability and the day-to-day management of custody were devolved to two BCU commanders who were chief superintendents covering the town of Swindon (D division) and the remaining county of Wiltshire (E division), though the BCU detective chief inspectors (DCIs) were tasked with ensuring that the custody suites delivered quality services.
- 3.4 The divisional custody suites were managed by inspectors who acted as the custody site manager. Within D division, this responsibility covered the Swindon suite, however, in E division, the custody site manager was responsible for both the Melksham and Salisbury custody suites. The inspectors were managed by the divisional DCIs.
- 3.5 Police and Criminal Evidence (PACE) issues and reviews of detention were carried out by duty inspectors, who also covered all critical incidents in their areas during their shift. These inspectors sometimes sought the assistance of the custody site managers to cover their PACE role. The custody site managers also had to cover the role of duty inspector, which led to them being taken away from their core duties for several days at a time. Staff expressed concerns that their tasks for the BCU sometimes conflicted with their duties in custody.
- 3.6 The custody site managers had line management responsibilities for the custody sergeants, detention officers (DOs) and variable hours detention officers (VHDOs) attached to their suites. The VHDOs were employed on a 'zero hours' contract and could be contacted at short notice to work at any custody suite in the force area. The police sergeants in the custody suites were posted into custody roles from their patrol teams shortly after promotion to the rank, to serve a minimum of one year in post. Overall, there were 20 custody sergeants across the force supported by 42 DOs and 18 VHDOs.

- 3.7 We had concerns about the current staffing model, which had been introduced under the Quest workforce modernisation programme. Under this, DOs were responsible for booking-in detainees on to the Niche electronic custody system, while the sergeant monitored this at all the booking-in terminals. Although the DO asked questions to establish the detainee's level of risk, the sergeant needed to engage with the detainee to carry out the overall risk assessment and set the level of observations they required. Because they were inputting information on to the computer system, the DOs were restricted in carrying out their primary role of dealing with the physical needs of detainees.
- 3.8 Staffing levels in the custody suite varied according to other force demands. For example, Swindon was staffed by one custody sergeant and three DOs or, at busier times, two custody sergeants and four DOs, to cover 40 cells. As a result two DOs could be booking-in or dealing with relevant computer issues, which left the remaining two DOs to deal with the physical welfare and safety of potentially 40 detainees - while also taking their fingerprints, photographs, DNA tests and footwear impressions. Staff said they felt under pressure at busy times when custody numbers were high.
- 3.9 Staff were well trained and focused on the needs of detainees. All custody sergeants and detention staff had received specific custody training before their deployment to the custody suites. The custody training course was a three-week in-force course based on a nationally approved model. This covered all aspects of custody duties, including legislation, roles and responsibilities, managing risk and harm, conflict management, use of the police national computer (PNC) and Niche custody system, and first aid. Refresher training was due to be offered to staff later in the year. A comprehensive custody procedures manual incorporated many aspects of the safer detention and handling of persons in police custody guidance and assisted staff in discharging their duties.
- 3.10 Rostered handover periods were factored into all shifts, except for the night shift to day shift handover at 7am, when the force was relying on the goodwill of custody staff to arrive early to complete the handover. However, following staff negotiations, it was agreed that from 26 October 2009, the next working day would begin at 6.30am, allowing the custody sergeant to be rostered formally for an early morning handover.
- 3.11 Six-weekly strategic custody management group meetings, chaired by the head of justice, were supported by monthly meetings of custody managers, chaired by the justice department chief inspector, and custody users meetings chaired by the custody site managers. The custody users meetings were attended by external representatives from G4S medical and forensics, arrest referral workers, crisis team workers, independent custody visitors (ICVs), social work, youth offending teams (YOTs), drugs intervention programme (DIP) and defence solicitors, and internal representatives from estates, health and safety, detention officers, local crime team and the DCI. This meeting was a forum to discuss and resolve local issues, but there was no such forum at a strategic level. Apart from the police authority lead member for custody, the membership of the strategic custody management group was restricted to internal departments.
- 3.12 There some good working relationships with partners across Wiltshire, although there was poor engagement with health services, which affected the delivery of these services to detainees. The police authority was positive about its relationship with the force.
- 3.13 There was a police authority lead for the ICV scheme, which was seen as an important independent oversight mechanism. ICVs were scheduled to visit the three main designated custody suites at least once a week, but this was not always achieved at Swindon. Salisbury had a problem with the recruitment and retention of ICVs, but had managed to achieve the

most visits. Feedback forms submitted after every visit were left with the custody sergeant, with whom any issues were raised, and then viewed by the custody site managers. These forms were routed back to the respective area coordinators who could seek resolution of any problem formally and informally with the custody site manager or through the police authority custody lead. ICV coordinators had recently been invited to attend the monthly custody user meetings.

- 3.14 Management was aware of the complaints process as the chief inspector of the professional standards department fed information about complaints trends and patterns through the strategic custody management group meetings, which filtered them down to the supporting meetings. But we were not convinced that the force had communicated either to detainees or to staff how complaints in custody should be dealt with (see also paragraphs 5.23-25).
- 3.15 Although the justice department provided policies and procedures for the guidance of BCUs, there were some policy gaps that needed to be underpinned by standard operating procedures. These included guidance on the taking, storage, transportation and subsequent destruction of DNA and forensic samples.
- 3.16 In line with policy, the use of force was routinely recorded in officers' pocket notebooks, detainees' custody records and the use of force return form. These forms were submitted to the force officer safety and public order team, which monitored them to identify future training scenarios and any staff who needed additional training. However, the information was not collated and analysed to identify patterns and monitor trends.
- 3.17 Staff could readily access good practice information, the Independent Police Complaints Commission (IPCC) *Learning the Lesson* newsletter and other relevant material through the force intranet. The justice department had also introduced a four-monthly *Custodybeat* newsletter circulated to all custody staff. This had up-to-date news on force-wide developments, inspection outcomes, identified DNA issues, changes to PACE, etc.

Recommendations

To Wiltshire Constabulary and police authority

- 3.18 The force and police authority should develop a long-term plan to improve and upgrade the facilities and infrastructure at the Salisbury custody suite.

To Wiltshire Constabulary

- 3.19 The current role and duties of the custody site managers should be reviewed.
- 3.20 The workforce modernisation programme should be reviewed to ensure that staffing arrangements are suitable for custody suites and minimise risks to detainees and staff.
- 3.21 A chief officer at strategic level should address the lack of engagement with health partners.
- 3.22 The membership of the strategic custody group should be expanded to include representatives of external partners.

- 3.23 Use of force should be monitored centrally to enable managers to identify patterns and monitor trends, and to assure that it has been deployed appropriately and proportionately.

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 Staff were respectful towards detainees, but there was limited recognition of the different needs of women and juveniles, and little provision for detainees with disabilities. Risk assessments were completed on arrival. Staff carried anti-ligature knives. Force was not overused. Cells needed a deep clean, and there were many ligature points. Mattresses, pillows, and blankets were routinely provided for detainees, but hygiene packs for women were not, and toilet paper had to be requested at Melksham. Detainees could not use the toilet in privacy in some cells. There was limited access to showers, and some did not offer privacy. Detainees whose clothing was removed were usually offered paper suits. The outside exercise areas were rarely used. A range of reading material was available. Closed visits were occasionally facilitated at two sites but not at the third. Daily and weekly health and safety checks were not always carried out.

Respect

- 4.2 Detainees were brought to the suites in police vehicles and Reliance contractors transported them to court.
- 4.3 We observed staff talking to detainees in a sensitive manner. We saw a very patient exchange between a custody sergeant and a vulnerable adult. The sergeant took time to fully explain to the detainee what was happening and what would happen, and the appropriate adult who was also present. In one case in Swindon, a detention officer used de-escalation techniques to calm down a vulnerable and agitated detainee, which defused a potentially difficult situation. The use of first or preferred names was the norm.
- 4.4 There was little substantive difference in the way that custody staff treated different groups of people. They were unaware of the differing needs of women detained in custody, or the higher risks associated with their caring responsibilities. However, we observed some interactions with juveniles, females and detainees with disabilities where custody sergeants, in particular, took their time to explain what was happening in an empathetic manner.
- 4.5 When juveniles were detained, staff checked parents and used them as the first port of call, unless local knowledge, police national computer or intelligence checks identified them as being unsuitable, when they would use social services or the youth offending team. Juveniles tended to wait in the detention room until an appropriate adult arrived, and any strip searches were conducted in their presence. Juveniles were routinely placed on at least 30-minute observations, and we saw examples where young or vulnerable detainees were held in interview rooms rather than cells. They were sometimes kept in overnight if the appropriate adult was not available until the morning. Melksham had four dedicated detention rooms for juveniles and Salisbury had two. Although there were no separate cells for juveniles at Swindon, appropriate adults were permitted to wait with juveniles in the interview room.
- 4.6 Salisbury had limited access for people with mobility needs through the front door, but detainees could be brought in through the back via a ramp and a wheelchair was available.

