



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

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by HM Inspectorate of Prisons and
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Contents

1. Introduction	5
2. Background and key findings	7
3. Strategy	13
4. Treatment and conditions	19
5. Individual rights	33
6. Healthcare	51
7. Summary of recommendations	59

Appendices

I Inspection team	65
II On-site police custody survey	66

1. Introduction

This is the seventh in a series of reports 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, agreed by Ministers. They also contribute to the United Kingdom's compliance with 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.

Cambridgeshire Constabulary has eight custody suites designated for the reception of detainees under the Police and Criminal Evidence Act 1984 (PACE). However, the vast majority of detainees passed through only four of these: Peterborough Thorpewood, Cambridge Parkside, Huntingdon and Wisbech. Around a fifth of those detained by Cambridgeshire police were immigration detainees. Strategic leadership rested with an Assistant Chief Constable, but operational responsibility was largely devolved to basic command unit (BCU) commanders.

We were disappointed at the lack of effective strategic attention to custodial issues in Cambridgeshire, evidenced by little meaningful progress on rectifying problems identified by the force's own internal audit of custody and the relevant National Policing Improvement Agency (NPIA) peer review. No adequate alternative plans for future improvement had been put in place following the force's withdrawal in April 2008 from the Three Counties Custody Project, a joint endeavour with Norfolk and Suffolk. With new suites now delayed to 2015, it is our assessment that the force will struggle to comply with national Safer Detention and Handling of Persons in Custody Guidance by the due date of April 2010.

There was no centralised policy framework for custody and a paucity of clear individual local or force-wide policies to drive through improvements. Staff appeared confused about the force's approach to custody, a number were not adequately trained and matters were compounded by the disparate approach taken by BCU commanders. The result was some very weak custody arrangements, including numerous safety issues, dirty conditions, inadequate processing of forensic and DNA samples, poorly managed healthcare services and variable provision for those with mental health and drug issues.

Many cells were not fit for purpose, particularly the older ones in Peterborough and Cambridge, which were dark, dingy, smelly and covered in graffiti. There were numerous safety hazards in many cells, including ligature points and sharp edges, compounded by an inconsistent approach to the carrying of ligature knives by staff. We also saw staff inappropriately muting cell bells at Cambridge. There was insufficient provision to address the particular needs of female, juvenile and immigration detainees. Access to showers, food and replacement clothing was inconsistent. We were disturbed by the unprofessional and uncaring approach displayed by some staff in Cambridge, particularly in respect of handling vulnerable detainees and the provision of food.

Appropriate attention was generally paid to individual rights as required under PACE. There was little privacy available for the use of telephones, access to appropriate adults was sometimes difficult and use of force forms were not always fully completed. Complaint processes were difficult to access.

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

Healthcare was poorly managed and we could not be assured from the available records that medical staff attended in a timely fashion. Cleanliness and infection control were weak. There was poor local multi-agency cooperation to manage vulnerable people and practice varied across the county, although there were good links with the psychiatric unit in Peterborough. There were also variations in the availability of drug services. Fridges in most suites were full of forensic samples that had not been dealt with and there was widespread evidence of systemic failings in the handling, storing and destruction of forensic and DNA samples.

This independent inspection of the police custody suites of Cambridgeshire Constabulary has exposed considerable shortfalls in many aspects of strategic management and service delivery. Urgent improvement is required to bring these suites up to a satisfactory standard. In the circumstances, we have referred details to the regional HM Inspector of Constabulary, for on-going monitoring, and we will return sooner rather than later to assess progress on the large number of recommendations that we have made, in order to reassure ourselves and the public that expeditious improvements have been made to the unsatisfactory custody provision currently provided by Cambridgeshire Constabulary.

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May 2009

2. Background and key findings

Background

- 2.1 Cambridgeshire Constabulary has eight custody suites designated under the Police and Criminal Evidence Act 1984 for the reception of detainees. However, the vast majority of detainees passed through four suites: Peterborough Thorpewood, Cambridge Parkside, Huntingdon and Wisbech. Ely, March, Peterborough Bridge Street and St Neots had shorter opening hours and more limited use. St. Neots was temporarily closed for refurbishment.
- 2.2 National Strategy for Police Information Systems (NSPIS) custody system data for the period from 25 August to 25 October 2008 indicated that the number of detainees passing through each suite was:
- Peterborough Thorpewood – 2,503 including 258 juveniles
 - Cambridge Parkside – 1,927 including 270 juveniles
 - Huntingdon – 1,047 including 151 juveniles
 - Wisbech – 657 including 81 juveniles
 - Ely – 122 including 33 juveniles
 - March – 66 including 14 juveniles
 - Peterborough Bridge Street – 12 with no juveniles
 - St Neots – 5 including 3 juveniles
- 2.3 It was not possible to extract figures for the number of immigration detainees. Managers estimated that they comprised about a fifth of the total throughput.
- 2.4 This inspection focused on the four main custody suites. The other four were also briefly visited and the main findings are outlined in this report as appropriate. Inspectors examined overall area custody strategies, treatment and conditions, individual rights and healthcare in each suite across the three basic command units (BCUs). A survey of prisoners at HMP Peterborough who had formerly been detained in Cambridgeshire custody suites was conducted by HM Inspectorate of Prisons researchers before the inspection to obtain additional evidence (see Appendix 2).

Strategic overview

- 2.5 A serious lack of effective strategic oversight contributed to poor outcomes in most sites. A thorough internal audit for custody had identified problems highlighted by this inspection up to a year previously, but few of these issues, including numerous ligature points, dirty conditions and inadequate processing of blood and DNA samples, had been dealt with effectively. Contrary to force policy, trained custody staff were not routinely used in all suites, resulting in a lack of consistency and an increase in risk.
- 2.6 The custody management model was not centralised and BCU commanders retained a high degree of autonomy and responsibility. The lack of a strong central framework to drive progress had resulted in a generally incoherent approach to the management of custody. There were few policies to inform and drive working practice. This in turn meant that frontline custody staff were unclear about Cambridgeshire Constabulary's approach to a range of issues, such as the management of immigration detainees and juveniles. The health services contract was inadequately managed and there was poor local agency cooperation in relation to

managing those taken to a place of safety under section 136 of the Mental Health Act. The quality of drug services provision varied greatly depending on where detainees were held.

Findings from the four main custody suites

Peterborough Thorpewood

Treatment and conditions

- 2.7 The 13 older cells were dark and dingy. Some were very smelly and had doors covered in graffiti. Several had ligature points and there were some examples of dangerous disrepair, such as a chipped glass block with a sharp edge. The 17 newer cells had anti-graffiti paint, were brightly lit and clean and provided a reasonable environment. Five cells had no natural light and were an inappropriate environment in which to hold people for any length of time. There was no evidence that showers and meals were offered. There were no designated cells for women or juveniles and no criteria for allocation of accommodation to ensure that the better cells were used first. We observed reasonable and respectful treatment by staff. Call bells were responded to, although not all detainees understood when to use them. Staff could not clearly see closed-circuit television (CCTV) monitors. Some clothing was available, but no underwear or socks. There was a store of books, but detainees were not routinely offered newspapers and magazines.

Individual rights

- 2.8 Custody reviews took place on time. As in other suites, there was no difference in the way juveniles were booked in and interviewed. Juveniles were located near to the desk, but this meant they were in the older cells. On one day of the inspection, an 11 year-old boy was subject to hourly observations in a cell with no CCTV. This was changed to half-hourly observations during our visit, but staff interacted very little with the child. A number of foreign national and immigration detainees were held and interpreters were routinely used. Female staff were not always available. Detainees were allowed a mobile telephone to talk to solicitors, but could not do so in private. Staff complained of the problems with getting trained custody sergeants. Fridges were full of forensic samples that had not been dealt with, including some for serious cases. The complaints system was not user-friendly and we spoke to staff who were actively trying to discourage detainees from making complaints.

Cambridge Parkside

Treatment and conditions

- 2.9 Most cells were dimly lit, dirty and had graffiti in them. A large swastika had been carved into the wall of one cell and left for some months, although staff knew it was there. There were no designated areas for women or juveniles and no clear criteria for allocation of accommodation to ensure that better cells were used first. Cell cleaning was unhygienic, with the same mop used to clean floors, walls, plastic-covered mattresses and pillows. None of the sampled NSPIS records showed detainees being offered showers and we did not see any offered. Most cells had ligature points, but staff did not routinely carry ligature knives. There was no privacy in the main booking area and we saw one distraught woman giving details of a recent miscarriage while six male staff stood around listening. We saw staff muting cell call bells rather than answering them promptly. We did not see detainees offered meals and custody records showed that detainees waited as long as 24 hours between meals. Some staff

displayed a disrespectful and uncaring attitude, including watching a disturbed man throwing himself around a cell for about 20 minutes on CCTV, apparently with some amusement and making no attempt to calm him down. Records also showed that a detainee had his trousers removed, apparently because of suicide risk. He was not given alternative rip-proof clothing, although plenty was available, and his trousers were returned to him shortly afterwards, without any clear reasons recorded for removing or returning them. This detainee complained of being strip-searched for no reason when surveyed in HMP Peterborough. Some clothing was available, but no underwear or socks. There was a store of books, but detainees were not routinely offered newspapers and magazines.

Individual rights

- 2.10 Custody reviews took place on time. Juveniles were located in more modern cells covered by CCTV, but there was an over-reliance on technology to observe them and too little emphasis on the need to interact with them. Detainees had good access to telephones, but could not use them in private. Hygiene packs were available for women, but were not routinely given out. Although comprehensive statistics could not be provided, immigration detainees were held regularly, often for three to four days. Interpreters were used regularly. The PACE book was not up to date. No information was given out about complaints. One custody record showed that a detainee had asked to see the inspector to make a complaint about treatment by an officer, but no one had come to see him. We were told that solicitors and appropriate adults generally came quickly when called and the latter praised good access to detainees, but no appropriate adults were available between 11pm and 9am. Use of force forms did not identify individuals against whom force was used, so it was not possible to trace cases of concern. There was no routine practice or policy to deal with detainees' dependants or children. There were no formal pre-release risk management policies, although staff responded in an ad hoc way to vulnerability. There were no female staff on any shift.

Huntingdon

Treatment and conditions

- 2.11 There was no graffiti in the cells and we spoke to a professional and committed sergeant and detention officers. Some cells had filthy drains that could also be used as ligature points. Use of cell call bells was explained to new arrivals and staff routinely carried ligature knives. Staff spoken to were custody trained, but we were told that the suite did not always have such staff available. As in other suites, no underwear or socks were available. There was a small store of books and some magazines, but these were not necessarily offered to detainees. Detainees were not given regular meals and custody records showed that some waited at least 13 hours between meals.

Individual rights

- 2.12 Custody reviews took place on time. Social services were not routinely contacted if children were brought in at night; if they had information relevant to risk, this was not therefore available to custody staff. All juveniles were treated as high-risk detainees and placed on half-hourly observations. However, as elsewhere, staff had no specific training or policies for working with juveniles. Male staff often supervised women, which was a particular problem around shower areas.

Wisbech

Treatment and conditions

- 2.13 The cells had poor natural light and were badly lit and many had a musty urine smell. The suite was badly designed, with cells a long way from the main desk. The custody sergeant did not carry a ligature knife, but detention officers did. A cell had been decommissioned earlier in the year, because a detainee had found a way to attempt to self harm in it. Toilet roll was not routinely provided. The waiting area was outside. Showers could not be taken in private. Detainees waited long periods between meals, with one custody record showing one man waiting 15 hours. Use of cell call bells was not explained to detainees. Some limited reading material was available, but was not routinely offered.

Individual rights

- 2.14 Reviews were completed on time. There were no significant adjustments in the approach to juveniles. Appropriate adults were quickly available for juveniles, but not between 11pm and 7.30am. Appropriate adults were not always available for those who were vulnerable for other reasons, such as learning disability. Limited sanitary products were available for women. Foreign national and immigration detainees were often held and interpreters were used. Detainees could take a mobile telephone into their cells to speak to solicitors. There was no routine link with drug and alcohol services. There was no formal complaints procedure, although detainees were given the long and complex IPCC form if they wanted to complain. Most staff were male. There was no evidence of systematic pre-release arrangements.