- 4.7 Sergeants told us that they had not had any specific training in dealing with women detainees. Staff received training about working with vulnerable and juvenile detainees during the initial custody module, and there were plans to offer refresher training on relevant areas.
- 4.8 At Salisbury, staff were particularly knowledgeable about the support available and mental health issues affecting serving and ex-forces personnel who made up a significant part of the local population.
- 4.9 The front-of-custody desks at Swindon and Melksham provided good observation of the cell block for staff, but poor privacy when booking in detainees. The desks in the booking areas were too high, which hindered effective communication between staff and detainees. The desk at Melksham was extremely high, and detainees were requested to stand well back from it and behind a red line. This could be somewhat intimidating. There were no discrete booking in or charging areas, and there was a lack of privacy when detainees were asked about any mental health or medical issues. This could undermine the risk assessment process as detainees may be unwilling to share sensitive or private information in a public area.
- 4.10 On the other hand, custody sergeants took positive steps to minimise the number of people congregating at front desks when detainees were booked in, particularly at Melksham and Salisbury. At Salisbury, detainees waited in the holding room and the detention room if there was a queue.
- 4.11 There was a range of materials for worship, including prayer mats, compasses, Qur'ans and Bibles. If detainees arrived with prayer beads, they were allowed to retain them based on a thorough risk assessment.

Safety

- 4.12 All new custody staff completed safer custody training in the initial training course. Initial risk assessments were generally completed by detention officers under supervision from sergeants, and we saw some thorough risk assessments that went beyond what was needed for the Niche records. Risk levels were determined by the custody sergeant and were reviewed or revised as circumstances changed. Warning markers for detainees at risk of harm to others were displayed on the Niche system. If they were very violent when they arrived, they were often taken straight to the cell. Staff routinely roused detainees when appropriate, and the detained persons observation list was displayed behind the booking-in desk. Staff carried ligature knives and these were also available behind custody desks. We observed good handovers between shifts, with the exception of the night to day shift (see paragraph 3.10).
- 4.13 Relatively few cells or corridors were covered by CCTV, and the quality of the systems at Melksham and Salisbury were poor. In Salisbury, the holding room and one male cell had CCTV. At Melksham, the vulnerable detainee dry cell, a female cell and two of the male cells had CCTV. Only four of the 40 cells at Swindon had CCTV, but there was some corridor coverage. None of the detention rooms designated for juveniles had CCTV.
- 4.14 It was notable that in our prisoner survey, only 24% of respondents, against the comparator² of 41%, said they felt unsafe while in detention. There was generally no cell sharing, and detainees were held separately in the holding area.

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

- 4.15 Custody officers had undertaken an e-learning course on signals of child abuse within the last six months.

Use of force

- 4.16 If detainees were brought in wearing handcuffs, the custody sergeant asked the arresting officer to provide an explanation as to why they were still in handcuffs, and following a discussion with the detainee the handcuffs were removed as soon as it was safe to do so.
- 4.17 Before using force, officers said they tried to talk to the individual in the first instance and, if this failed, used restraint, usually leg restraints and handcuffs. If there was a visible injury following use of force, G4 medical staff were contacted.
- 4.18 All DOs were trained in restraint. Custody staff received officer safety training annually, sergeants for two days and DOs for one day.

Physical conditions

- 4.19 Swindon was a large modern suite, which had been built to the Home Office specification. It was free of graffiti and superficially clean, although we found dirt and hairs in corners and under mattresses, and many cells and corridors needed deep cleaning. There were dirty floor grilles in corridors and chewing gum in shower grilles. Mattresses and pillows were put on dirty cell floors when cells were cleared after a detainee had been in them. All cells had low-level plinths, which were difficult for detainees with mobility problems. There was little natural light in the cells.
- 4.20 Melksham was also superficially clean, but we found dirty cells and old stains on some walls and ceilings. There was a small amount of ingrained graffiti on the back of cell doors, but this was minimal.
- 4.21 Although Salisbury had the oldest custody suite, this was very clean, light and airy, although there was a little graffiti. Some of the cells at Melksham and Salisbury were cold. At both these suites contract cleaning took place daily. In between cell occupations, detention officers generally cleared away any litter, but did not always wipe down mattresses and pillows.
- 4.22 Most of the cells we surveyed – 48 out of 57 – failed to pass safety tests because of the presence of ligature points. Most of these were design faults. We advised the force of this, and the fact that some staff could not recognise potential ligature points. The force took steps during the week of the inspection to remedy some of these problems, although others required the investment of considerable resources.
- 4.23 At Melksham, ongoing maintenance work was done as and when required. If necessary the suite was closed and the other suites used. Salisbury had a local maintenance worker available at all times. The custody suite at Swindon was a private finance initiative building and any maintenance requests were e-mailed to the contractor.
- 4.24 The custody suites had a no-smoking policy and custody staff provided detainees with nicotine replacement chewing gum if required. Several custody staff said that detainees could have one piece of gum every four hours, and one said that he requested the used gum back from the detainee before issuing another piece. However, in our prisoner survey, 87% of respondents said that they had not been offered anything as an alternative to smoking, and only 6% said that they had been offered nicotine gum (6% did not smoke).

- 4.25 The call bell system was usually explained to detainees, and we observed quick responses to call bells.
- 4.26 Staff in the custody suites were expected to carry out daily checks to identify health and safety, maintenance and cleanliness issues. The custody site managers were also expected to carry out a similar check each week, although in E division, the responsibility for checking the Salisbury custody suite had been delegated to the duty inspector. We found evidence that these checks were not always completed, and those that were varied in quality, as the BCUs used different checklists with little guidance on what they were to check.
- 4.27 A health and safety assessor and police search adviser also made a formal six-monthly health and safety check. We found evidence that these had been carried out, but it was unclear from the documentation if detainees had been moved out of occupied cells to facilitate checks. Although some cells were identified as having possible ligature points, these were only assessed as medium risk and were not taken out of service.
- 4.28 Custody site managers carried out quality assurance checks through sampling two custody records per custody sergeant per month for their areas, although this target was not always achieved. In addition, the chief inspector and inspector in the justice department sampled five custody records each across the force area. The details of these checks and any findings were discussed at the strategic custody management group meetings.
- 4.29 Fire evacuation plans and equipment were up to date, and there had been fire evacuation drills in all suites within the last six months. There were sufficient handcuffs to evacuate detainees.

Personal comfort and hygiene

- 4.30 Mattresses, pillows and blankets were provided at all sites. Toilet paper was routinely provided at Swindon and Salisbury but had to be requested at Melksham. Handwashing facilities were available in all cells at Swindon and Melksham. Female sanitary packs were available but were not routinely offered.
- 4.31 Some cells in all suites lacked adequate privacy for toilet use. Toilets in cells with CCTV coverage were not pixilated or otherwise obscured.
- 4.32 Showers were available but custody records indicated that these were rarely offered. Custody staff said that detainees were offered a shower if they were going to court and if they were not too busy. Only Salisbury had shower curtains. The lack of privacy in showers at Swindon and Melksham was a particular problem for women, who could be seen from the corridor due to the half-stable door. In our survey, only 9% of respondents said they had been offered a shower.
- 4.33 Paper suits were provided routinely for detainees whose clothes were removed. Staff told us that tracksuits were available but were reserved for those being released. Staff allowed relatives and friends to bring in a change of clothes for detainees. No underwear was provided at any of the sites.

Catering

- 4.34 At Swindon, meals were provided from the staff canteen during the working day and microwave meals at other times, although the selection of these was poor. At the other two suites only microwave meals were available, although there was a better selection, including sufficient halal and vegetarian options. The calorific content of the microwave meals provided

was poor. Staff allowed families and friends to bring in food for longer stay detainees, if it was in a sealed container. Drinks were freely offered. DOs received food hygiene and food handling training during their initial training.

Activities

- 4.35 Outside exercise yards were available at all suites, but custody records and our prisoner survey indicated they were rarely offered. Detainees were routinely given reading materials, including daily newspapers at Melksham, and in our survey, significantly more respondents than the comparator said this facility had been offered (29% against 13%). We found a good spread of reading material, and a selection of magazines and papers was available.
- 4.36 At Melksham and Swindon, staff sometimes allowed closed visits. Depending on the individual risk assessment, visits took place in interview rooms or the closed visit room. No visits were allowed at Salisbury.

Recommendations

- 4.37 Booking-in desks should be of an appropriate height, and the reception area should allow adequate privacy for new arrivals.
- 4.38 All cells should be fit for purpose and free of ligature points, which custody staff should be trained to identify.
- 4.39 There should be clear policies to meet the needs of female detainees and those with disabilities or mobility issues while they are in custody.
- 4.40 There should be cells adapted for use by detainees with disabilities.
- 4.41 Regular health and safety, maintenance and cleanliness checks should be formalised across the custody estate, and should be fully recorded and monitored by custody site managers and the headquarters justice department to ensure that there is appropriate action on identified issues.
- 4.42 Quality assurance sampling checks should be recorded and monitored by headquarters justice department to ensure these are completed on time, and that identified issues are addressed and learning points are disseminated.
- 4.43 Cells, mattresses and pillows should be cleaned between use and kept clean, free of graffiti and functional for use.
- 4.44 Detainees held overnight and those who are dirty should be offered a shower.
- 4.45 Shower areas should allow sufficient privacy, particularly for female detainees.
- 4.46 Toilet paper should be provided routinely in all suites.
- 4.47 Views of in-cell toilets covered by closed-circuit television should be obscured.

- 4.48 Tracksuits, underwear and plimsolls should be provided when clothing is removed from detainees, unless there is a specific need for an alternative.
- 4.49 Detainees held for longer periods should be offered outdoor exercise.

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 Reviews of detention were completed on time. Detainees could have someone informed of their whereabouts, but did not always have the opportunity to make a free telephone call. Information about rights and entitlements was available in a range of languages. Dependency issues were not routinely identified. There were pre-release risk assessments, with some support put in place for identified risks. There was a 24-hour appropriate adult service for juveniles, but not for 17 year olds, and there were some significant delays in attendance out of hours. Access to an appropriate adult service for vulnerable adults was problematic. Detainees were not told how to make a complaint, and processes to deal with low-level complaints required clarification. Some DNA and forensic samples were stored inadequately, and many had been held for some years.

Rights relating to detention

- 5.2 Our observations at all suites assured us that custody sergeants were robust in considering the circumstances of and evidence relating to detainees being received to ensure arrests were lawful and detention necessary.
- 5.3 Reviews of detention were primarily the responsibility of the designated duty inspector. Custody sergeants and duty inspectors actively monitored the Niche system, which flagged up times when reviews were due. Records indicated that reviews took place within the timescales specified under the Police and Criminal Evidence Act (PACE).
- 5.4 Wherever possible, reviews were conducted in person by the duty inspector (see paragraph 3.5). If this was not possible, telephone reviews were conducted. Staff told us that such reviews took place over the telephone in the cell, which gave an appropriate degree of privacy, although Salisbury had poor telephone reception in some cells so such reviews were not always possible.
- 5.5 Custody records we sampled clearly recorded the reasons for inspectors conducting reviews on detainees while they were asleep. A pro forma was drawn up in the custody suite following a sleeping review, and custody staff informed the detainee that a review had taken place at the earliest opportunity. The custody record was updated to indicate that the detainee had been informed of the review when they awoke.
- 5.6 Custody suites were not used as a place of safety for children and young people. We were told by staff that they liaised with the child protection unit at the station to find a more appropriate place to hold a child.
- 5.7 All custody records examined indicated that the right to have someone informed of arrest was communicated to the detainee, and we also observed this during inspection.
- 5.8 There were few foreign nationals detained in the custody suites during our inspection. Custody staff liaised with immigration services to ensure immigration issues were dealt with promptly. Custody staff in Melksham liaised with the immigration services in Manchester and Bristol. We

were told that there were often delays in transferring foreign national detainees from the Melksham custody suite, particularly at weekends.

- 5.9 Detainees were informed of their rights and entitlements during the booking-in process and had to sign their custody record to indicate that their rights had been explained to them. Records we sampled indicated that detainees were informed of their right to have someone told of their whereabouts, although in our custody record analysis only 10% of detainees had been offered a free phone call (see Appendix II).
- 5.10 Detainees were given a notice of their rights and entitlements, which was available in a range of languages. Custody staff had access to telephone interpreting services and a national database of interpreters, although demand was low given the local demographics. Telephone interpreting was used for the booking in and risk assessment of detainees with little English. An interpreter was called in for the interview itself and remained to translate the charge and bailing process. Staff said that there could be delays if an interpreter was required to attend the suite.
- 5.11 Information about how to contact British Sign Language interpreters was displayed at the booking-in desk in Salisbury, although the custody sergeant had not used the service. Hearing loops were available in the suites. In the Melksham custody suite, staff had access to two videos that could be used for interviews with detainees who were profoundly deaf, although the custody sergeant had no recourse to use these videos. All suites had some basic information available in a pictorial format.
- 5.12 Detainees were not routinely asked if they needed to make arrangements for dependents to be looked after. We were told that women detainees usually raised any such concerns with the arresting officers or custody staff relied on detainees to raise any concerns about dependency obligations. When they did, custody staff said they allowed detainees to telephone family or friends to arrange childcare during their detention.
- 5.13 A pre-release risk assessment was completed for all detainees before their discharge from custody and documented on Niche. The risk assessment covered any foreseeable medical or other risks beyond release, and recorded any action to minimise identified risks. Custody staff had a printed risk assessment guide, which included a comprehensive list of risk indicators, to help them complete pre-release assessments. All detainees were given a support agency leaflet before their release, which included contact telephone numbers of agencies such as the Samaritans and Shelter. Specific support had included arranging transport home for women released at night. Our analysis of custody records identified other examples of support in response to identified risks, such as arrangements for family members to collect detainees from custody.

Rights relating to PACE

- 5.14 We found that the requirements of the Police and Criminal Evidence Act (PACE) were largely adhered to. Custody staff reported no problems with obtaining duty solicitors, and the custody records we sampled showed that solicitors were contacted in a timely manner. In one record, custody staff had attempted to locate a detainee's named legal representative through an internet search, but had also contacted the duty solicitor to minimise delays in interviewing. Custody staff said it could be difficult to obtain legal representation for immigration detainees.
- 5.15 Each suite held up-to-date copies of PACE code C, and we observed detainees informed of their right to access the document. We checked a number of custody records and found that

where detainees were under the influence of drugs or alcohol they were detained until sober or ready for interview.

- 5.16 In accordance with PACE, juveniles under 17 were not interviewed unless an appropriate adult was present, but 17 year olds were not provided with an appropriate adult unless they were vulnerable for reasons other than their age (by contrast, the Children Act 1989 defines a child as anyone up to 18). Custody sergeants considered family and friends to act as appropriate adults in the first instance, and assessed their suitability for this. A team of volunteers coordinated by Wiltshire youth offending team (YOT) provided appropriate adult cover for all suites between 9am and 10pm on weekdays. The emergency duty service provided an out-of-hours service, although custody sergeants said there were often significant delays. The service for vulnerable adults was more ad hoc. Appropriate adults could be provided by statutory services if the detainee already had such support, for example, their social worker or community psychiatric nurse could fulfil this role. Although volunteers had been used as appropriate adults for vulnerable detainees aged 17 and over, they had not had specific training in the issues vulnerable adults may present.
- 5.17 The custody records we sampled showed that detainees were given appropriate breaks and had access to food and drink during interviews. The eight-hour breaks were enforced and recorded appropriately in custody records.
- 5.18 Custody staff at Salisbury reported a positive relationship with the local court, which had recently reopened after refurbishment. Detainees could be produced at court up to 4.30pm on weekdays. Given the court's proximity to the suite, detainees were often transported there by the police. At Melksham, the cut-off time for afternoon appearances was 2pm. Custody staff had sometimes involved duty inspectors in challenging the court when there was an apparent inflexibility in arranging timely court appearances. The Swindon suite had a good relationship with the local courts and, wherever possible, the court arranged for a detainee to come before them if they were sitting. There was no set cut-off time, and the process was managed through negotiation with the court clerk. None of the suites had a video-link facility.
- 5.19 Custody staff said that detainees could obtain a full copy of their custody record by making a written request on their release, but were not routinely given a summary of their custody record. A solicitor in Melksham told us he was routinely given a copy of a detainee's custody record when he attended the suite.
- 5.20 PACE kit continuity sheets were meant to be used to record DNA samples placed in freezers. When the samples were collected each week, the sheet was endorsed by the special property register member of staff to confirm collection and transportation to the divisional submissions unit, where the receipt of the samples was signed for. Although this provided a clear audit trail for all samples obtained within the custody suite, we found a number of samples that were not entered on to the continuity sheet and which remained in the custody freezers.
- 5.21 We also found a large number of forensic samples that were stored inadequately in fridges and freezers. These included blood, urine and forensic samples at four sites, the oldest dating back to 2005, and it was unclear whether these should have been sent for analysis, stored elsewhere if still required, or disposed of in a suitable manner if no longer required as evidence.

Rights relating to treatment

- 5.22 Detainees were not routinely informed how to make a complaint about their treatment. The custody records we reviewed indicated that if a detainee was in custody long enough to have their detention reviewed by an inspector, they were routinely asked if they wanted to make any representations about their time in custody. Although inspectors intended this as an opportunity for detainees to raise complaints, we were not assured that this was always made clear to detainees. We observed a review in Salisbury when the reviewing inspector put this question to a detainee. It was apparent that the detainee did not fully understand the question. Although it was repeated at the detainee's request, the inspector gave no further explanation or definition of the term 'representation'.
- 5.23 Custody sergeants were clear that complaints were not taken while a detainee was in the custody suite, and that the formal process was for them to raise a complaint in writing after release using the Independent Police Complaints Commission (IPCC) complaint forms, which were usually available at the station front desk or in the custody suite. We were told that there were some circumstances when the custody sergeant would immediately inform the duty inspector of a complaint from a detainee, such as an allegation of assault by a member of staff.
- 5.24 There appeared to be a lack of clarity in how low-level complaints were managed. The custody sergeant at Salisbury said that he could not manage low-level complaints about treatment or conditions without raising the matter at least with the CDI. However, the custody sergeant at Melksham endeavoured to deal with such complaints informally and with some immediacy where possible. At Swindon we were told by staff that most complaints would not be dealt with until detainees were released from custody.
- 5.25 Custody staff were unaware of separate procedures to deal with or monitor trends in racial complaints.