Brief findings on the four infrequently used/closed suites

- 2.15 All the remaining suites had ligature points in many or all cells. At Peterborough Bridge Street, the plaster around some glass blocks in the cells had been chipped away to expose sharp edges and making it possible to wedge something in the gap. St. Neots had been closed for refurbishment for a few days. One cell had no natural light and all had ligature points prior to the refurbishment. We pointed out that one cell would still have obvious ligature points (large holes in the heating grille) after the refurbishment. The building supervisor said this would be rectified. While the cells in the lesser-used suites were generally clean, some toilets at Bridge Street were filthy. In March, the three men's cells were light, but the single women's cell was very dark with an unused shower area. Custody logs in all the lesser-used suites indicated irregular access to food and showers.
- 2.16 All custody suites were regularly run by staff who were not custody trained. Reviews were carried out on time and interpreters were used in most appropriate cases. Staff at St Neots expressed frustration at the lack of clarity about the Constabulary's approach to immigration detainees. There were no particular differences in the approach to juveniles. Solicitors and appropriate adults were contacted as required. There were no formal pre-release risk management arrangements anywhere.

Healthcare across all suites

- 2.17 Fundamentally sound clinical governance arrangements were undermined by a lack of basic contract monitoring. Officers often did not record when they called doctors and incomplete records meant it was hard to identify how long patients waited to be seen after a doctor was

called. However, custody records showed a number of cases where detainees waited over an hour before seeing the requested doctor. Officers could telephone Essex Forensic Medical Services for approval to give out medications such as paracetamol and inhalers.

- 2.18** About 40 people a month were detained under Section 136 of the Mental Health Act and most were taken to Cambridge Parkside or Peterborough Thorpewood. About two-thirds of detainees were triaged out, often because they were drunk rather than mentally disordered. There was poor local multi-agency cooperation to manage vulnerable people and variable practices depending on which part of the county people were detained. There were reasonable relationships with the psychiatric unit in Peterborough, but little evidence of constructive professional relationships elsewhere.
- 2.19** Fridges and freezers in most suites contained old blood, urine and DNA samples. There was also out-of-date medical equipment at Peterborough Thorpewood, including testing strips and syringes, with serious implications for the gathering of evidence. There was no infection control in some treatment rooms; the Wisbech room was dusty and had full clinical waste bins. There was a fractured approach to drugs services provision, with different systems depending on location in the county. The northern BCU was an intensive drug intervention programme area, but it was not clear what happened to drugs referrals in the southern and central BCUs.

3. Strategy

- 3.1 There was little evidence of strategic priority or direction in relation to custody. Little progress had been made since Cambridgeshire Constabulary's decision to withdraw from the Three Counties Custody Project. Few issues identified in an internal audit for custody had been dealt with. Trained custody staff were not routinely used in all suites. Central direction was limited and there were few policies to drive working practice forward. The health services contract was inadequately managed and drug services provision varied greatly depending on where detainees were held.

Expectation

- 3.2 There is a policy focus on custody issues at a chief officer level that is concerned with developing and maintaining the custody estate, staffing custody suites with trained staff, managing the risks of custody, meeting the health and wellbeing needs of detainees and working effectively with colleagues in the health service, immigration service, youth offending service, criminal justice teams, Crown Prosecution Service (CPS), courts and other law enforcement agencies.

Findings

- 3.3 Cambridgeshire Constabulary had planned to develop its custody estate as part of the Three Counties Custody Project involving collaboration with Norfolk and Suffolk Constabularies. This was due to provide three large private finance initiative custody suites by 2010 that would have been compliant with Safer Detention and Handling of Persons in Custody Guidance (SDHP). However, the force withdrew from the project in April 2008. This put delivery of new custody suites back by five years, with completion anticipated in 2015. There had been no contingency plan for working towards compliance with SDHP in the event of the failure of the Three Counties Custody Project or in the event of a decision by any force to pull out. It was therefore questionable whether Cambridgeshire Constabulary could achieve compliance with SDHP by the agreed date of April 2010.
- 3.4 An assistant chief constable (ACC) had portfolio responsibility for custody matters. A detective superintendent in the headquarters (HQ) Investigations Directorate had oversight of custody, although management of custody policies and procedures rested with a temporary chief inspector at HQ. The ACC and a chief superintendent sat on the Cambridgeshire Custody Development Project board, which was responsible for the implementation of SDHP, the refurbishment of some custody suites and future new builds. Operational responsibility was devolved to three BCU commanders who were chief superintendents covering the northern, central and southern areas of Cambridgeshire. A number of the custody suites had custody managers who worked shifts while holding other roles and discharging other responsibilities, which severely restricted the time they had to dedicate to custody duties.
- 3.5 Historically, limited strategic leadership appears to have been given to the management of custody suites. There had been a failure to address serious and long-standing issues identified by the National Policing Improvement Agency (NPIA) Peer Review carried out in November 2007. The NPIA findings were sent to the force in January 2008. The force had not effectively addressed the findings of its own Annual Custody Health and Safety Inspection carried out in

January 2008, although the ACC was under the impression that most of the issues had been addressed. This raised questions about quality assurance structures and processes developed by BCUs to deliver the required improvements.

- 3.6 The Cambridgeshire Policing Plan (CPP) 2008-11 stated that a Custody Development Project should 'scope and develop the force custody function', while incorporating issues identified by the NPIA Peer Review and the force's own annual health and safety inspections. It highlighted the need to develop and implement policy guidance to ensure force-wide compliance with NPIA Safer Handling guidance, 'review the current custody management structure' and 'develop protocols with health service partners in relation to dealing with vulnerable detainees'. However, Custody Development Project board minutes dated October 2008 demonstrated a lack of clarity around the project brief, including whether it should cover governance and management structures, systems and policies.
- 3.7 There was a dearth of policies relating to issues contained within SDHP. This had been raised by the NPIA in a letter of January 2008, which stated "these are all critical policies which should be in place to support successful management of the custody environment". There had been a strategic failure to address these shortcomings with many of the required policies still at draft stage (see paragraph 3.18). At the time of inspection, the situation had not been remedied.
- 3.8 In contravention of force policy, not all custody sergeants and detention staff had received approved custody training before their deployment in custody suites. Custody sergeants were deployed in custody suites without 'module 3' first aid training despite this being objected to by HQ staff tasked with implementing SDHP. BCU management teams had overruled HQ staff, breaching the guidance contained in SDHP and contravening their own force policy. Defibrillators and oxygen were not provided in custody suites so staff were not trained in their use.
- 3.9 The need for ongoing refresher training had been identified, but was difficult to action as BCUs were reluctant to release staff. Access to a pool of trained custody sergeants in some of the busier custody suites was problematic and a source of friction between custody managers and BCU senior management teams (SMTs). There was under-investment in the role of custody sergeant in particular and this had also been highlighted to the force by the NPIA.
- 3.10 There was a lack of coherence and clarity in the management of custody suites. There was no strong central framework to drive progress, address concerns or maintain standards. BCUs operated custody suites as they saw fit with little effective control from HQ. The management structure was not delivering the improvements required to ensure compliance with SDHP. BCU and custody staff said the current management structure and meetings regime left important matters unaddressed and was not capable of delivering change. They expressed particular frustration with the fact that actions agreed by HQ and BCU custody staff were overruled by BCU senior management teams.
- 3.11 We considered that most cells should have been taken out of service as a result of safety concerns and were surprised that so many staff were unable to recognise obvious ligature points. The need for custody suites to be compliant with SDHP had not been acted on with due diligence at force or BCU level and there was a widespread culture of accepting high levels of risk in custody suites. Middle managers believed that decisions to take dangerous cells out of service would be overruled by superintendents because of operational pressures. Cambridgeshire Constabulary had therefore been knowingly operating custody suites with high levels of associated risk for at least a year. This culture and the working practices that had flowed from it were wholly indefensible.

- 3.12 In some custody suites, there was an apparent apathy towards safety, whether demonstrated by a failure to acknowledge cell bells or a failure by staff to carry ligature cutters, even though these had been issued. Lessons from near misses were evidently not being learned or enforced by managers. One member of staff remarked that 'we are overdue a death in custody. We will learn lessons from it and move on'.
- 3.13 Contracts for fixing or refurbishing cells were awarded on an ad hoc basis, which resulted in cells being out of service for three to six months and sometimes longer. This was not sustainable and was costly in terms of resources and money. It also placed unnecessary and additional pressures on custody and BCU management teams challenged with operational demands.
- 3.14 The force had outsourced the provision of healthcare in custody suites. However, the lack of contract management had implications for the care of detainees and incomplete records meant it was not possible to determine how long detainees waited between a doctor being requested and their being seen. The force had a reasonable relationship with the psychiatric unit at Peterborough, but there was little evidence of effective relationships elsewhere. There was poor multi-agency cooperation in managing vulnerable people. Drug service provision varied greatly depending on the area.
- 3.15 There was little evidence of a strategic approach to the management of immigration detainees. Staff were unclear about how they were required to deal with the UK Border Agency (UKBA) and there was a lack of knowledge about immigration detainees. There were differences between what managers believed was happening with the detention of immigration detainees and what we were told was actually happening in custody suites.
- 3.16 We were told that the force had a positive relationship with the Crown Prosecution Service (CPS), with ongoing partnership work being developed at Local Criminal Justice Board level. The quality of CPS cover and advice was described as 'mixed'. There was no process or forum at force level for engaging with defence solicitors to resolve ongoing issues.

Expectation

- 3.17 **There is an effective management structure for custody that ensures that policies and protocols are implemented and managed and that there are mechanisms for learning from adverse incidents, rubbing points or complaints.**

Findings

- 3.18 Drafting of some force policies had been delegated to busy operational custody sergeants, who had no experience of writing policies and who, because of their role, lacked strategic oversight. This meant policies took longer to draft and a number were simply inadequate to meet the needs of the force. Consequently, the lack of force policies to inform and drive practice meant frontline staff were unclear about their roles and obligations (see paragraph 3.7).
- 3.19 With operational responsibility devolved to each BCU, there were different working practices in staffing custody suites. A lack of consistently deployed custody staff put additional pressures on some custody sergeants. The lines of command and control were not well understood by all staff and some found the lines of accountability confusing.
- 3.20 There was no formal force policy covering cell bell usage and how staff should react to them. Some audible cell bells had been turned off because staff found them 'intrusive'. This practice

presented an additional risk to detainees, who would have been unable to summon assistance in an emergency.

- 3.21 Custody inspectors had been unsuccessful in their attempts to get BCUs to improve the management of old forensic samples and forensic exhibits.
- 3.22 The Constabulary DNA manager said the standard operating procedure for officers wanting to get rid of unwanted DNA was to dispose of it as clinical waste, with the paperwork shredded separately. This was obviously not known to operational officers. It also raised questions about audit trails for recording the destruction of DNA and how the Constabulary updated the National DNA Database or the Police National Computer as warranted by individual cases.
- 3.23 There was ample and widespread evidence of systemic failings in the handling, storing, submission and destruction of forensic and DNA samples. The situation was highly unsatisfactory, with potential failings to bring offenders to justice and cases being unnecessarily discontinued by the CPS as a result of police failings. This raised the prospect of miscarriages of justice and had serious implications for the administration of justice and maintaining public confidence in forensic or DNA evidence.
- 3.24 There were no specific policies dealing with the needs of juveniles, women and UKBA detainees detained beyond 24 hours or any guidance to custody staff about the different impact of custody on juvenile and female detainees.
- 3.25 Staff were unclear about the correct management of complaints. No information was given to detainees about how they could make a complaint while they were in custody. There was evidence in custody records to support grounds for making complaints and requests from detainees to speak to an inspector about making a complaint appeared to have been ignored. We witnessed treatment that should have led to complaints, in that the most basic welfare needs of detainees such as providing food were not being met in some of the busiest custody suites. While those detained at the police stations did not raise any concerns about their treatment when we spoke to them, a different picture emerged when we spoke to detainees in the local prison. Many complained about their treatment and the conditions in Cambridgeshire custody suites, although a minority said they had been treated humanely while detained.

Expectation

- 3.26 Maintenance of facilities only occurs when the suite is closed down.

Findings

- 3.27 The age and limited capacity of cell provision in Cambridgeshire Constabulary meant that maintenance work was completed when facilities were open, although future planned refurbishment was due to take place when custody suites were closed.