Recommendations

- 5.26 The force should liaise with the UK Border Agency to ensure that immigration detainees are held for the shortest possible time.
- 5.27 Custody staff should identify and, where possible, address any dependency issues for detainees.
- 5.28 Appropriate adults should be available 24 hours a day to support juveniles and vulnerable adults in custody.
- 5.29 Detainees aged 17 years should be provided with an appropriate adult.
- 5.30 There should be an urgent review of the processes used to take, store, track and submit all DNA and forensic samples taken from detainees, volunteers and victims. This should identify gaps in policies, training, storage facilities and destruction audit trails, with a senior officer responsible for delivery of an action plan to address these.
- 5.31 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.

- 5.32 Detainees should be able to make a formal complaint about their treatment during arrest or detention while they are still in custody, and all such complaints should be investigated promptly and fully.
- 5.33 The number and nature of complaints with a racial element should be monitored and any trends identified acted on.

Good practice

- 5.34 *Staff ensured support for detainees on release where there were identified risks, such as making arrangements for family members to collect detainees from custody.*

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 Healthcare was provided by G4S medical and forensic services. There were reasonable clinical governance arrangements, although staff skills in mental health were less developed. Clinical rooms were passable, but we had some concerns about infection control. Medicines management by G4S was reasonable, with few stocks held, but we had concerns about the management of medicines held by custody staff. There was resuscitation equipment in each suite, but there was little evidence that these were regularly checked. Most detainees were seen by healthcare professionals within an hour. Although some detainees could continue prescribed medications, others, particularly those using methadone, could not. Services for substance users varied greatly across the county, and were far superior in Swindon. There was little provision for referral of detainees with alcohol issues. There were ill-defined policies and protocols for mental health, but engagement with mental health services was being resolved at senior management level.

Clinical governance

- 6.2 Wiltshire Constabulary commissioned healthcare in the custody suites from G4S medical and forensic services. They employed both doctors and nurses to provide healthcare services to the custody suites.
- 6.3 Detainees were treated in a professional and caring manner. A woman doctor was not always available, and it was not clear whether women detainees were told that they could see a woman health professional or have a chaperone. There was evidence that interpretation services and telephone translation were used when needed. Healthcare records indicated that the social circumstances of detainees were considered as part of the assessment, including details about family and carers. Involvement with external health and social care services was taken into account as part of the treatment plan.
- 6.4 There was a clinical governance framework and contract monitoring, but it was not clear what process was in place for Wiltshire Constabulary to check that annual appraisals were completed for G4S healthcare professionals, that supervision was provided and accessed, or that continuous professional development was undertaken in line with the requirements of their professional bodies.
- 6.5 There were arrangements for supervision, training and appraisal of health professionals, which were used by all the healthcare professionals we interviewed. The doctors said that they were currently registered with the General Medical Council with up-to-date and appropriate medical insurance. Generally, healthcare professionals worked 12-hour shifts, but were sometimes asked to work longer hours (24-hour shifts) if there was a shortage of cover.
- 6.6 Although healthcare staff's expertise in primary care was evident, mental health services and custody staff consistently said that G4S healthcare professionals did not have the training, skills or expertise to undertake mental health assessments effectively.

- 6.7 The forensic medical examination (FME) room in each custody room allowed private consultations, in conditions that maintained decency, privacy and dignity. Systems to promote infection control were not robust, and there was no evidence that an infection control audit had been carried out in any custody suite. Cleaning schedules were not displayed, and there was no evidence of how cleaning schedules were monitored. Custody staff told us that contract cleaners were responsible for cleaning the FME rooms. The Melksham and Swindon custody suites were clean and generally fit to be used. The custody suite at Salisbury was not fit for purpose. It was not as clean as the other suites, with thick dust on the pipe work above the clinical examination couch. We found fabric-covered chairs in two of the suites, which could not be cleaned sufficiently and posed an infection control risk.
- 6.8 Not all the FME rooms were locked. A small stock of medication was stored securely in the rooms. Each FME room had a safe with a digital code known to the healthcare professionals, but not to custody staff. A G4S designated driver came to the custody suites each week to stock up on medications. However, the governance framework for monitoring medication stock levels and the disposal of redundant medication lacked rigor. We found medication that was out of date and no longer in use in all the FME rooms. The recording of administered medication was also weak, and there was no evidence of a medication audit.
- 6.9 Custody suite staff had access to a small supply of stock medication. This appeared to vary in each suite, but included paracetamol and GTN spray (for angina). This was stored in a variety of locations, such as a stationery cupboard, none of which was locked. However, medications were not always in their original containers so it was not always easy to determine what they were or the date they should be used by. Some medications were labelled with previous detainees' names, which suggested that detainees were released without the medication being given to them. There was evidence that GTN sprays and asthma inhalers were possibly used by more than one detainee. In Swindon we found a GTN spray that had been dispensed by a local pharmacy for 'the custody suite' rather than a specific individual.
- 6.10 There was a defibrillator in each custody suite – in Swindon this was kept in the FME room that was unlocked, in Salisbury it was in the staff rest room, and in Melksham it was easily accessible at the custody desk. There was no system to demonstrate that the defibrillator was checked regularly. At Melksham we found a book that clearly stated that the defibrillator should be checked weekly, but it had only three entries for 2009, the last one being at least 10 weeks previously. Oxygen was available in all the custody suites, with documented evidence that it was checked weekly. Custody staff told us that their annual first aid training included the use of the resuscitation equipment. G4S staff were also trained in resuscitation. There were well-equipped first aid kits in each custody suite, but no recorded evidence that they were checked regularly.
- 6.11 The only formal protocols between the police and the provider trusts that we found concerned the health assessment of people who appeared drunk and in need of medical assistance. There were no formal information-sharing protocols.

Patient care

- 6.12 Detainees were generally offered the opportunity to see a healthcare professional on arrival and on request. They could also be seen by a healthcare professional at the discretion of the custody sergeant if there were any health concerns. The electronic custody record and the healthcare records demonstrated that calls and response times were consistently recorded. Where there was an obvious acute physical need, such as open wounds, the detainee was immediately taken to the nearest accident and emergency department for treatment. Custody

staff contacted a central call centre and their request was passed to a health professional to deal with.

- 6.13 There was one nurse and one doctor to cover the whole of the force's area at any one time. However, as G4S also provided health services to the neighbouring counties of Gloucestershire and Hampshire, staff were allocated on the basis of availability rather than by county. We had some concerns that staff covering custody suites from a neighbouring county did not have the local knowledge required for referring detainees to hospital or other health services.
- 6.14 Our analysis of custody records (Appendix II) indicated that 23% of detainees had requested to see a health professional. Custody staff were aware of the need to monitor response times, and most healthcare professionals responded within an hour. Healthcare professionals contacted the custody suite to inform staff of any delays in response, and this was also recorded. G4S provided monthly reports to the constabulary. In the three full months before our inspection, most calls had been responded to within 30 minutes, and three-quarters had been responded to within an hour. The contract with G4S was monitored, and if it failed to meet at least 70% of calls within one hour over two successive quarters, there was a financial penalty for each missed call. About 6% of calls a month to G4S resulted in telephone advice.
- 6.15 Detailed patient group directions provided clear guidelines to allow nurses to supply and administer specified medicines to detainees. Doctors prescribed medications from the stock lists, but if a detainee required a specific medication, this was brought from their home or a prescription was written and obtained from the local pharmacy. The exception to this was methadone. If a detainee required repeated doses of a medication, it was taken from the stock in the FME room and put into individual bags that were labelled. While it was acceptable for doctors to perform this secondary dispensing, it was not for nurses to do so (Medicines Act 2003). Medication was also clearly prescribed on form 450, a 'detained persons medication form', that was scanned on to the Niche electronic custody system.
- 6.16 Although G4S had a controlled drugs policy, it did not appear to be used in practice for the safe management of medication relief for drug and alcohol withdrawal symptoms, including the prescribing and administering of methadone. It was reported that generally the FMEs did not prescribe methadone or other opiate substitutes, even if detainees had brought in their own. Instead, detainees were given dihydrocodeine tablets to provide short-term symptomatic relief while they were in custody. The drug intervention programme (DIP) team and custody staff raised concerns about this, as detainees were often left in distress without their prescribed methadone. In Swindon, the DIP team had raised this concern at the drug reference sub-group of the community safety partnership forum. As a result, the DIP team had been asked to make a three-month record of all concerns raised by detainees in relation to methadone access; this was ongoing at the time of our inspection. Results for the first week of the audit showed that detainees had complained on six occasions about missing their dose of methadone. The length of time they went without methadone ranged from six to 20 hours.
- 6.17 The electronic custody record started when detainees were received into custody included the recording of any health event or assessment. All clinical records were paper-based and kept in a locked metal safe accessible only to G4S staff. Clinical records were collected weekly by G4S, scanned and digitalised, and stored at another location. A form 450 was also completed for use by custody staff; clinical details were kept to a minimum to ensure confidentiality and the form was scanned on to the Niche system. The clinical records consisted of a four-sided booklet that provided a good assessment of the detainee's medical condition. Detainees were asked for their consent for this sharing of information, and to sign the clinical record.