Recommendations

To Cambridgeshire Constabulary

- 3.28 Strategic leaders should ensure that custody services are safe and fit for purpose and comply with Safer Detention and Handling of Persons in Custody Guidance.
- 3.29 The recommendations of existing reports by the National Policing Improvement Agency and Cambridgeshire Constabulary should be addressed immediately.
- 3.30 The aims and scope of the Custody Development Project should be reviewed in the light of this inspection report.
- 3.31 All outstanding force policies relating to custody should be ratified and implemented.
- 3.32 Police officers and staff should not be deployed in custody suites without being given nationally approved training in custody duties as outlined by the National Policing Improvement Agency guidance.
- 3.33 Staffing of custody suites should reflect the pressures faced by busier custody suites.
- 3.34 Defibrillators and oxygen should be deployed in custody suites and staff suitably trained in their use.
- 3.35 An ongoing regime of refresher training that addresses core skills and knowledge should be implemented. This should be centrally managed, with basic command units directed to release staff for training.
- 3.36 A strong central framework for custody that incorporates all relevant policies should be developed, and the efficacy of the devolved custody model should be reviewed.
- 3.37 Robust quality assurance mechanisms should be established.
- 3.38 Strong leadership messages should reinforce the primacy of safety and welfare of detainees in custody.
- 3.39 A sustainable contract that offers value for money should be awarded that allows for the rapid turnaround of cells taken out of service.
- 3.40 Greater strategic effort should be put into addressing poor multi-agency arrangements and cooperation with regard to managing vulnerable people.
- 3.41 The UK Border Agency protocols should be re-visited to ensure strategic intent is matched by local delivery.
- 3.42 Social Services should be contacted routinely when children are brought into police custody during the night and this should be reflected in force policies.
- 3.43 Drafting of force policies should not be delegated to inexperienced staff with heavy operational commitments, but more suitably discharged by experienced HQ staff.

- 3.44 A formal force policy covering cell bell usage that details how staff must react to them should be introduced as soon as practicable and enforced.
- 3.45 A clear complaints policy should be advertised in custody suites and the number and nature of complaints analysed centrally so that underlying causes can be identified and addressed.

To Cambridgeshire Police Authority

- 3.46 Recommendation 3.28 should be overseen by the Police Authority lead for custody.

4. Treatment and conditions

- 4.1 Not all staff had received self-harm awareness training, but detainees were risk assessed on arrival. Detainees almost never shared cells. All cells had call bells, but systems varied and their use was not always explained. Some call bells were muted. Cleanliness of cells ranged from good to very poor. Not all toilets and showers were screened. Some cells contained obvious ligature points. Detainees frequently waited too long between meals and not all were offered blankets. Few were routinely offered exercise or showers. Some reading material was provided, but none of the suites could accommodate visits.

Expectation

- 4.2 Custody staff are aware of the risk of self-harm from:

- attempted suicide
- drugs ingestion
- medical conditions
- alcohol

and these risks are assessed, monitored and managed appropriately.

Findings

Thorpewood

- 4.3 Custody sergeants had received specialist suicide and self-harm training and demonstrated a good understanding of the risks. Other staff had received more general training and had a reasonable understanding of the risks. Custody sergeants conducted assessments using the standard NSPIS format, often supplemented by additional information from internal systems such as the intranet. Notices outside each cell prompted staff to carry out checks in a standardised way and cell checks appeared to be carried out as specified on the initial risk assessment. A list outside each cell door detailed each check carried out. Staff tended to use common sense and this resulted in an appropriately cautious approach to the initial assessment of risk.

Parkside

- 4.4 A generic reception risk assessment was used for all detainees irrespective of gender, age or risks posed. This covered suicide, drugs and alcohol use, medical conditions and medications. Information was gathered from the detainee and the escorting officer and we saw staff seeking information from a detainee's doctor because the detainee was too drunk to answer the questions. The main booking in area was in the middle of the custody area and offered little privacy. One distressed female detainee had to give details of a miscarriage to the custody sergeant in the presence of six male staff. A second booking in desk was completely private.
- 4.5 Risk assessments were usually carried out by the custody sergeant authorising the detention and in a matter of fact way. The level of observations agreed reflected the risks posed and detailed records of observations by staff were kept, particularly when the detainee needed to

be roused. Detainees new to custody were identified and subject to hourly observations unless the risk assessment suggested these should be more frequent. The heavy reliance on closed-circuit television (CCTV) and life signs monitoring sometimes bordered on dangerous. We saw one inebriated detainee shown on CCTV falling over in his cell and banging his head against a wall. The six staff, including the custody sergeant, watching the screen laughed at this potentially harmful incident and it was at least 15 minutes before someone went to check on him.

- 4.6 All staff had been issued with ligature knives, but we did not see anyone carrying them and some were stored in lockers. Staff showed little understanding of why they should carry ligature knives. All staff on duty carried keys.

Huntingdon

- 4.7 No staff we asked had received specialist training, but all had a basic understanding of risk, apparently through their generic custody training. The custody sergeant carried out a formal risk assessment built into the NSPIS system, but this did not appear to form any subsequent care plan. Staff said the one detainee held during the inspection had been severely inebriated on arrival. He had been placed on high-risk (30 minute) observations and roused each time, which seemed appropriate. The handover we observed was good quality, with all relevant and necessary information passed to the oncoming custody sergeant.

- 4.8 One cell had CCTV, one had life-signs monitoring and one had both. There was no formal policy for determining the circumstances when each cell should be used, but the custody sergeant demonstrated a sound approach to this based on the risks involved. Both the custody sergeant and the one other member of staff on duty carried keys and a ligature knife. All regular staff had been issued with ligature knives and there was a stock of spares that could be issued to non-regular staff.

Wisbech

- 4.9 Risks of suicide, drug or alcohol use and medical conditions were thoroughly covered in private when detainees were booked in. Staff said detainees deemed at risk could be placed on more frequent observations or put in the CCTV cell or the cell with life signs monitoring. In a recent initiative, referrals could be made to the community drug intervention programme, but staff said they had only shown detainees a telephone number they could ring for help with substance use. Cells were checked between use.
- 4.10 Detainees were not left unsupervised before being booked in. When a lot of detainees came into custody, the suite at March was opened as an overspill area. The one detention officer on duty carried a ligature knife, but the custody sergeant relied on the knife stored behind the booking in desk, which was a concern as cells were down two flights of stairs and out of earshot.
- 4.11 We were shown details of a near miss incident at Thorpewood that had been circulated with learning points. The two-week training attended by all custody staff before working in the custody suite included half a day on mental health issues.

Additional information from other suites

- 4.12 In Bridge Street, custody records from when the cells had been used indicated that staff were aware of medical issues and these were reflected on the risk assessments. We could not

examine records of those held as part of Operation Safeguard (prison lock outs) as these had been archived.

Expectation

- 4.13 Custody staff are aware of any risk of harm to others and this is managed appropriately. Detainees are not placed in cells together unless a risk assessment indicates that it is safe to do so. Risk assessments include whether the detainee has previous convictions for racially aggravated offences.

Findings

Thorpewood

- 4.14 There was no formal cell-sharing policy, although the custody sergeant said there had been some work on a draft policy. Staff said detainees did not share cells, but that the prospect had been broached by senior managers. Men, women and juveniles were held in separate cells, but not in separate areas. Allocation decisions appeared to be based on the custody sergeant's discretion.

Parkside

- 4.15 There was one general holding area. Staff said detainees of all ages could be held in this area, with an officer supervising when more than one detainee was present. We saw some detainees left alone in the holding area supervised through CCTV. Detainees did not routinely share cells and there was no evidence that this had happened recently.

Huntingdon

- 4.16 There was no formal cell-sharing policy, but a risk assessment template was provided should this be necessary. The custody sergeant said this had never happened and that he would take any other course of action rather than putting detainees he did not know in the same cell. Men, women and juveniles were kept in separate cells, but not in separate areas.

Wisbech

- 4.17 A cell-sharing policy included a detailed risk assessment. Staff could remember only one occasion when detainees had shared and this involved two detainees speaking the same language and able to offer each other additional support. Otherwise, detainees usually came into contact with each other only when moving in or out of the suite, when they were escorted by an officer.

Additional information from other suites

- 4.18 Detainees at Bridge Street did not share cells and staff said this would happen only if the entire custody capacity of the force was in use. There was no cell-sharing protocol.

Expectation

- 4.19 Holding cells are equipped with call bell systems and their purpose is explained to detainees. They are responded to within a reasonable time.

Findings

Thorpewood

- 4.20 All cells had a call bell, but three different systems were operating and not all detainees we asked knew how they worked. Call bells were responded to promptly the few times they were used during the inspection.

Parkside

- 4.21 All cells had working call bells, but detainees said it took a long time for staff to respond. We saw staff immediately muting every call bell alarm and then taking up to 20 minutes to respond. There was a heavy reliance on CCTV and life signs monitoring rather than personal contact.

Huntingdon

- 4.22 The one detainee we saw arriving was given a full explanation of the call bell system and encouraged to use it. Call bells were responded to promptly the few times they were used during the inspection.

Wisbech

- 4.23 All cells had working call bells, but the system was not always explained to detainees. One detainee said he thought it was for emergencies only.

Additional information from other suites

- 4.24 The call bells we tested at Bridge Street were working, but we did not see them being used.

Expectation

- 4.25 Holding areas, cells, interview rooms and detention rooms are:

- clean
- free from graffiti
- in good decorative order
- of a suitable temperature
- well ventilated
- well lit
- equipped with somewhere to sit
- free of ligature points.

Findings

Thorpewood

- 4.26 The holding cells were clean and tidy, but appeared little used. The old cells were dirty, dimly lit, poorly ventilated and the air was stale. There was graffiti on the wooden plinths and all over the painted metal doors. Both holding rooms and old cells were cold. The new cells, or pods, were quite well equipped, clean and brightly lit. None of the cells contained obvious ligature

points apart from a broken window in one. A recent audit had identified spaces between the door and door frames in the old cells as a potential hazard.

Parkside

- 4.27 The custody suite was an older building in a poor state of repair. A caretaker on duty daily was responsible for cleaning cells and communal areas, but there were no cleaning schedules and standards of cleanliness were poor. All surfaces, including walls, floors and mirrors, were cleaned using the same mop and cleaning fluid. Water was leaking from the roof into the communal area in the cellblock, where there were also overflowing laundry bins and dirty laundry on the floor. Staff did not know how often the laundry was collected. Staff said the older cells contained some asbestos that was due to be removed during refurbishment in January 2009.
- 4.28 There were 15 cells in four blocks, none of which was designated for particular use. All had graffiti on the walls, benches and doors. One cell had a large swastika carved into the wall that had been there for some months. Staff showed little understanding of its potential impact on individual detainees and on the force's image in the local community. It was removed after we pointed it out to senior managers. Most cells had little natural light, and ventilation in the cell blocks was poor as the grilles had been painted over. Cells in D block, the most recent addition, contained sinks as well as integral sanitation. All toilets were very dirty. There was one shower and sink in A and B blocks, but these were unscreened and dirty, with paint peeling off the walls.
- 4.29 Cells in A, B and C blocks had ligature points around the ventilation panels and drainage grills. CCTV covered 13 cells, while eight had life signs monitoring. The Smartwater screening system installed in the holding area offered several ligature points or could easily be removed from the wall and used as a weapon.

Huntingdon

- 4.30 Cells were basic but clean, apart from those with grates in the floor, which had clearly not been cleaned for some time. There was no graffiti. Staff said they checked every cell before discharging a detainee, who was asked to clean up any graffiti they had done. In extreme cases, individuals were charged for repairs to any damage. This was explained to all detainees on reception. All cells were reasonably warm and well lit, but lacked natural light. All were free of ligature points, apart from the two with grates in the centre of the floor.

Wisbech

- 4.31 The booking in area was at ground level, but the custody suite was down two sets of stairs and inaccessible to anyone unable to manage stairs. Staff said these detainees were dealt with immediately or taken to another station. There were two women's cells and three for men, although this distinction did not appear to be observed. All cells were warm enough. Staff said cells were cleaned every day, but despite no obvious dirt or graffiti, there was an unpleasant smell of mustiness and stale urine. The cleaning company attended within about 30 minutes to deal with spillages.
- 4.32 Both interview rooms appeared appropriate. The holding room was the exercise yard, which was cold and not appropriate. Detainees were always supervised in the yard. When there was more than one detainee waiting, others waited in the van.

- 4.33 There were no obvious ligature points. There was CCTV coverage in one cell and two with life signs monitoring. One cell with a low plinth was used for inebriated detainees. Another cell on the ground level was more modern with better light, but had not been used since a female detainee had tried to hang herself from the door hinge.