- 6.18 Healthcare record keeping was consistent and of a good standard overall. We reviewed a sample and found that the health assessment record was generally detailed and relevant. In the main, consent was obtained appropriately, and, where feasible, the detainee signed the consent section. We observed an FME explaining to a detainee that his records could be used in evidence. Custody staff said that if a detainee requested a copy of their clinical records, this was referred to G4S.

Substance use

- 6.19 The organisation of the drug intervention programme (DIP) varied across the county. For example, the DIP team was based at the police station in Swindon, but not in Salisbury and Melksham. DIP workers also said that Salisbury lacked a broad range of community support services compared with other areas. In our survey, 64% of respondents said that they had a drug or alcohol problem.
- 6.20 DIP workers described positive relationships with custody staff in all the suites. They attended custody suites at least daily to see if any detainees would benefit from the service, and there were systems for custody staff to refer detainees to the DIP team. However, DIP workers consistently expressed a lack of confidence in these systems and believed that many detainees with drug problems were missed. DIP workers saw detainees (aged 18 and over) on a sessional basis after release and/or referred them on to other organisations depending on need. Services for juveniles were limited in custody to the workers signposting relevant organisations in the community.
- 6.21 Drug services were piecemeal with a lack of clear and robust structures. The best situation was in Swindon, as the service was longer established and had the advantage that the DIP team was based at the police station. The DIP team here had set up an established needle exchange at the custody suite, and drug users were offered clean needles, syringes and a small sharps bin on release. Condoms were offered to drug users on release, and the DIP team maintained the stock so knew that this occurred.
- 6.22 The drugs workers in Salisbury commented on the paucity of services for those with substance use issues. Waiting lists for the prescribing service were long, even for persistent and prolific offenders who were meant to be fast tracked to services. There was limited psychosocial support, and DIP workers saw most clients on their caseload for a maximum of six occasions. During our inspection, the drug worker's next available appointment was not until six days' time. Needle exchange in Salisbury was provided by another external organisation, which added to the perception that services were fragmented.
- 6.23 There were slightly better services in Melksham, where DIP workers could refer to local GPs who undertook substance use work (shared care), an interim prescribing service and a specialist team for clients with poly substance use or who were pregnant. There was also a drop-in centre where users could obtain clean needles.
- 6.24 DIP workers described very good working relationships with the G4S nurses, who made consistent and appropriate referrals to the team, across the county. Although the county DIP team had offered training to custody staff in drug issues and needle exchange, no such training had been taken up in the last five years.
- 6.25 DIP workers raised concerns about the lack of conditional cautions given to detainees. Since December 2008, they had not had any referrals involving a conditional caution, which would have assisted in engaging drug users in harm-reduction work.

- 6.26 Referral to alcohol services varied across the county, and there was a voluntary referral system. If the custody sergeant determined that alcohol was a factor contributing to the arrest, the detainee was informed about the alcohol service and sentencers were advised about any attendance on an alcohol programme. In Salisbury, detainees were offered one-to-one sessions with a counsellor.
- 6.27 Alcohol-related reoffenders were being targeted by the police and other agencies in Wiltshire. The police custody alcohol service was monitored against this target, and this was reported to the community safety partnership board, and we were told some good results were being achieved.
- 6.28 Swindon was one of only nine police force areas in England and Wales to be selected by the Home Office for its £1 million roll-out of a new alcohol arrest referral pilot project. The Swindon community safety partnership was working with Swindon and Wiltshire alcohol and drugs service to implement this pilot, which became operational in autumn 2008.

Mental health

- 6.29 Custody staff referred detainees displaying a mental health need or who requested to see a mental health professional to the G4S health service. In our survey, 42% of respondents (significantly higher than the comparator of 24%) said that they had mental healthcare needs. The G4S doctor or nurse carried out an initial assessment. Where this led to a mental health concern, custody staff made a referral to the local community mental health service for a mental health needs or a Mental Health Act assessment by crisis team staff employed by Avon and Wiltshire NHS Partnership Trust. As the crisis team only accepted referrals from the doctor, if a detainee had been assessed by the nurse they had to be reassessed by the doctor to be referred. Custody staff said that this created delays.
- 6.30 There was a general view across the county that the responsiveness of the mental health service was not consistent, and at times unpredictable. Custody staff reported wide variations in response times, and detainees sometimes had to wait for long periods to see a mental health professional. Custody staff also felt that detainees were given a lower priority for assessment as they were seen to be in a place of safety.
- 6.31 There were separate crisis teams for Swindon and for the rest of the county. The crisis teams consistently raised the lack of mental health expertise and skills among G4S health professionals, and an ineffective mental health service, as concerns. This had resulted in an increase in referrals to them, including an increase in what they perceived to be inappropriate emergency duty service referrals for Mental Health Act assessments. On the other hand, G4S doctors said that mental health staff had been obstructive and rude, often questioning the necessity of the referral for a mental health and/or Mental Health Act assessment.
- 6.32 The Swindon crisis team said that the service had improved over the last 18 months, following a review and redefinition of systems and management arrangements. The team also identified that the police were more responsive and had a stronger focus on vulnerability. Although they believed that they responded to referrals in a timely manner, they commented that the more inappropriate referrals received, the slower the response times.
- 6.33 There were quarterly meetings between the Swindon crisis team, the police, emergency duty service, section 12 doctors³ and G4S. These meetings were developing a process of mental

³ Qualified to carry out mental health assessments.

health assessment for the G4S health professionals, which took into account a care pathway process. The crisis team said that the obstacles to effective mental health service delivery in custody had been raised with the primary care trust (PCT) commissioning team, but the PCT had taken no action to date. Senior police staff assured us that mental health provision across the county was being discussed at senior management level in the police and health services.

- 6.34** There were three section 136 suites⁴ in Wiltshire. The suites were managed and staffed by the crisis mental health teams. The arrangements and experiences of section 136 assessments differed significantly between Swindon and the rest of Wiltshire.
- 6.35** The mental health crisis team in Swindon said the management of patients referred under section 136 was an area of positive practice. The partnership trust had invested heavily in the 136 suite, which could accommodate two patients at a time. The suite accepted patients of all ages but it was not always possible to provide a place of safety for those under 18. The suite was managed and staffed by the crisis team, and included a bedroom with an en suite accessible toilet, meeting room and lounge. The crisis team said that although most patients were discharged, the majority of section 136 referrals had been appropriate. There was effective communication between the police and the crisis team for accessing the suite.
- 6.36** Patients could be admitted to the section 136 suite if they had consumed alcohol. A protocol outlined a threshold for admission equivalent to the UK drink driving limit, and the crisis team breathalysed detainees if they believed they were over this limit to ensure that an effective mental health assessment was possible.
- 6.37** The crisis teams in the other two suites took a different approach and said that people were not admitted if they had consumed alcohol. They breathalysed anybody they suspected of consuming any alcohol. It was not clear if this practice was formally outlined in policy or detailed in the section 136 joint protocol. This was an issue of contention between the police and the crisis teams. Detainees had to be taken to a custody suite to sober up before they could be seen by the mental health team.
- 6.38** Another area of contention had been police arriving at the suite with a detainee to be admitted without any prior communication. This had led to police being turned away when the suite was in use.

Recommendations

- 6.39** Women detainees should be able to see a woman doctor on request and be informed of this possibility.
- 6.40** The contract monitoring of health services should ensure that robust clinical governance arrangements are in place.
- 6.41** Healthcare staff should have the appropriate knowledge and skills to meet all the physical and mental health needs of detainees.
- 6.42** There should be clear infection control procedures, including cleaning schedules that should be adhered to, and monitored.

⁴ For people sectioned under the Mental Health Act, section 136.

- 6.43 There should be safe pharmaceutical management and use of medications. All medications should be stored safely and securely, and disposed of safely if not consumed.
- 6.44 All resuscitation equipment should be checked at least weekly, and there should be documentary evidence that these are completed.
- 6.45 Secondary dispensing by nurses should cease.
- 6.46 Detainees should be able to continue prescribed medication for any clinical condition, and to receive medications to provide relief for drug and alcohol withdrawal symptoms if needed.
- 6.47 Services for detainees with substance use issues should be provided consistently across the county, including access to clean needles.
- 6.48 Services for detainees with mental health needs should be provided consistently across the county.

Housekeeping points

- 6.49 The forensic medical examiner rooms should be locked when not in use.
- 6.50 Sharps bins should be dated and signed on commencement of use.
- 6.51 There should be regular checks of all stocks to ensure that they are not out of date.