Additional information from other suites

- 4.34 The Bridge Street cells were largely clean, although some toilets were very dirty and there was some graffiti on the wooden doors. A cleaning contractor maintained a cleaning rota of the cells area. There was little natural light, but overhead lights were working. Some cells had potential ligature points from the ventilation grills.
- 4.35 March had three men's cells and one for women, all of which had ligature points. Most had some graffiti. The women's cell was dark, but the others had acceptable natural light. All contained toilets. At least one cell had a grate in the floor with stagnant water underneath. All had somewhere to sit. A number had a glass plate covering a light that was easily accessible and appeared easily breakable. Ventilators had black marks around them.
- 4.36 The suite at St Neots had five cells, one reserved for women. One had no natural light and all had ligature points prior to the refurbishment. We pointed out that a cell with a low plinth, usually used for drunken detainees who might pose a risk to themselves, would still have obvious ligature points in the form of large holes in the heating grille after the refurbishment. The building supervisor said this would be rectified. In one cell, the rubber flooring strip around the edges had worked loose and could have been used as a ligature. The cell had been taken out of use as a result. We were told that staff, who had not received nationally approved custody training, sometimes supervised custody.
- 4.37 Ely had three cells and one detention room, none of which were fit for purpose. Staff had little understanding of how to identify ligature points and had not seen annual custody inspections.

Expectation

- 4.38 **A smoking policy for staff and detainees is enforced that respects the right of individuals to breathe clean air in the custody suite.**

Findings

Thorpewood

- 4.39 The no smoking policy was enforced.

Parkside

- 4.40 The no smoking policy was enforced and nicotine replacement therapy was given only on the advice of a doctor.

Huntingdon

- 4.41 The no smoking policy was enforced.

Wisbech

- 4.42 The no smoking policy was enforced. Staff said detainees could have regular nicotine lozenges on request.

Additional information from other suites

- 4.43 The no smoking policy was enforced at Bridge Street.

Expectation

- 4.44 Detainees are provided with suitable meals that cater for special dietary requirements, and drinks at appropriate intervals.

Findings

Thorpewood

- 4.45 Standard microwave food was offered three times a day and included halal and vegetarian options. The food was unappetising and unpopular. Hot and cold drinks were provided only on request and were not freely available as staff were often busy.

Parkside

- 4.46 Staff said drinks and microwave meals catering for all dietary requirements were offered at set times throughout the day, but we did not see detainees offered food. Records for the previous four months showed that this rarely happened, particularly if detainees were asleep or being interviewed at meal times. Several detainees had gone without food for over 20 hours and one who had been drunk had been refused food even though his custody record indicated that he had sobered up. Many of the meals were still packaged in the delivery boxes and had not been put in the food storage area.

Huntingdon

- 4.47 A large supply of meals was available on request. Staff said there was no limit to how much they could have and the custody record for the intoxicated detainee showed that he had asked for, and been given, food in the previous six hours. However, a random sample of custody records on 24 September showed that some detainees had waited a minimum of 13 hours between meals.

Wisbech

- 4.48 Microwave meals to suit most diets were available, but all meat was halal, which would not have been acceptable to some detainees. The kitchen area was clean. Food temperatures were taken and occasionally recorded. No staff had completed food hygiene training. Detainees were not offered food at acceptable intervals. Two detainees who arrived shortly after midnight were not offered breakfast because they 'appeared asleep' and were not then offered another meal. Both asked for food shortly after 2pm, with one given something to eat 30 minutes later. The other detainee waited over two hours before finally getting a meal 15 hours after arriving in custody.

Additional information from other suites

- 4.49 A range of microwave meals was available at Bridge Street, although stock was limited. Staff said additional supplies were procured from Thorpewood when the custody suite was due to open.

Expectation

- 4.50 Detainees are provided with a mattress, pillow and clean blankets if held overnight.

Findings

Thorpewood

- 4.51 All cells had a mattress, but blankets were available only on request and there were insufficient pillows for all registered cells.

Parkside

- 4.52 Detainees were given a mattress, and clean blankets and pillows were available in some cells. Staff said they occasionally ran out of blankets.

Huntingdon

- 4.53 All cells had a mattress and pillow, but blankets were available only on request. Staff said detainees not knowing they could ask for a blanket had never been an issue.

Wisbech

- 4.54 Detainees were given a mattress and pillow and were offered a blanket regardless of how long they were staying.

Additional information from other suites

- 4.55 All Bridge Street cells had mattresses, but none had pillows. There was a stock of clean blankets. In March, all cells had a mattress and pillow.

Expectation

- 4.56 Detainees are able to use a toilet in privacy, and toilet paper and washing facilities are provided.

Findings

Thorpewood

- 4.57 Toilets were provided in all cells and were suitably screened. CCTV screens were covered to provide some privacy, but detainees were not aware of this. Toilet paper appeared to be provided automatically, but the only washing facilities were sinks outside the cells.

Parkside

- 4.58 Toilets were provided in all cells, but were not screened and some were clearly visible from the cell door. Some CCTV screens were taped to provide privacy, but this was removed if the detainee posed a risk of self-harm. Toilet paper was provided and detainees could flush the toilet themselves. Few cells had washing facilities, and towels and soap were not routinely provided.

Huntingdon

- 4.59 Toilets were provided in all cells and were suitably screened. Toilet paper appeared to be provided automatically, but the only washing facilities were two sinks outside the cells.

Wisbech

- 4.60 Toilets were provided in all cells and most had toilet paper, although this was removed and made available only on request if the detainee posed a heightened risk of self-harm. Hand washing facilities and soap were available on request.

Additional information from other suites

- 4.61 At Bridge Street, toilets and toilet paper were provided in all cells and detainees could flush the toilet themselves. There were some washing facilities outside the cells, but these were allowed only on request. Supplies of men's hygiene items such as shaving products and soap were available, but there was nothing specifically for women.
- 4.62 At March, toilets and toilet paper were provided in all cells, but detainees could not flush the toilets in their cells. Hand washing facilities were available outside the cell and were not clean.

Expectation

- 4.63 Detainees whose clothing is taken for forensic examination are provided with suitable alternative clothing before being released or transferred to court.

Findings

Thorpewood

- 4.64 Detainees whose clothing was taken were given paper suits while in the suite and those being released or appearing at court were given T-shirts, jogging bottoms and plimsolls.

Parkside

- 4.65 Detainees whose clothing was taken were given paper suits while in the suite and those being released or appearing at court were given T-shirts, jogging bottoms and plimsolls.

Huntingdon

- 4.66 Detainees were given T-shirts, jogging bottoms and plimsolls, regardless of the circumstances. The intoxicated detainee received during the inspection was given fresh clothes as his own were in poor condition.

Wisbech

- 4.67 Detainees whose clothing was taken were given paper suits while in the suite and those appearing at court were given a jogging suit, although supplies were limited. Staff said detainees being released who had no one to collect them were given a lift home so they did not have to walk in public in a paper suit.

Additional information from other suites

- 4.68 Bridge Street had a supply of paper suits and some tracksuit clothing. Staff said further supplies would be brought over from Thorpewood if the suite was open.

Expectation

- 4.69 Detainees who are held for more than 24 hours are able to take a shower and a period of outdoor exercise.

Findings

Thorpewood

- 4.70 Showers and exercise were offered only in exceptional circumstances.

Parkside

- 4.71 Staff said detainees could have a shower on request, but custody records showed that no one had been given a shower in the previous four months. There was no outside exercise area.

Huntingdon

- 4.72 Detainees could use one of two showers on request, but these did not afford much privacy and staff said they were offered usually only when someone was due to appear in court. It was not unusual for staff on duty to be male, which was not ideal should any female detainee want to shower. The exercise yard was a reasonable size. Staff said exercise was not routinely offered and that detainees rarely requested it as they were not explicitly told it was available. Most detainees who remained in the custody suite for prolonged periods were immigration detainees awaiting deportation, who were unlikely to have experience of custody suites and therefore know that exercise was possible.

Wisbech

- 4.73 There was one shower with a shower curtain, but it was in an exposed area. It could be used only on request and at the custody sergeant's discretion, although staff said they would try to allow someone to shower if they were going to court the next day or had stayed overnight. The exercise yard had three chairs, but was austere and rarely used other than as a holding room. It could be used on request and at the custody sergeant's discretion.

Additional information from other suites

- 4.74 The two working showers in Bridge Street were reasonably clean, in working order and offered a degree of privacy. They were available only on request and there was no record that they were used. There was an exercise yard for men and one for women, but these were available

only on request and were not routinely offered. The shower area at March was in full view of other cells and had no curtain. The exercise yard was small, dirty and austere. Staff said neither the shower area nor the exercise yard was used.

Expectation

- 4.75 Detainees who are held in custody for several days are provided with suitable reading material. Visits are also allowed, and changes of clothing, especially underwear, are facilitated.

Findings

Thorpewood

- 4.76 A small stock of books and magazines was held for detainees. Visits were not allowed. Underwear was available for women, but not men.

Parkside

- 4.77 There was a large selection of reading material and many detainees had books in their cells. Visits were not allowed, but families and friends could leave clothes at the front desk. No underwear was available.

Huntingdon

- 4.78 A small stock of books and magazines was held for detainees. Visits were not allowed. Staff said this was mainly because there were no suitable rooms or enough staff to supervise. Underwear was not available.

Wisbech

- 4.79 Some reading material was provided, but it was in English only and some, including a shooting magazine, was unsuitable. It had not been offered to detainees. Visits were not allowed. No underwear was provided.

Additional information from other suites

- 4.80 There were some books available at Bridge Street. Visits were not allowed due to the lack of a suitable room. No underwear was provided.

Expectation

- 4.81 Custody suite staff have received fire safety training and evacuation procedures are practised frequently.

Findings

Thorpewood

- 4.82 Staff had received basic fire safety training, but no one we spoke to had received specialist training. Evacuation procedures were practiced about every two months.

Parkside

- 4.83 Staff had received appropriate training, but said there had been only one fire evacuation exercise in the previous three years.

Huntingdon

- 4.84 Custody officers had received basic fire safety training, but no refresher training. Neither of the custody sergeants we spoke to had received any fire safety training. Evacuation procedures were practised about every two months.

Wisbech

- 4.85 There had been a fire drill in the week before the inspection. Procedures were displayed and staff were familiar with them. However, there had been no evacuation training and staff could not remember any evacuation drills before the previous week.

Additional information from other suites

- 4.86 The Bridge Street suite was staffed by police personnel on overtime arrangements so it was not possible to identify levels of fire safety training. There were fire evacuation plans and supplies of temporary plastic handcuffs.

Recommendations

- 4.87 All custody suite staff should undertake specialist training in awareness and management of the risk of self-harm in custody.
- 4.88 A formalised system for the management of detainees identified as at risk of self-harm should be introduced, specifically incorporating the use of care plans and clear guidelines identifying under which circumstances the cells with closed-circuit television and life signs monitoring are most appropriately used.
- 4.89 All cells with ligature points should be taken out of service until the ligature points have been removed.
- 4.90 Ligature cutters should be carried by all staff working in custody suites and this policy should be enforced.
- 4.91 Cells without natural light should be taken out of service completely.
- 4.92 Detainees placed in cells with closed-circuit television should be made aware of the privacy screening.
- 4.93 Formal links with the community drug intervention programme should be established.
- 4.94 Allocation of cells should be based on agreed criteria.
- 4.95 Cleaning schedules should be developed and implemented.
- 4.96 All cells, showers and toilets should be deep cleaned and graffiti removed.

- 4.97 Toilets and showers should be adequately screened.
- 4.98 All detainees should routinely be offered blankets unless an assessment of risk of self-harm indicates that rip-proof alternatives be offered.
- 4.99 Dirty laundry should be collected and washed regularly.
- 4.100 Where necessary, the main booking in areas should be redesigned to provide privacy to detainees.
- 4.101 Child and gender specific risk assessments should be developed and implemented.
- 4.102 Detainees should be offered showers when held for more than 24 hours.
- 4.103 An outside exercise area should be provided in all suites and exercise offered routinely to detainees held for more than 24 hours.
- 4.104 Detainees should be offered regular meals, including non-halal meals.
- 4.105 All staff who prepare meals should complete a food hygiene course.
- 4.106 Detainees should have easy access to drinks.
- 4.107 Cell call bells should be answered promptly and their use explained to detainees.
- 4.108 Clothing offered to detainees should include underwear.
- 4.109 Detainees whose clothing has been taken should be given proper replacements rather than paper suits.
- 4.110 Visits for detainees should be facilitated.
- 4.111 All reading material should be appropriate and routinely offered.
- 4.112 Fire evacuation procedures should be practised regularly.

5. Individual rights

- 5.1 Detention was appropriate, but some detainees, particularly immigration detainees, were held for up to four days. Not all were asked if they wanted to see a doctor and telephones could not be used in private. Interpreters were well used when necessary. There were no local policies specific to the management of juveniles in detention. Access to appropriate adults was difficult at night. Many staff were unaware of any specific needs of female detainees and issues to do with dependents were not routinely addressed. Detainees were given the opportunity to have a solicitor present when interviewed and were allowed regular breaks. They were not routinely told how to make a complaint and there was no formal procedure for reporting racist incidents. There was no formal pre-release management.