Good practice

- 6.52 *Clinical records were kept securely in line with Caldicott principles on confidentiality of personal health information.*
- 6.53 *Clean needles, syringes and other equipment and information for injecting drug users provided harm minimisation.*

7. Summary of recommendations

Strategy

To Wiltshire Constabulary and police authority

- 7.1 The force and police authority should develop a long-term plan to improve and upgrade the facilities and infrastructure at the Salisbury custody suite. (3.18)

To Wiltshire Constabulary

- 7.2 The current role and duties of the custody site managers should be reviewed. (3.19)
- 7.3 The workforce modernisation programme should be reviewed to ensure that staffing arrangements are suitable for custody suites and minimise risks to detainees and staff. (3.20)
- 7.4 A chief officer at strategic level should address the lack of engagement with health partners. (3.21)
- 7.5 The membership of the strategic custody group should be expanded to include representatives of external partners. (3.22)
- 7.6 Use of force should be monitored centrally to enable managers to identify patterns and monitor trends, and to assure that it has been deployed appropriately and proportionately. (3.23)

Treatment and conditions

- 7.7 Booking-in desks should be of an appropriate height, and the reception area should allow adequate privacy for new arrivals. (4.37)
- 7.8 All cells should be fit for purpose and free of ligature points, which custody staff should be trained to identify. (4.38)
- 7.9 There should be clear policies to meet the needs of female detainees and those with disabilities or mobility issues while they are in custody. (4.39)
- 7.10 There should be cells adapted for use by detainees with disabilities. (4.40)
- 7.11 Regular health and safety, maintenance and cleanliness checks should be formalised across the custody estate, and should be fully recorded and monitored by custody site managers and the headquarters justice department to ensure that there is appropriate action on identified issues. (4.41)
- 7.12 Quality assurance sampling checks should be recorded and monitored by headquarters justice department to ensure these are completed on time, and that identified issues are addressed and learning points are disseminated. (4.42)

- 7.13 Cells, mattresses and pillows should be cleaned between use and kept clean, free of graffiti and functional for use. (4.43)
- 7.14 Detainees held overnight and those who are dirty should be offered a shower. (4.44)
- 7.15 Shower areas should allow sufficient privacy, particularly for female detainees. (4.45)
- 7.16 Toilet paper should be provided routinely in all suites. (4.46)
- 7.17 Views of in-cell toilets covered by closed-circuit television should be obscured. (4.47)
- 7.18 Tracksuits, underwear and plimsolls should be provided when clothing is removed from detainees, unless there is a specific need for an alternative. (4.48)
- 7.19 Detainees held for longer periods should be offered outdoor exercise. (4.49)

Individual rights

- 7.20 The force should liaise with the UK Border Agency to ensure that immigration detainees are held for the shortest possible time. (5.26)
- 7.21 Custody staff should identify and, where possible, address any dependency issues for detainees. (5.27)
- 7.22 Appropriate adults should be available 24 hours a day to support juveniles and vulnerable adults in custody. (5.28)
- 7.23 Detainees aged 17 years should be provided with an appropriate adult. (5.29)
- 7.24 There should be an urgent review of the processes used to take, store, track and submit all DNA and forensic samples taken from detainees, volunteers and victims. This should identify gaps in policies, training, storage facilities and destruction audit trails, with a senior officer responsible for delivery of an action plan to address these. (5.30)
- 7.25 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. (5.31)
- 7.26 Detainees should be able to make a formal complaint about their treatment during arrest or detention while they are still in custody, and all such complaints should be investigated promptly and fully. (5.32)
- 7.27 The number and nature of complaints with a racial element should be monitored and any trends identified acted on. (5.33)

Healthcare

- 7.28 Women detainees should be able to see a woman doctor on request and be informed of this possibility. (6.39)
- 7.29 The contract monitoring of health services should ensure that robust clinical governance arrangements are in place. (6.40)

- 7.30 Healthcare staff should have the appropriate knowledge and skills to meet all the physical and mental health needs of detainees. (6.41)
- 7.31 There should be clear infection control procedures, including cleaning schedules that should be adhered to, and monitored. (6.42)
- 7.32 There should be safe pharmaceutical management and use of medications. All medications should be stored safely and securely, and disposed of safely if not consumed. (6.43)
- 7.33 All resuscitation equipment should be checked at least weekly, and there should be documentary evidence that these are completed. (6.44)
- 7.34 Secondary dispensing by nurses should cease. (6.45)
- 7.35 Detainees should be able to continue prescribed medication for any clinical condition, and to receive medications to provide relief for drug and alcohol withdrawal symptoms if needed. (6.46)
- 7.36 Services for detainees with substance use issues should be provided consistently across the county, including access to clean needles. (6.47)
- 7.37 Services for detainees with mental health needs should be provided consistently across the county. (6.48)

Housekeeping points

Healthcare

- 7.38 The forensic medical examiner rooms should be locked when not in use. (6.49)
- 7.39 Sharps bins should be dated and signed on commencement of use. (6.50)
- 7.40 There should be regular checks of all stocks to ensure that they are not out of date. (6.51)

Good practice

Individual rights

- 7.41 Staff ensured support for detainees on release where there were identified risks, such as making arrangements for family members to collect detainees from custody. (5.34)

Healthcare

- 7.42 Clinical records were kept securely in line with Caldicott principles on confidentiality of personal health information. (6.52)
- 7.43 Clean needles, syringes and other equipment and information for injecting drug users provided harm minimisation. (6.53)

Appendix I : Inspection team

Sean Sullivan	-	HMIP team leader
Anita Saigal	-	HMIP inspector
Andrea Walker	-	HMIP inspector
Paddy Craig	-	HMIC inspector
Fiona Sheerlaw	-	HMIC inspector
Gary Boughen	-	HMIC inspector
Elizabeth Tysoe	-	HMIP healthcare inspector
Anne McCaffery	-	CQC healthcare inspector
Catherine Nichols	-	HMIP researcher

Appendix II : Custody record analysis

Background

As part of the inspection of Wiltshire police custody cells, a sample of custody records of detainees held between 15 and 20 September 2009 was analysed. Custody records were held electronically on the Niche electronic custody system. A total of 30 records were analysed from across the Wiltshire area:

Custody suite	Number of records analysed
Swindon	12
Melksham	10
Salisbury	8
TOTAL	30

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

Demographic information

- Six (20%) of the detainees were women and 24 (80%) were men.
- Seven people (23%) under 17 were included in the sample, the youngest was 12 years old. The oldest detainee in the sample was 74.
- Twenty-six (87%) detainees were white, and four were from a black and minority ethnic background.
- Eight (27%) detainees had been held overnight, including those that had arrived during the night and were not released until the morning. One (3%) had been held for more than 24 hours. Two (7%) had been held for less than an hour.
- All detainees could speak and understand English, and so the use of interpreters could not be determined.
- Two detainees were foreign nationals, but neither was informed of their foreign national rights.
- Five (17%) detainees had a risk of self-harm or suicide, six (20%) had disclosed mental health issues and 11 (37%) were intoxicated on arrival. No custody record noted that it was a detainee's first time in custody.

Removal of clothing

Three detainees had had clothing removed from them:

- One detainee had had his clothing seized, but no replacement clothing documented. However, the photo taken at the station showed him in a blue paper suit. There was no indication that he was given any other clothing before he was released.
- One detainee, who was 15 years old, had his trousers forcibly removed by three officers in his cell, because they had a cord in them. There was no record of replacement clothing being given, but blankets were frequently offered.
- One record showed that replacement clothing was issued, but there was no indication of when the original clothing was removed.

Young people

- For all but one of the young people in our sample, appropriate adults had been requested. The one detainee without an appropriate adult was released within an hour, was not interviewed and no further action was taken. In two cases, there were significant delays in getting an appropriate adult from the emergency duty service. In one instance in Melksham, the wait was from 9.44am and the expected arrival time was after the next shift started at 9pm, leading the police to bail the young person after six hours in custody waiting for an appropriate adult. The second long wait was in Swindon, from 11.08pm until 10.50am, as the appropriate adult was dealing with a section 136 case.
- All the young people were informed of their rights a second time, when the appropriate adult was present.
- All those interviewed had appropriate adults present, but in some cases this was poorly documented and could only be deduced from signatures and timings of the appropriate adults activity in the detention log.
- There was one case where the young person asked for her father not to be contacted and for him not to be the appropriate adult, but he was used as the appropriate adults although her mother had been contacted.

Immigration detainees

- One detainee was flagged up as of interest to UKBA. However, UKBA was aware of the man, and as he was registered at an address he was of no interest to them. This response was rapid and early in the morning. The detainee, however, stated he was no longer at the address and wished to return to Iran. After being informed of the change in circumstance, UKBA was no longer responsive, despite numerous attempts at contact from the police, and he was released. Advice from UKBA was to go to his embassy to get documentation and then go to his local UKBA office.

Inspector reviews

Inspector reviews were held in line with requirements. A few reviews were delayed due to other operational commitments, and one was held over the phone. There were reminders on Niche to inform the detainee of their rights and of the review when sleeping reviews had happened etc.

Services

- All detainees had been asked whether they wanted someone informed of their arrest, but only three (10%) had been offered the opportunity to make a phone call themselves.
- All detainees had been routinely asked if they wanted a solicitor, but only 12 (40%) accepted this offer. Those who declined legal advice were regularly reminded of their rights, and when some changed their minds at this point, solicitors were quickly contacted.
- No detainees saw a drugs worker, but one saw an alcohol worker and one was referred, with consent, to the crisis team.
- No detainees shared a cell while in custody.

- Seven (23%) detainees had requested to see the FHCP (forensic healthcare professional). All seven saw an FHCP, but one asked to see one twice and left before the second FHCP arrived – he had Asperger's Syndrome, ADHD and a blood clot, which had hospitalised him over the weekend. The medical record of the FHCP's visit, which was usually scanned in, was not there, so it was not possible to determine the advice or diagnosis, or if he required an appropriate adult. The longest wait for a FHCP was six hours; this was for a man who was hearing voices and had self-harm/suicide issues.
- One detainee who was on numerous medications did not request to see an FHCP, but the police called G4S to determine whether he was fit for interview and advice was given over the phone that he would be fit.
- One young woman who entered custody said she had a dislocated knee, but did not ask for and was not offered the opportunity to see an FHCP.
- Fifteen (50%) detainees had eaten at least one meal while in custody. Only two detainees, detained longer than 12 hours left without eating a meal, the longest being 16 hours.
- One detainee in Salisbury who had spent 36 hours in custody was given a shower. No other detainees requested or received a shower.
- Two detainees, both in Melksham, were allowed outside exercise. No other detainees were offered or asked for exercise.
- Six detainees (20%) had been provided with reading materials, three of whom were in custody on a weekday in Melksham.

Additional points of note

- In two cases in Swindon, it was noted that only a verbal handover was possible, as only one sergeant was on duty and there was a high volume of detainees in custody.
- Detainees were routinely given a leaflet and risk assessed on release. In five cases, officers took detainees home, after risk was noted on their pre-release risk assessment. In other cases, arrangements were made in custody for relatives to collect detainees, or the charge desk phone was used to call a taxi. The response of the police was tailored to the individual, particularly in domestic violence offences and with vulnerable detainees. However, one 19-year-old woman was released from Salisbury police station at 1am with no risk flagged up on her pre-release risk assessment
- The risk assessment in custody was also responsive to individual need, as one older man was allowed to keep his walking stick in the cell to facilitate mobility, despite a prohibited elastic drawstring attached to it. In another case, the police, with consent, used the detainee's keys to enter his property to collect his medicine.
- In one case, the detainee's partner called the station to make a complaint about the investigation. They were asked to call the control room and speak with an operator to channel the call accordingly.
- In Salisbury, food items were brought in for a detainee.
- In Melksham, a mother who was acting as an appropriate adult for her son had her role and rights, as an appropriate adult, explained to her by the police.

Appendix III : Summary of detainee questionnaires and interviews

Prisoner survey methodology

A voluntary, confidential and anonymous survey of the HMP Bristol prisoner population who had been through a police station in Wiltshire 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 23 September 2009. A list of potential respondents to have passed through Melksham, Swindon and Salisbury police stations was created, listing all those who had arrived from Trowbridge, Salisbury, Devizes, Chippenham and Swindon Magistrates courts within the past month.

Selecting the sample

In total, 34 respondents were approached. One respondent reported being held in a police station outside of Wiltshire.

On the day, the questionnaire was offered to 33 respondents; there were no refusals or non-returns, but one questionnaire was returned blank. All of those sampled had been in custody within the last month.

Completion of the questionnaire was voluntary. One interview was carried out with a prisoner who 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:

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

Respondents were given a choice about putting their names on their questionnaire.

Response rates

In total, 32 (97%) 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 14 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?**
Unrecorded: 2; Swindon: 16; Melksham: 12; Salisbury: 2
- Q3 What type of detainee were you?**
- | | |
|--|------|
| <i>Police detainee</i> | 100% |
| <i>Prison lock-out (i.e. you were in custody in a prison before coming here)</i> | 0% |
| <i>Immigration detainee</i> | 0% |
| <i>I don't know</i> | 0% |
- Q4 How old are you?**
- | | | | |
|----------------------------------|-----|--------------------------------|-----|
| <i>16 years or younger</i> | 0% | <i>40-49 years</i> | 13% |
| <i>17-21 years</i> | 10% | <i>50-59 years</i> | 3% |
| <i>22-29 years</i> | 32% | <i>60 years or older</i> | 0% |
| <i>30-39 years</i> | 42% | | |
- Q5 Are you:**
- | | |
|--------------------------------------|------|
| <i>Male</i> | 100% |
| <i>Female</i> | 0% |
| <i>Transgender/Transsexual</i> | 0% |
- Q6 What is your ethnic origin?**
- | | |
|---|-----|
| <i>White - British</i> | 84% |
| <i>White - Irish</i> | 6% |
| <i>White - Other</i> | 6% |
| <i>Black or Black British - Caribbean</i> | 3% |
| <i>Black or Black British - African</i> | 0% |
| <i>Black or Black British - Other</i> | 0% |
| <i>Asian or Asian British - Indian</i> | 0% |
| <i>Asian or Asian British - Pakistani</i> | 0% |
| <i>Asian or Asian British - Bangladeshi</i> | 0% |
| <i>Asian or Asian British - Other</i> | 0% |
| <i>Mixed Race - White and Black Caribbean</i> | 0% |
| <i>Mixed Race - White and Black African</i> | 0% |
| <i>Mixed Race - White and Asian</i> | 0% |
| <i>Mixed Race - Other</i> | 0% |
| <i>Chinese</i> | 0% |
| <i>Other ethnic group</i> | 0% |
| <i>Please specify:</i> | |
- Q7 Are you a foreign national (i.e. you do not hold a British passport, or you are not eligible for one)?**
- | | |
|------------------|-----|
| <i>Yes</i> | 3% |
| <i>No</i> | 97% |
- Q8 What, if any, would you classify as your religious group?**
- | | |
|-------------------|-----|
| <i>None</i> | 35% |
|-------------------|-----|

Church of England	26%
Catholic	23%
Protestant	3%
Other Christian denomination	3%
Buddhist	0%
Hindu	0%
Jewish	3%
Muslim.....	3%
Sikh	3%
Any other religion, please specify	

Q9 How would you describe your sexual orientation?

Straight / Heterosexual.....	100%
Gay / Lesbian / Homosexual	0%
Bisexual.....	0%
Other (please specify):	

Q10 Do you consider yourself to have a disability?

Yes.....	23%
No	68%
Don't know	10%

Q11 Have you ever been held in police custody before?

Yes.....	97%
No	3%

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.....	0%
More than 6 hours, but less than 12 hours.....	0%
More than 12 hours, but less than 24 hours	25%
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).....	18%
72 hours (3 days) or more	14%

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

Yes.....	80%
No	13%
Don't know/Can't remember	7%

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

Yes.....	58%
No	19%
I don't know what this is/I don't remember	23%

Q15	If your clothes were taken away, were you offered different clothing to wear?		
	<i>My clothes were not taken</i>		57%
	<i>I was offered a tracksuit to wear</i>		7%
	<i>I was offered an evidence suit to wear</i>		25%
	<i>I was offered a blanket</i>		11%
Q16	Could you use a toilet when you needed to?		
	<i>Yes</i>		94%
	<i>No</i>		3%
	<i>Don't Know</i>		3%
Q17	If you have used the toilet there, were these things provided?		
		<i>Yes</i>	<i>No</i>
	<i>Toilet paper</i>	41%	59%
Q18	Did you share a cell at the police station?		
	<i>Yes</i>		3%
	<i>No</i>		97%
Q19	How would you rate the condition of your cell:		
		<i>Good</i>	<i>Neither</i>
		<i>Bad</i>	
	<i>Cleanliness</i>	58%	26%
	<i>Ventilation /air quality</i>	33%	11%
	<i>Temperature</i>	14%	29%
	<i>Lighting</i>	41%	22%
			37%
Q20	Was there any graffiti in your cell when you arrived?		
	<i>Yes</i>		27%
	<i>No</i>		73%
Q21	Did staff explain to you the correct use of the cell bell?		
	<i>Yes</i>		29%
	<i>No</i>		71%
Q22	Were you held overnight?		
	<i>Yes</i>		100%
	<i>No</i>		0%
Q23	If you were held overnight, which items of clean bedding were you given?		
	<i>Not held overnight</i>		0%
	<i>Pillow</i>		28%
	<i>Blanket</i>		55%
	<i>Nothing</i>		18%
Q24	Were you offered a shower at the police station?		
	<i>Yes</i>		10%
	<i>No</i>		90%
Q25	Were you offered any period of outside exercise whilst there?		
	<i>Yes</i>		6%
	<i>No</i>		94%