Expectation

- 5.2 Detention is appropriate, authorised and lasts no longer than is necessary. In the case of immigration detainees alternative disposals are expedited.

Findings

Thorpewood

- 5.3 Records showed that detention was authorised properly by custody sergeants, but some detainees were held for long periods and it was not unusual for detainees such as those held under immigration legislation to be held for two or three days. In other cases, there was no evidence of undue delay.
- 5.4 The Thorpewood custody suite benefited from some good support structures. Staff from CID acted as 'gatekeepers' to individual cases, providing advice and guidance about charging issues and the process of the investigation. Two staff from the Crown Prosecution Service (CPS) were also based at the station and provided direction about the prosecution of cases. This meant staff could expedite cases more quickly during office hours on weekdays. We observed two juveniles who were released on bail following CPS advice. At other times, procedures were more laborious and information had to be faxed to a central office, which could take more time.

Parkside

- 5.5 Custody sergeants carried out the initial authorisation, while initial reviews were carried out by an inspector. Custody records showed that reviews took place on time and a detailed explanation was given on the few occasions they were late (such as when the detainee was in an interview).
- 5.6 Records showed that detention was appropriate, but there were cases where release or other disposals such as to court were delayed. Local courts had a daily cut-off time of 2.30pm and 9.30am at weekends. Juveniles could be held overnight as there was no emergency provision for appropriate adults between 11pm and 9am. Immigration detainees were often held for three to four days while enquiries and arrangements were completed with the UK Border Agency (UKBA), although alternative disposals such as bail were sometimes used.

Huntingdon

- 5.7 Records showed that detention was appropriate and properly authorised. Six- and nine-hourly reviews by an inspector were held to determine the appropriateness of continued detention.
- 5.8 UKBA was contacted as soon as immigration detainees were received in custody, but these detainees were consistently held for up to four days while UKBA arranged transport.
- 5.9 There was no policy on the management of juveniles, which clearly depended on the custody sergeant's discretion. Staff said juveniles were held overnight rather than bailed depending on 'the level of questioning' required. When juveniles were held, arrangements to ensure the presence of an appropriate adult appeared robust, but no one else was allowed to visit the juvenile and neither parents nor the appropriate adult (if not the same) were allowed to visit them if held overnight.

Wisbech

- 5.10 The NSPIS custody system contained authorisation and reasons for initial detention, and subsequent reviews were conducted by an inspector. Custody sergeants said they had never refused custody or deemed it inappropriate. Reviews were conducted on time and with an interpreter present when necessary. Detainees were dealt with promptly and rarely stayed more than 24 hours. Immigration detainees were usually taken to Peterborough or Huntingdon, but were held at Wisbech occasionally and staff said they were seen by UKBA.
- 5.11 Juveniles who came in after 11pm without an appropriate adult were held overnight and the Youth Offending Service arranged for an appropriate adult to join them the following morning. Staff said this rarely happened and the last juvenile to be held overnight was two weeks before the inspection. About 60% of juvenile arrests were prearranged. Juveniles held overnight could not have visits.

Additional information from other suites

- 5.12 Detention at Bridge Street was properly authorised by custody sergeants. Apart from those held under Operation Safeguard, most were held at Bridge Street following a specific police operation, such as crowd control at football matches. Most were held for under five hours and released on police bail, although three juveniles had been held overnight. There was nothing to suggest that this was inappropriate.

Expectation

- 5.13 Detainees, including immigration detainees, are told that they are entitled to have someone concerned for their welfare informed of their whereabouts. Any delay in being able to exercise this entitlement, such as phoning a person concerned for their welfare, is authorised at the level of Inspector or above. They are asked if they wish to see a doctor.

Findings

Thorpewood

- 5.14 Detainees were asked about informing someone of their whereabouts when booking in and telephone calls were made on their behalf.
- 5.15 There was no indication that detainees were asked about seeing a doctor and those we spoke to were unsure whether or not this had been raised. However, custody logs recorded contact with medical staff and information about medical help was included on the notice of rights and entitlements.

Parkside

- 5.16 All detainees were given a leaflet setting out their rights and entitlements during the booking in process unless they were violent, inebriated or under the influence of drugs, in which case they were placed immediately in a cell and custody records annotated to show that rights had not been explained. The leaflet was available in different languages. Staff made every effort to contact someone nominated by the detainee and usually allowed the detainee to speak to them. Staff were reasonable about allowing detainees to make necessary telephone calls and were mindful of when calls were not permitted, such as to preserve evidence. However, the only telephone for use by detainees was in the main custody area and offered no privacy.
- 5.17 All detainees were asked if they wanted to see a doctor. A doctor was also called for those who could not be fully processed and about whose physical or mental well being there were concerns.

Huntingdon

- 5.18 Detainees were informed of their entitlement to have someone concerned about their welfare informed of their whereabouts. However, the location of the telephone for use by detainees did not offer any privacy.

Wisbech

- 5.19 Detainees were informed of their rights and staff said they could use the telephone at the reception desk if agreed by the custody sergeant. They were given a summary of PACE, which was available in 43 languages.
- 5.20 None of the detainees booked in during the inspection were asked if they wanted to see a doctor.

Additional information from other suites

- 5.21 Custody records at Bridge Street showed that telephone calls were made on detainees' behalf in most cases. The only telephone available was at the main booking in desk and did not offer privacy. There was no evidence that detainees were asked if they wanted to see a doctor, although custody logs recorded contact with medical staff.

Expectation

- 5.22 Detainees who have difficulty communicating are adequately provided for with staff who can communicate with them or interpreters.

Findings

Thorpewood

- 5.23 Details of telephone interpreting services were displayed at the booking in desk and staff could also use civilian interpreters employed by Cambridgeshire Constabulary. Custody records showed that these services were used. A conference telephone was located at the booking in desk.

Parkside

- 5.24 Custody staff used a telephone interpreting service when booking in detainees who did not speak English, but did not always record this in the custody record so it was unclear whether this was always the case. The records showed that interpreters were called for detainees before they were interviewed. There was a comprehensive list of interpreters experienced in sign language for those with hearing impairments.

Huntingdon

- 5.25 Custody staff could use a telephone interpreting service or, for more informal processes, one of a list of civilian interpreters employed by Cambridgeshire Constabulary. Only approved interpreters were used during interviews relating to any charges. The custody sergeant used a website that translated detainees' rights and entitlements into over 40 languages and paper copies of these were kept on file should the IT system fail. A number of posters on display also gave basic information in about 12 languages, most of which were appropriate to the majority of Huntingdon's foreign national detainees.

Wisbech

- 5.26 A high proportion of Wisbech's detainees were Eastern European and a telephone interpreting service was used. Approved interpreters were brought in for all formal procedures, including the solicitor's interview. A list of civilian interpreters covering some more unusual languages was also available. There was no formal help for more informal situations and staff and detainees tended to muddle through by miming. Apart from the summary of rights and entitlements, there were no leaflets or posters in languages other than English.

Additional information from other suites

- 5.27 At Bridge Street, details of telephone interpreting services were displayed at the booking in desk. None of the records highlighted any language needs.

Expectation

- 5.28 There are special arrangements for detained young people that cover:
- the limited use of restraints
 - the conduct of any strip search
 - location in unlocked detention rooms close to the custody desk where possible for observation purposes
 - separation from adults at all times including in showers and exercise yard
 - specially trained officers allocated until the appropriate adult arrives

- whether appropriate adults are indeed appropriate for the task
- the capacity for the relative, guardian or appropriate adult to remain with the detained young person during waiting periods, in the detention room if necessary.

Findings

Thorpewood

- 5.29 There were no local policies specific to the management of juveniles in detention. Over a three-month period, 250 of just over 2500 detainees held had been juveniles. There were no designated juvenile cells and juveniles were not separated from adult detainees. Staff were usually able to get appropriate adults during office hours, but this was often more problematic at other times. Out of hours, the local emergency duty team comprised just two staff for the whole of Cambridgeshire and they were unable to attend until the morning. There was no capacity for an appropriate adult to wait with the detainee, such as a separate interview room. No staff had received child protection training, although all were aware of the specialist family unit in the division.
- 5.30 During the inspection, an 11 year-old boy was brought into custody. He was placed in one of the older cells nearer to the front desk, but without CCTV. He was deemed not vulnerable and placed on 60-minute observations, although this was later changed to 30 minutes on account of his age. The accompanying adult was not allowed to stay with him. Staff tried to deal with him as efficiently as possible, but did not fully engage with him.

Parkside

- 5.31 There were no local policies specific to the management of juveniles in detention. There were no designated juvenile cells and staff said they would use the newer cells on D block, even though these were furthest away from the custody desk. Juveniles were held in these cells for several hours with the doors locked. Juveniles were not separated from adult detainees. Staff ensured that suitable appropriate adults were provided and levels of observation could be increased for some juveniles, but otherwise arrangements were the same as for adults. Staff tended to take more care with juveniles and their custody records were more detailed. Appropriate adults could wait with juveniles, but often refused the offer as it meant waiting in the cell area, which was an unpleasant environment. Youth Offending Service workers attending as appropriate adults praised the access they were given to juvenile detainees. Staff had not received any child welfare training and some said they would take no special measures apart from providing a suitable adult.

Huntingdon

- 5.32 There were no local policies specific to the management of juveniles in detention. Staff said they treated all juveniles as 'high risk' on at least 30-minute observations and tried to place them in a cell with CCTV or life signs monitoring. Records showed that juveniles were given prompt access to an appropriate adult.

Wisbech

- 5.33 There were no local policies specific to the management of juveniles in detention, but those aged 16 and under were automatically put on 30-minute observations, handcuffed only when there were specific concerns and, where possible, put in a cell covered by CCTV. When no appropriate adult was immediately available, they were booked in without an appropriate adult present. However, they were informed of their rights again in the presence of the appropriate

adult when they arrived. Staff had not had specific training. Appropriate adults were checked out only if they appeared drunk or staff were aware of concerns about them. Appropriate adults could not wait in cells with juveniles, but could wait with them in interview rooms if they were not going to be held for long. Staff said where possible they tried to avoid bringing juveniles into the custody suite.

Additional information from other suites

- 5.34 Bridge Street had no local policies specific to the management of juveniles in detention. The two designated juvenile cells were closest to the booking in desk, but one was used for storage and the other was not in use. Staff were usually able to get appropriate adults during office hours, but this was often more problematic at other times. Out of hours, the local emergency duty team comprised just two staff for the whole of Cambridgeshire and they were unable to attend until the morning. There was no capacity for an appropriate adult to wait with the detainee. Neither police constables nor detention officers were trained in child protection.

Expectation

- 5.35 Female detainees are able to be dealt with by female staff, or where this is not possible, hygiene packs for women are routinely provided. Staff are aware that the impact of detention on women is different to the impact on men, and adapt their level of observation and support appropriately.

Findings

Thorpewood

- 5.36 There was no evidence that female detainees were dealt with by female staff. The ratio of male to female custody detention staff was described as 50:50, but there was no evidence that staff were particularly aware of any special needs of female detainees. Hygiene packs were available and one woman said a female detention officer had asked her about sanitary needs. There was no system to determine childcare needs, although staff said this would be dealt with individually and gave one example from the previous week when two children had been taken into foster care following their parents' arrest.

Parkside

- 5.37 There were no female custody staff, but we were told that two were being recruited. Female officers would be called in, but may not have been trained in custody procedures. If the arresting officer was female, she was asked to stay to carry out any necessary searching, but once the initial booking in was complete, female detainees were supervised by male staff. Hygiene packs were available, but only on request. There were no special arrangements for female detainees and staff were unaware of their different needs. There was no system to determine childcare needs of single-parent families. Staff said that when no family or friends could collect children from school, this would be done by police officers and the children brought to the station to await release of their parent.

Huntingdon

- 5.38 Female staff were not always available and staff had not received any training to understand the different impact of custody on women. Hygiene packs were available, but only on request. There was no system to determine childcare needs of single-parent families, but the custody

sergeant believed Cambridgeshire Constabulary operated a policy of detention as the last resort in such circumstances and so rarely encountered such a situation.

Wisbech

- 5.39 There were few female custody staff. Where a detainee specifically requested a woman, one would come over from the station. Sanitary products were available on request and there was a note to this effect on the corridor wall, but supplies were inadequate. Staff were unaware of the different impact of custody on female detainees.