Q26	Were you offered anything to:			
		Yes	No	
	Eat?	88%	13%	
	Drink?	79%	21%	
Q27	Was the food/drink you received suitable for your dietary requirements?			
	<i>I did not have any food or drink</i>		13%	
	Yes.....		45%	
	No.....		42%	
Q28	If you smoke, were you offered anything to help you cope with the smoking ban there?			
	<i>I do not smoke</i>		6%	
	<i>I was allowed to smoke</i>		0%	
	<i>I was not offered anything to cope with not smoking</i>		87%	
	<i>I was offered nicotine gum</i>		6%	
	<i>I was offered nicotine patches</i>		0%	
	<i>I was offered nicotine lozenges</i>		0%	
Q29	Were you offered anything to read?			
	Yes.....		29%	
	No.....		71%	
Q30	Was someone informed of your arrest?			
	Yes.....		52%	
	No.....		23%	
	<i>I don't know</i>		6%	
	<i>I didn't want to inform anyone</i>		19%	
Q31	Were you offered a free telephone call?			
	Yes.....		43%	
	No.....		57%	
Q32	If you were denied a free phone call, was a reason for this offered?			
	<i>My phone call was not denied</i>		54%	
	Yes.....		0%	
	No.....		46%	
Q33	Did you have any concerns about the following, whilst you were in police custody:			
		Yes	No	
	Who was taking care of your children	4%	96%	
	Contacting your partner, relative or friend	46%	54%	
	Contacting your employer	17%	83%	
	Where you were going once released	28%	72%	
Q34	Were you interviewed by police officials about your case?			
	Yes.....	81%		
	No.....	19%	If No, go to Q36	
Q35	Were any of the following people present when you were interviewed?			
		Yes	No	Not needed
	Solicitor	77%	15%	8%

Appropriate adult	11%	22%	67%
Interpreter	6%	28%	67%

- Q36 How long did you have to wait for your solicitor?**
- I did not requested a solicitor* 13%
- 2 hours or less 27%
- Over 2 hours but less than 4 hours 10%
- 4 hours or more 50%
- Q37 Were you officially charged?**
- Yes 91%
- No 3%
- Don't Know 6%
- Q38 How long were you in police custody after being charged?**
- I have not been charged yet* 3%
- 1 hour or less 7%
- More than 1 hour, but less than 6 hours 7%
- More than 6 hours, but less than 12 hours 10%
- 12 hours or more 72%

Section 3: Safety

- Q40 Did you feel safe there?**
- Yes 76%
- No 24%
- Q41 Had another detainee or a member of staff victimised (insulted or assaulted) you there?**
- Yes 45%
- No 55%
- Q42 If you have felt victimised, what did the incident involve? (Please tick all that apply)**
- I have not been victimised* 31% *Because of your crime* 13%
- Insulting remarks (about you, your family or friends)* 15% *Because of your sexuality* 0%
- Physical abuse (being hit, kicked or assaulted)* . 7% *Because you have a disability* 4%
- Sexual abuse* 0% *Because of your religion/religious beliefs* 4%
- Your race or ethnic origin* 2% *Because you are from a different part of the country than others* 4%
- Drugs* 22%
- Please describe:*
- Q43 Were you handcuffed or restrained whilst in the police custody suite?**
- Yes 35%
- No 65%
- Q44 Were you injured whilst in police custody, in a way that you feel was not your fault?**
- Yes 27%
- No 73%

Q45	Were you told how to make a complaint about your treatment here, if you needed to?	
	Yes	21%
	No	79%

Section 4: Healthcare

Q47	When you were in police custody were you on any medication?	
	Yes	58%
	No	42%

Q48	Were you able to continue taking your medication whilst there?	
	<i>Not taking medication</i>	43%
	Yes	13%
	No	43%

Q49	Did someone explain your entitlements to see a healthcare professional, if you needed to?	
	Yes	32%
	No	57%
	<i>Don't know</i>	11%

Q50	Were you seen by the following healthcare professionals during your time there?	Yes	No
	Doctor	55%	45%
	Nurse	48%	52%
	Paramedic	5%	95%
	Psychiatrist	9%	91%

Q51	Were you able to see a healthcare professional of your own gender?	
	Yes	33%
	No	37%
	<i>Don't know</i>	30%

Q52	Did you have any drug or alcohol problems?	
	Yes	65%
	No	35%

Q53	Did you see, or were offered the chance to see a drug or alcohol support worker?	
	<i>I didn't have any drug/alcohol problems</i>	35%
	Yes	29%
	No	35%

Q54	Were you offered relief or medication for your immediate symptoms?	
	<i>I didn't have any drug/alcohol problems</i>	35%
	Yes	19%
	No	45%

Q55	Please rate the quality of your healthcare whilst in police custody:						
		I was not seen by health-care	<i>Very Good</i>	<i>Good</i>	<i>Neither</i>	<i>Bad</i>	<i>Very Bad</i>
	Quality of Healthcare	33%	7%	13%	7%	7%	33%

Q56 **Did you have any specific physical healthcare needs?**
No 52%
Yes 48%
Please specify:

Q57 **Did you have any specific mental healthcare needs?**
No 59%
Yes 41%
Please specify:

Thank you for your time



Prisoner Survey Responses for Wiltshire Police 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

		Wiltshire Police	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		
Number of completed questionnaires returned		32	505
SECTION 1: General Information			
2	Are you a Police detainee?	100%	86%
3	Are you under 21 years of age?	9%	9%
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)	2%	38%
6	Are you a foreign national?	2%	16%
7	Are you Muslim?	2%	13%
8	Are you homosexual/gay or bisexual?	0%	2%
9	Do you consider yourself to have a disability?	22%	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?	76%	64%
12	Were you given information about your arrest and entitlements when you arrived?	80%	73%
13	Were you told about PACE?	58%	53%
14	If your clothes were taken away, were you given a tracksuit to wear?	17%	41%
15	Could you use a toilet when you needed to?	94%	88%
16	If you did use the toilet, was toilet paper provided?	42%	54%
17	Did you share a cell at the station?	2%	3%
18	Would you rate the condition of your cell, as 'good' for:		
18a	Cleanliness?	58%	28%
18b	Ventilation/air quality?	33%	19%
18c	Temperature?	15%	14%
18d	Lighting?	40%	44%
19	Was there any graffiti in your cell when you arrived?	27%	58%
20	Did staff explain the correct use of the cell bell?	29%	21%
21	Were you held overnight?	100%	91%
22	If you were held overnight, were you given clean items of bedding?	22%	32%
23	Were you offered a shower?	9%	7%

Key to tables

	Any percent highlighted in green is significantly better	Wiltshire Police	Police custody comparator
	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?	7%	5%

Key to tables

		Wiltshire Police	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		
25a	Were you offered anything to eat?	87%	79%
25b	Were you offered anything to drink?	78%	82%
26	Was the food/drink you received suitable for your dietary requirements?	53%	40%
27	For those who smoke: were you offered nothing to help you cope with the ban there?	87%	76%
28	Were you offered anything to read?	29%	13%
29	Was someone informed of your arrest?	52%	42%
30	Were you offered a free telephone call?	43%	51%
31	If you were denied a free call, was a reason given?	0%	17%
32	Did you have any concerns about:		
32a	Who was taking care of your children?	3%	18%
32b	Contacting your partner, relative or friend?	46%	54%
32c	Contacting your employer?	18%	22%
32d	Where you were going once released?	28%	36%
34	If you were interviewed were the following people present:		
34a	Solicitor	76%	75%
34b	Appropriate adult	11%	8%
34c	Interpreter	4%	9%
35	Did you wait over 4 hours for your solicitor?	58%	65%
37	Were you held 12 hours or more in custody after being charged?	76%	65%
SECTION 3: Safety			
39	Did you feel unsafe?	24%	41%
40	Has another detainee or a member of staff victimised you?	46%	44%
41	If you have felt victimised, what did the incident involve?		
41a	Insulting remarks (about you, your family or friends)	26%	26%
41b	Physical abuse (being hit, kicked or assaulted)	13%	15%
41c	Sexual abuse	0%	2%
41d	Your race or ethnic origin	2%	6%
41e	Drugs	39%	16%
41f	Because of your crime	22%	20%
41g	Because of your sexuality	0%	0%
41h	Because you have a disability	7%	3%
41i	Because of your religion/religious beliefs	7%	4%
41j	Because you are from a different part of the country than others	7%	5%
42	Were you handcuffed or restrained whilst in the police custody suite?	36%	48%

Key to tables

	Any percent highlighted in green is significantly better	Wiltshire Police	Police custody comparator
	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		
43	Were you injured whilst in police custody, in a way that you feel is not your fault?	27%	27%

Key to tables

	Any percent highlighted in green is significantly better	Wiltshire Police	Police custody comparator
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	Any percent highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
44	Were you told how to make a complaint about your treatment?	21%	13%
SECTION 4: Healthcare			
46	Were you on any medication?	58%	44%
47	For those who were on medication: were you able to continue taking your medication?	24%	39%
48	Did someone explain your entitlement to see a healthcare professional, if you needed to?	32%	36%
49	Were you seen by the following healthcare professionals during your time in police custody:		
49a	Doctor	56%	50%
49b	Nurse	48%	18%
49c	Paramedic	3%	2%
49d	Psychiatrist	9%	3%
50	Were you able to see a healthcare professional of your own gender?	34%	28%
51	Did you have any drug or alcohol problems?	64%	58%
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?	45%	42%
53	Were you offered relief medication for your immediate symptoms?	30%	36%
54	For those who had been seen by healthcare, would you rate the quality as good/very good?	30%	31%
55	Do you have any specific physical healthcare needs?	48%	35%
56	Do you have any specific mental healthcare needs?	42%	24%