Additional information from other suites

- 5.40 There was no evidence that female detainees at Bridge Street were dealt with by female staff. Staff were unaware of the different impact of custody on female detainees. There were no hygiene packs in the custody suite, but staff said these would be brought from Thorpewood when necessary. There was no system to determine childcare needs, although staff said this would be dealt with individually.

Expectation

- 5.41 Persons detained who have dependency obligations are catered for.

Findings

Thorpewood

- 5.42 Custody logs indicated that no detainee had declared any obligations to dependents and that staff had not asked about any.

Parkside

- 5.43 Staff said anyone with dependent children would be facilitated to make arrangements for the care of them, but children had occasionally been brought to the police station when there was no other option. A telephone call would be facilitated to ensure care of dependents.

Huntingdon

- 5.44 There was no evidence of detainees with obligations to dependents, nor of staff asking about such concerns.

Wisbech

- 5.45 Staff did not ask about dependency obligations, but said they would try to ensure that anyone raising a concern was discharged if possible or allowed to use the telephone to make alternative arrangements or contact social services.

Additional information from other suites

- 5.46 Custody logs at Bridge Street indicated that no detainee had declared any dependents and there was no evidence that staff had asked about this.

Expectation

- 5.47 Detainees are able to have a solicitor present when interviewed by police officers. Those under the age of 17 or vulnerable adults or those with learning disabilities are not interviewed without a relative, guardian or appropriate adult present. Solicitors and advocates arrive promptly so as not to unnecessarily prolong the period in custody. Detainees are able to consult with legal representatives in privacy.

Findings

Thorpewood

- 5.48 Detainees were routinely and repeatedly asked about legal representation. They mostly used the duty solicitor scheme and there was usually a timely response. The custody suite had several small interview rooms that could be used by legal advisers and three 'consultation' booths, one of which was used for storage. Staff said solicitors disliked these arrangements and preferred to use an open space. There was a mobile telephone that detainees could use in their cells to consult a legal representative, but calls were not private as the detention officer remained outside the cell area while the telephone was in use.

Parkside

- 5.49 Detainees were always given the opportunity to have a solicitor present when interviewed by police and appropriate adults or a relative or guardian could be present with juveniles and vulnerable adults. Solicitors arrived promptly and could interview their clients in private, but telephone consultations took place in the main custody area and were not private.

Huntingdon

- 5.50 Custody records indicated that staff always followed the correct protocol. The one detainee admitted during the inspection was offered legal representation, but declined it.

Wisbech

- 5.51 An effective duty solicitor scheme was in operation and solicitors reported no significant delays, good access to custody records and that they were able to speak with detainees in private. Telephone calls to solicitors were made on a mobile telephone in private from the detainee's cell.
- 5.52 The Youth Offending Service provided appropriate adults for juveniles and vulnerable adults until 5pm. They were generally available within the hour. Between 5pm and 7.30am, the service was provided by the emergency duty team (social services). One apparently vulnerable woman was booked in during the inspection. She reported ongoing treatment for mental health and alcohol-related problems and was a frequent self-harmer. No appropriate adult was called. She said an appropriate adult had been with her during previous arrests, but this time she just wanted to get home and did not want to have to wait for one.

Additional information from other suites

- 5.53 Most detainees held at Bridge Street were released quickly. They usually used the duty solicitor scheme and there was usually a timely response. There was a small interview room

that could be used by legal advisers, but it also served as the main interview room for the station. There was no other interview space. At March, the one interview room had dirty and damaged walls and was unsuitable.

Expectation

- 5.54 Detainees are not interviewed by police officers while under the influence of alcohol or drugs, or if medically unfit unless in circumstances provided for under PACE.

Findings

Thorpewood

- 5.55 Detainees admitted under the influence of alcohol or drugs were routinely given time to recover before being interviewed. Those held overnight were usually interviewed the following morning.

Parkside

- 5.56 Detainees admitted under the influence of alcohol or drugs were given time to recover before being interviewed. Medical staff were called to confirm fitness to interview if there was any doubt.

Huntingdon

- 5.57 An intoxicated detainee admitted during the inspection was given time to recover before being interviewed.

Wisbech

- 5.58 Detainees admitted under the influence of alcohol or drugs were routinely given time to recover before being interviewed. Solicitors confirmed that this was the case.

Additional information from other suites

- 5.59 Detainees admitted to Bridge Street under the influence of alcohol or drugs were routinely given time to recover before being interviewed. Those held overnight were usually interviewed the following morning.

Expectation

- 5.60 Suitable legal advice is available for both police detainees and immigration detainees.

Findings

Thorpewood

- 5.61 A community defence team was contacted quickly following a request and this was logged on custody sheets. The community legal advice agency had contacts with a specialist immigration advice team, but we could not evaluate the service offered.

Parkside

- 5.62 All detainees were offered suitable legal advice. This was explained to them and outlined in the leaflet explaining their rights. Access to a solicitor was through a call centre that passed on the request to a criminal or immigration lawyer.

Huntingdon

- 5.63 The detainee admitted during the inspection was told that legal advice would be made available regardless of his ability to pay for it. This facility was also advertised on a number of posters in different languages. Staff were not aware of any similar specialist advice service for immigration detainees and did not know whether duty solicitors would have this knowledge.

Wisbech

- 5.64 A duty solicitor scheme operated 24 hours a day. This routed requests to an immigration or criminal lawyer. Staff said solicitors arrived promptly.

Additional information from other suites

- 5.65 At Bridge Street, a community defence team was contacted quickly following a request and this was logged on custody sheets. The community legal advice agency had contacts with a specialist immigration advice team, but we could not evaluate the service offered.
- 5.66 Staff at St Neots expressed frustration at the lack of clarity about the approach to immigration detainees and complained that they did not know if there was a protocol for their management.

Expectation

- 5.67 Detainees are not subject to inhuman or degrading treatment in the context of being interviewed, or in the denial of any services they need. They are allowed a period of eight hours continuous break from interviewing in a 24-hour period.

Findings

Thorpewood

- 5.68 Records showed that no detainees were interviewed without proper rest periods. Most detainees were held for relatively short periods, although some, particularly immigration detainees, were held overnight.

Parkside

- 5.69 Staff were aware of the need for detainees to have suitable breaks between interviews. However, records showed that some, including juveniles and women, were not offered food at regular intervals, even when they were being interviewed at mealtimes.

Huntingdon

- 5.70 Records suggested that detainees were treated appropriately. The detainee admitted and interviewed during the inspection was positive about his experience and said he had been treated appropriately.

Wisbech

- 5.71 There was no evidence of inappropriate treatment during interview. Staff were aware that detainees needed sufficient breaks between interviews and the custody sergeant put detainees on an eight-hour rest period where necessary.

Additional information from other suites

- 5.72 At Bridge Street, PACE was adhered to properly and records showed that no detainees were interviewed without proper rest periods. Most detainees were held for relatively short periods.

Expectation

- 5.73 Detainees are not handcuffed in secure areas unless there is a risk of violence to other detainees or staff.

Findings

Thorpewood

- 5.74 We saw the arresting officer remove handcuffs from detainees at the booking in desk. The only exception to this was that detainees placed in the secure holding cells in an adjoining corridor were usually left in handcuffs until moved to the main booking in area. The holding cells were rarely used.

Parkside

- 5.75 Detainees remained handcuffed in the holding area. Handcuffs were removed on entry to the custody area, unless the detainee was violent and posed a risk to others. When restraints were used on detainees in cells, a use of force form was completed and forwarded to a central office in headquarters. However, these did not name the detainees involved so it was not possible to trace cases of concern.

Huntingdon

- 5.76 The detainee admitted during inspection was released from his handcuffs as soon as he entered the custody suite. Staff said handcuffs were used in the suite only if detainees became refractory.

Wisbech

- 5.77 Most adults and about 30% of juveniles arrived handcuffed. Handcuffs were removed on entering the custody suite unless a risk was identified.

Additional information from other suites

- 5.78 Staff at Bridge Street said handcuffs were removed at the booking in desk.

Expectation

- 5.79 Those charged are produced at court promptly either in person or via video link.

Findings

Thorpewood

- 5.80 Detainees charged early in the day were usually dealt with at court. The cut-off time for court bookings was between 1pm and 2pm on weekdays and as early as 10am on Saturdays, so detainees charged after the deadline had to spend additional time in police custody.

Parkside

- 5.81 Most detainees were produced at court on the same or following day. The local court cut-off time of 2.30pm on weekdays and 9.30am on Saturdays meant some were delayed in going to court.

Huntingdon

- 5.82 Staff interviews and custody records showed that detainees were produced at court promptly.

Wisbech

- 5.83 Staff said there was no problem getting detainees to court in the morning, but that it was more difficult to get GSL staff to collect detainees after 11am. Courts would often refuse to take any more detainees after about 1pm or 2pm.

Additional information from other suites

- 5.84 Detainees at Bridge Street charged early in the day were usually dealt with at court. The cut-off time for court bookings was between 1pm and 2pm on weekdays and as early as 10am on Saturdays, so detainees charged after the deadline had to spend additional time in police custody.

Expectation

- 5.85 Detainees know how to complain about their care and treatment. They are not discouraged from doing so but are supported in doing so where necessary.

Findings

Thorpewood

- 5.86 There was no official complaints procedure, but staff believed detainees were asked about their treatment before being discharged. We spoke to staff who were actively trying to discourage detainees from complaining and who had little notion that this was inappropriate.

Parkside

- 5.87 Detainees we spoke to did not know how to make a complaint and this did not appear to be explained to them. Custody sergeants did not routinely give out this information because they wanted to avoid encouraging complaints. They said complaints were referred to the inspector or the complainant was given the Independent Police Complaints Commission (IPCC) complaints booklet, which was long, complicated and only in English.

Huntingdon

- 5.88 The only formal complaint process was devised to begin post-detention and was not routinely explained to detainees.

Wisbech

- 5.89 Detainees were not routinely given information about making a complaint, but anyone who wanted to complain was given the IPCC booklet (see above) and spoken to by the custody sergeant. Staff said that if someone complained about another detainee, they would speak to that detainee and would be prepared to move detainees to a different cell.

Additional information from other suites

- 5.90 There was no official complaints procedure at Bridge Street, but staff believed detainees were asked about their treatment before being discharged.

Expectation

- 5.91 There is an effective system in place for reporting and dealing with racist incidents.

Findings

Thorpewood

- 5.92 There was no system for reporting and dealing with racist incidents. Staff and detainees could report minor incidents to Peterborough Race Equality Council, but this information was not displayed so it was unclear how detainees would know about it.

Parkside

- 5.93 There was no racist incident reporting procedure. Staff said racist complaints were referred to the inspector.

Huntingdon

- 5.94 There was no formal racist incident reporting procedure. Staff said detainees wanting to make a racist complaint were referred to the inspector when he conducted his six- and nine-hourly reviews.

Wisbech

- 5.95 There was no formal racist incident reporting procedure and any incidents were dealt with in the same way as other complaints.

Additional information from other suites

- 5.96 There was no system for reporting and dealing with racist incidents at Bridge Street. Staff and detainees could report minor incidents to Peterborough Race Equality Council, but this information was not displayed so it was unclear how detainees would know about it.

Expectation

- 5.97 All custody suites hold a copy of the PACE Code of Practice C, and detainees, including immigration detainees, know they are able to consult it. Detainees or their legal representatives are able to obtain a copy of their custody record on release, or at any time within 12 months following their detention.

Findings

Thorpewood

- 5.98 There were several up-to-date copies of PACE and detainees we spoke to were aware of this. Detainees were given an information book of their rights, available in a range of languages, which specified their entitlement to ask to see the 'rule book'.

Parkside

- 5.99 There were several up-to-date copies of PACE, but no copies of the amendments. Detainees were routinely told of their right to consult it during the booking in procedure. Solicitors said they had no problems getting copies of their client's record on request. Detainees could also do this, but rarely did so.

Huntingdon

- 5.100 There was an up-to-date copy of PACE. The sergeant said there was no issue with detainees or their solicitors viewing their custody record on request.

Wisbech

- 5.101 There was a 2005 copy of PACE. Legal representatives reported no problems getting hold of custody records.

Additional information from other suites

- 5.102 Bridge Street had a 2006 copy of PACE. Detainees were given an information book of their rights, available in a range of languages, which specified their entitlement to ask to see the 'rule book'.

Expectation

- 5.103 Pre-release risk management is conducted and vulnerable detainees are released safely.

Findings

Thorpewood

- 5.104 There was no formal pre-release risk management, although staff said they would be aware of the needs of vulnerable detainees. This was not evident from custody records.

Parkside

- 5.105 There was no formal pre-release risk management, but we saw some good examples of detainees being released safely. Juveniles and vulnerable adults were always offered a lift home. One detainee arrested under section 136 had a mental health assessment carried out and was given a follow-up appointment with the mental health team.

Huntingdon

- 5.106 There was no formal pre-release risk management and arrangements for vulnerable detainees being released appeared ad hoc and based on the custody sergeant's discretion.

Wisbech

- 5.107 There was no formal pre-release risk management. Staff said arrangements were made individually and that they would seek the inspector's permission to issue warrants for train tickets or money for taxis when the detainee had none. Some detainees, such as those wearing paper suits who had no one to collect them, were given a lift home.

Additional information from other suites

- 5.108 At Bridge Street, there was no formal pre-release risk management, although staff said they would be aware of the needs of vulnerable detainees. This was not evident from custody records.

Additional information

- 5.109 Forensic samples and exhibits were routinely destroyed as clinical waste with ill defined audit trails, and sometimes when they were still needed for cases proceeding to court. At Peterborough Thorpewood, two full clinical waste bags had recently been disposed of because they were old, there was not the room to store them and officers had failed to respond to emails asking them for updates. We were told that destroyed samples were sometimes subsequently required for cases proceeding to court. This raised serious concerns about the administration of justice and had the potential to undermine public confidence in the criminal justice system.
- 5.110 Old blood, urine, DNA and forensic samples were found at most sites and it was unclear whether they should have been sent for analysis, stored elsewhere or suitably disposed of. We found DNA and forensic samples inadequately stored in fridges and freezers. Samples at

Cambridge Parkside were stored alongside unsealed foodstuffs, including frozen raw meat with frozen congealed blood.

- 5.111 Continuity of evidence in relation to forensic samples and exhibits also appeared to be a serious concern. We found evidence of paperwork and exhibit schedules relating to the seizure of samples by a forensic medical examiner (FME) being separated from the forensic samples/exhibits. This had the potential to undermine this case.
- 5.112 An old DNA sample, which had been taken incorrectly and was no longer required, was found in a clinical waste bag in a FME's room. The paperwork identifying the offence, suspect and officer in case (OIC) was in the DNA bag. The OIC stated that that was how he had been advised to dispose of the DNA.
- 5.113 We found many cases of DNA samples that had not been sent for analysis and of other dated forensic samples at the busier designated custody suites. This was also replicated at the non-designated custody suites, though in far smaller volumes (cleanliness of FME rooms was also an issue). In the FME room at March custody suite, we found blood samples stored alongside an old half-eaten take away meal, as well as a urine sample dating from February 2008 and forensic clippings dating from 2007 (interview notes and tapes had also been left unsecured in the interview room).
- 5.114 At St Neots, the fridge contained blood and urine samples dating from July 2007. There were also unsubmitted DNA samples dating from January 2007. The clinical waste bin was full of clinical and non-clinical waste even though the suite had been closed for some weeks. In Ely, the FME's room was dirty and unfit for purpose and the clinical bag had not been emptied for at least six weeks (see also healthcare section).

Recommendations

- 5.115 Detainees should be asked if they wish to see a doctor and this should be logged on custody records.
- 5.116 Detainees should be asked about their dependency and childcare obligations and this should be logged and any action taken as appropriate.
- 5.117 Arrangements should be made with the courts to ensure that those ready for court are listed at the earliest opportunity.
- 5.118 Leaflets and posters should be available in languages most commonly used by detainees.
- 5.119 A record should be made of when professional interpreting services are used during the booking in procedure.
- 5.120 Appropriate adults should be accessible and able to attend the police station 24 hours a day, and should be allowed to wait with juveniles in areas other than their cells.
- 5.121 The system for identifying vulnerable adults should be more robust and appropriate adults should automatically be called when a detainee is identified as vulnerable.
- 5.122 All custody staff should be aware of the differing needs of juveniles and women in detention and all policies should reflect their particular needs.

- 5.123 Female detainees should have access to female staff.
- 5.124 All female detainees should routinely be offered a hygiene pack that incorporates a range of suitable sanitary items.
- 5.125 Detainees should be able to make telephone calls to legal representatives in private.
- 5.126 The duty solicitor service should incorporate solicitors with an ability to provide specialist advice on immigration to immigration detainees.
- 5.127 Detainees should routinely be given clear and simple instructions on how to make a complaint, including racial complaints, and staff should not discourage them from doing so if they so wish.
- 5.128 Clear criteria for producing a pre-release plan should be developed and applied consistently in respect of vulnerable detainees.
- 5.129 Formal protocols should be put in place to ensure pre-release risk management is conducted on all vulnerable detainees being released and appropriate measures should be implemented based on the risk assessment and detailed on the custody records.
- 5.130 All interview rooms should be fit for purpose and confidential information should not be left lying around.
- 5.131 The force should urgently review how it takes, stores, tracks and submits all DNA and forensic samples taken from detainees, volunteers and victims. Robust monitoring of performance should be overseen by a senior officer.

6. Healthcare

- 6.1 Cambridgeshire Police contracted Essex Medical and Forensic Services to provide primary healthcare services to detainees. The contract apparently stated that all calls would be met within one hour. However, the contract was not routinely monitored by the force and there were examples of detainees waiting some considerable time to see a health professional. Detainees with mental health needs were not well served, particularly in the south of the county, where all those detained under section 136 of the Mental Health Act (MHA 1983) were taken to a police station and police staff reported poor working relationships with the local mental health service providers. Drug arrest referral workers were available only in the Peterborough custody suites.

Expectation

- 6.2 The decency, privacy and dignity of detainees are respected.

Findings

- 6.3 Nurses, paramedics (healthcare professionals - HCPs) and doctors (FMEs) employed by Essex Medical and Forensic Services (EMFS) provided cover to all the custody suites. There was at least one HCP and one FME on duty at all times, but the rota was confusing. Several FMEs working at Parkside police station were partners in Cambridge GP practices and, although they were rostered for 12-hour shifts with EMFS, had other commitments in daytime hours. EMFS reported that an additional FME/HCP was rostered to provide appropriate cover during GP surgery hours, but records indicated that usual practice was for EMFS to hold calls until the local duty GP was available, often meaning that detainees waited much longer than the contracted one hour response time.
- 6.4 The privacy and dignity of detainees were maintained appropriately. Custody staff did not enter healthcare rooms without knocking and were reluctant to interrupt consultations. Only one room (at Wisbech) had curtaining around the examination couch. One room (at Huntingdon) had an en suite toilet with a lockable door. Custody staff spoke well of EMFS staff and a mutual respect was evident.

Expectation

- 6.5 Detainees are treated by health care professionals and drug treatment workers in a professional and caring manner that is sensitive to their situation and their diverse needs, including language needs.

Findings

- 6.6 We observed only brief interactions between health professionals and detainees, but concluded that the conduct of FMEs and HCPs was appropriate. The EMFS staff were predominantly male and there was generally limited access to female HCPs and FMEs. The use of chaperones was reported, but not observed. Access to interpreting services was evident and their use was demonstrated in the records seen. We were concerned that detainees did not always realise that they had been seen by an HCP rather than a doctor.

Expectation

- 6.7 Clinical governance arrangements include the management, training and supervision and accountability of staff.

Findings

- 6.8 Some clinical governance arrangements were in place. There were lines of accountability and, in line with other custody suites we have inspected where EMFS provides health services, staff said there were formal peer group meetings for staff and training sessions. There was secure storage on all sites for records and medication, accessible by key code. Guidelines for practice were consistently displayed at all sites and consistent paperwork was available.

Expectation

- 6.9 Patients are treated by health care staff who receive ongoing training, supervision and support to maintain their professional registration and development. Staff have the appropriate knowledge and skills to meet the particular health care needs of detainees in police custody.

Findings

- 6.10 EMFS staff reported good access to training. We did not see any training records and it was unclear how the Constabulary assured itself that EMFS staff had relevant training and professional development. All FMEs/HCPs spoken to had appropriate and relevant experience. One FME said his contract required him to attend monthly FME meetings at least four times a year. Clinical records demonstrated the application of appropriate knowledge and skills.

Expectation

- 6.11 All equipment (including resuscitation kit) is regularly checked and maintained and all staff (healthcare and custody staff) understand how to access and use it effectively.

Findings

- 6.12 There was limited resuscitation equipment, with no defibrillators or oxygen in any of the custody suites visited and inconsistent provision of face masks, ambubags and airways. Custody staff said they would call an ambulance if a detainee collapsed. Healthcare rooms were not consistently equipped and some equipment was not functional, outdated and/or required servicing. There was no evidence that equipment checks were carried out. There were first aid kits in all medical rooms, but the contents varied and there was no evidence of checks made or routine re-stocking. Some of the first aid equipment was out of date.

Expectation

- 6.13 Detainees are able to request the services of a health care professional in and out of hours, and to continue to receive any prescribed medication for current health conditions or for drug maintenance.

Findings

- 6.14 Records were seen of the calls made to EMFS, the time of arrival of the FME/HCP and the time assessment/treatment was commenced and completed. This information was recorded on the patient record and a carbonated custody record, one copy of which was used by custody staff and another was entitled 'contract monitoring form'. Recording was inconsistent and there was no evidence of monitoring arrangements. On five of a sample of 10 records, the time of the call was not recorded and all remaining five recorded an arrival time in excess of one hour. FMEs/HCPs and custody staff considered monitoring to be the responsibility of EMFS.
- 6.15 Ongoing doses of prescribed medicines were supplied in sealed and labelled bags to be dispensed by custody staff according to prescriptions. There was a range of storage arrangements for these medicines, but custody staff were aware of local arrangements.
- 6.16 Detainees with a history of substance misuse (illicit drugs) were subject to a 'six-hour rule'. This meant they were not given any medication initially, but were re-examined after six hours for signs of withdrawal and, if indicated, appropriate medication was prescribed.

Expectation

- 6.17 Clinical examinations are conducted out of the sight and preferably out of the hearing of police officers. Treatment rooms provide conditions that maintain decency, privacy and dignity. Infection control facilities are implemented. There is at least one room that is forensically clean.

Findings

- 6.18 All healthcare facilities were locked, sited a discreet distance from the main custody suite area and doors were kept closed while consultations were in progress. None of the rooms seen was clinically clean and there were limited infection control arrangements. Some rooms (Wisbech, Bridge Street) were very dusty. Custody staff said rooms were cleaned by Norfolk County Services as part of the general cleaning arrangements, but healthcare staff were unaware of this.
- 6.19 There were sharps bins in all rooms, but they were not dated or signed and the one at Bridge Street was full and locked with no spare available. Clinical waste arrangements were in place at all sites, but full and unlabelled bags were awaiting collection at most sites and bins contained non-clinical waste. The inside of the lid of the clinical waste bin at Wisbech was splattered with blood and other substances.
- 6.20 Hand washing facilities with liquid soap and paper towels and latex gloves were available at all sites.
- 6.21 All couches were of fixed height and there were no footstools to assist access. There was no paper couch roll at any of the sites and only the room at Parkside had a pillow, but no pillow case. There was no cleaning fluid for the couch/surfaces at any of the sites.
- 6.22 Several rooms, such as those at Wisbech and Parkside, were small, making them unsuitable and unsafe for use for agitated detainees. Storage was limited in most sites, with items such as strip blankets and clothing stored under the couches at Parkside and Huntingdon. At

Huntingdon, the intoxiliser was in the medical room, so there was limited access and alcohol hand gel could not be used.

Expectation

- 6.23 Detainees are offered the services of a drugs or alcohol arrest referral worker where appropriate and referred on to community drugs/alcohol teams or prisons' drugs workers as appropriate.

Findings

- 6.24 The northern BCU was deemed an intensive drug intervention programme (DIP) site. As a result, staff from CRI (crime reduction initiative), a national charitable organisation, provided drug workers to the custody suites at Thorpewood and Bridge Street. CRI staff were available from 8.30am until 10pm on weekdays and from 9am to 5pm on Saturdays. CRI was funded for eight workers and there were six in post. They saw all adult detainees who tested positive to drugs following arrest for a 'trigger offence', following authorisation from a custody sergeant.
- 6.25 Whenever possible, an initial comprehensive assessment was carried out immediately and a further compulsory follow-up appointment was made. If the client was already being seen by other substance use services in the area, CRI workers acted as a conduit to refer clients back to their original support worker. When detainees required referral outside the working hours of the CRI workers, custody staff had access to a diary to arrange first contact appointments. However, the service was available only for detainees from the Peterborough area. Drug arrest referral workers were not available at the other custody suites in the central and southern BCUs. In our survey, 42% of detainees said they had seen or were offered the chance to see a drugs or alcohol support worker. Of the 40 prisoners surveyed, 75% had been held at Thorpewood.
- 6.26 CRI staff did not have direct access to interpreting services and relied on the goodwill of custody staff to organise interpreters for interviews or medical consultations at a time when a CRI worker was available.
- 6.27 Detainees seen at Thorpewood or Bridge Street who were not from the Peterborough area could be referred to DIP workers in their area. If detainees failed to attend appointments with DIP workers, CRI staff would make every effort to contact them and refer them back to the police to be arrested for failing to meet their conditions of bail. If their client was remanded in custody, CRI staff would try to make contact with the relevant drugs team in the prison, although staff said that obtaining information from the courts about where a client had been remanded was often a slow process.
- 6.28 Support services for detainees with an alcohol problem were less robust. At Thorpewood, CRI workers would refer them to 'Drinksense', but it was unclear whether this was the practice in other suites.

Expectation

- 6.29 A liaison and/or diversion scheme enables mentally disordered detainees to be identified and diverted into appropriate mental health services, or referred on to prison health care services.

Findings

- 6.30 Access to mental health services was reported to be variable across the county. A new psychiatric intensive care unit was planned for Peterborough, opening in May 2009 in Edith Cavell Hospital. The Police Service had been working closely with the acute trust in designing and developing this service, which included a dedicated police suite for assessments and interviews. Joint protocols for admission were being developed. Staff at Thorpewood said court diversion schemes were regularly used, but it appeared that detainees with mental health problems were taken in to police custody.

Expectation

- 6.31 **Police custody is not used as a place of safety for section 136 assessments except where the detainee needs to be controlled for his or her own safety or the safety of others.**

Findings

- 6.32 There were high levels of arrests made under section 136 in some areas, particularly Parkside and Thorpewood. There appeared to be historical problems and ongoing difficulties with healthcare providers being reluctant to take S136 detainees. It was reported that detainees frequently remained in police custody at Parkside as Addenbrookes hospital accident and emergency and Cambridgeshire Mental Health Trust would not provide a place of safety for detainees. By contrast, Hinchingsbrooke hospital accident and emergency offered a place of safety provision in the central BCU area.
- 6.33 The force's electronic custody record system showed that in the previous three months, 3% of all arrests logged at Thorpewood and 2% at Parkside were S136 detainees. Less than 0.2% of detainees held at Huntingdon were for S136. Custody staff provided data about the arrests under S136, but the number varied considerably between sites. At Parkside, staff reported 146 such arrests between November 2007 and November 2008. At Thorpewood, staff reported 21 to 30 arrests under S136 each month and research was underway to identify inappropriate use of powers under S136 to inform staff training needs.
- 6.34 Access to approved social workers and S12-approved doctors was reported to be inadequate. One S12-approved FME said he was undertaking a minimum of 15 assessments monthly.

Expectation

- 6.35 **Each detainee seen by health care staff has a clinical record containing an up-to-date assessment and any care plan conforms to professional guidance from the regulatory bodies. Ethnicity of the detainee is also recorded.**

Findings

- 6.36 All clinical records were paper-based and kept appropriately in a locked metal safe that was accessible only by EMFS staff. Clinical records were collected regularly by EMFS, scanned and digitalised and stored at a central location. Records seen were generally completed appropriately and contained clear care plans and a record of detainee consent. Ethnicity was not routinely recorded on healthcare records, but was recorded on the electronic custody

record. It was not always possible to identify the qualifications of the HCP who had seen the detainee, particularly on the carbonated copy of the clinical record that was made available to custody staff.

Expectation

- 6.37 Any contact with a doctor or other health care professional is also recorded in the custody record, and a record made of any medication provided. The results of any clinical examination are made available to the detainee and, with detainee consent, his/her lawyer.

Findings

- 6.38 EMFS staff did not have access to the electronic custody record, so the only computerised record of the attendance of EMFS was made by custody staff. Custody staff were given a summary of the clinical consultation on a carbonated record sheet. Detainees could obtain a copy of their medical records by contacting EMFS. This was usually done by their solicitor, via the police. Detainees were not routinely told this was possible. Staff were given training on statement writing.

Expectation

- 6.39 Information sharing protocols exist with all appropriate agencies to ensure efficient sharing of relevant health and social care information.

Findings

- 6.40 Staff at Thorpewood reported the recent development of an information-sharing agreement and joint paperwork with accident and emergency, but this was not replicated elsewhere in the force. The implementation of a PACE bed in the local accident and emergency department in the north of the county for detainees suspected of 'packing' drugs was also under discussion.

Expectation

- 6.41 All medications on site are stored safely and securely, and disposed of safely if not consumed. There is safe pharmaceutical stock management and use.

Findings

- 6.42 Medicines were stored in a key-coded safe, with access only by EMFS staff. Suites also had a locked box for unused medication, but this was not the same in all suites. These boxes were emptied regularly and the oldest medications we found had been prescribed only in the previous two weeks.
- 6.43 The range of stock medication was adequate, but varied between sites. Stock was recorded in a logbook kept in the locked safe. Stock was checked, discarded and replenished at intervals, but the frequency of this varied between sites. Stock at all sites visited had last been checked in the week before the inspection and all medication was in date. However, glucometer reagent strips were out of date at two sites. BNFs dated September 2008 were available at all sites except Wisbech. There were no medication fridges at any sites.

- 6.44 FMEs prescribed and dispensed medications against a range of stock items. HCPs dispensed medications under verbal orders from a doctor at EMFS headquarters, but these were not routinely followed up by written confirmation on site. One of the HCPs said he had recently received training to administer medications against patient group directions (PGDs). It was therefore surprising to find reference in the minutes of the custody policy group meetings to the fact that it had been 'agreed regionally these would not be used', particularly as it did not appear that any HCPs were members of the group.
- 6.45 Prescribed medications were put in a small plastic bag by the HCP and labelled. Instructions on when and how the medication should be administered were then provided to custody staff. In most cases, these medications were kept locked away, but those at Thorpewood were merely clipped to the custody records held in slots behind the custody desk. Custody staff we spoke to were well aware of their responsibilities regarding the administration of medications. In one instance, the detention officer had noted a discrepancy between the time for administration of a medication written on the bag and the custody record. He took appropriate action to confirm the correct time and documented his actions appropriately.
- 6.46 There was a limited range of medication (paracetamol, ibuprofen, Gaviscon and a salbutamol inhaler) for custody staff to issue to detainees after telephone consultation with an FME when a HCP was not on site.

Recommendations

- 6.47 The Constabulary should monitor all aspects of the health services contract, including response times, professional training and registration of staff.
- 6.48 Healthcare professionals contracted for police work should not have any other contractual obligations at the same time that could lead to a conflict of time allocated to police work.
- 6.49 Detainees should have access to a relevant healthcare professional of their own gender.
- 6.50 There should be clear lines of accountability for the checking of resuscitation equipment and first aid kits and such checks should be documented.
- 6.51 There should be a full range of resuscitation equipment, including an automated external defibrillator and oxygen, available in each suite. The kit should be the same in each suite.
- 6.52 All staff should have annual training in resuscitation, including the use of an external automated defibrillator.
- 6.53 There should be a formalised cleaning contract for the clinical rooms and formalised infection control guidelines.
- 6.54 All detainees should be offered the services of a drugs or alcohol arrest referral worker where appropriate and be referred to relevant services if required.
- 6.55 There should be a liaison and/or diversion scheme to enable mentally disordered offenders to be identified and diverted into appropriate mental health services.

- 6.56 Police custody suites should not be used as a place of safety for section 136 assessments.
- 6.57 Patient group directions should be introduced to ensure the safe prescribing of medications.

Housekeeping points

- 6.58 Detainees should be told the job title of the healthcare professional with whom they are consulting.
- 6.59 All the examination couches should have paper roll to cover them.
- 6.60 The time a healthcare professional is called should be recorded by custody staff on the paper custody record as well as the electronic record.
- 6.61 Detainees should be told that they can obtain a copy of their clinical records.

Good practice

- 6.62 *The management of clinical records was good and records were kept securely in line with Caldicott principles. It was a system that could be emulated by other custody suites.*

7. Summary of recommendations

Strategy

To Cambridgeshire Constabulary

- 7.1 Strategic leaders should ensure that custody services are safe and fit for purpose and comply with Safer Detention and Handling of Persons in Custody Guidance. (3.28)
- 7.2 The recommendations of existing reports by the National Policing Improvement Agency and Cambridgeshire Constabulary should be addressed immediately. (3.29)
- 7.3 The aims and scope of the Custody Development Project should be reviewed in the light of this inspection report. (3.30)
- 7.4 All outstanding force policies relating to custody should be ratified and implemented. (3.31)
- 7.5 Police officers and staff should not be deployed in custody suites without being given nationally approved training in custody duties as outlined by the National Policing Improvement Agency guidance. (3.32)
- 7.6 Staffing of custody suites should reflect the pressures faced by busier custody suites. (3.33)
- 7.7 Defibrillators and oxygen should be deployed in custody suites and staff suitably trained in their use. (3.34)
- 7.8 An ongoing regime of refresher training that addresses core skills and knowledge should be implemented. This should be centrally managed, with basic command units directed to release staff for training. (3.35)
- 7.9 A strong central framework for custody that incorporates all relevant policies should be developed, and the efficacy of the devolved custody model should be reviewed. (3.36)
- 7.10 Robust quality assurance mechanisms should be established. (3.37)
- 7.11 Strong leadership messages should reinforce the primacy of safety and welfare of detainees in custody. (3.38)
- 7.12 A sustainable contract that offers value for money should be awarded that allows for the rapid turnaround of cells taken out of service. (3.39)
- 7.13 Greater strategic effort should be put into addressing poor multi-agency arrangements and cooperation with regard to managing vulnerable people. (3.40)
- 7.14 The UK Border Agency protocols should be re-visited to ensure strategic intent is matched by local delivery. (3.41)
- 7.15 Social Services should be contacted routinely when children are brought into police custody during the night and this should be reflected in force policies. (3.42)

- 7.16 Drafting of force policies should not be delegated to inexperienced staff with heavy operational commitments, but more suitably discharged by experienced HQ staff. (3.43)
- 7.17 A formal force policy covering cell bell usage that details how staff must react to them should be introduced as soon as practicable and enforced. (3.44)
- 7.18 A clear complaints policy should be advertised in custody suites and the number and nature of complaints analysed centrally so that underlying causes can be identified and addressed. (3.45)

To Cambridgeshire Police Authority

- 7.19 Recommendation 3.28 should be overseen by the Police Authority lead for custody. (3.46)

Treatment and conditions

- 7.20 All custody suite staff should undertake specialist training in awareness and management of the risk of self-harm in custody. (4.87)
- 7.21 A formalised system for the management of detainees identified as at risk of self-harm should be introduced, specifically incorporating the use of care plans and clear guidelines identifying under which circumstances the cells with closed-circuit television and life signs monitoring are most appropriately used. (4.88)
- 7.22 All cells with ligature points should be taken out of service until the ligature points have been removed. (4.89)
- 7.23 Ligature cutters should be carried by all staff working in custody suites and this policy should be enforced. (4.90)
- 7.24 Cells without natural light should be taken out of service completely. (4.91)
- 7.25 Detainees placed in cells with closed-circuit television should be made aware of the privacy screening. (4.92)
- 7.26 Formal links with the community drug intervention programme should be established. (4.93)
- 7.27 Allocation of cells should be based on agreed criteria. (4.94)
- 7.28 Cleaning schedules should be developed and implemented. (4.95)
- 7.29 All cells, showers and toilets should be deep cleaned and graffiti removed. (4.96)
- 7.30 Toilets and showers should be adequately screened. (4.97)
- 7.31 All detainees should routinely be offered blankets unless an assessment of risk of self-harm indicates that rip-proof alternatives be offered. (4.98)
- 7.32 Dirty laundry should be collected and washed regularly. (4.99)
- 7.33 Where necessary, the main booking in areas should be redesigned to provide privacy to detainees. (4.100)

- 7.34 Child and gender specific risk assessments should be developed and implemented. (4.101)
- 7.35 Detainees should be offered showers when held for more than 24 hours. (4.102)
- 7.36 An outside exercise area should be provided in all suites and exercise offered routinely to detainees held for more than 24 hours. (4.103)
- 7.37 Detainees should be offered regular meals, including non-halal meals. (4.104)
- 7.38 All staff who prepare meals should complete a food hygiene course. (4.105)
- 7.39 Detainees should have easy access to drinks. (4.106)
- 7.40 Cell call bells should be answered promptly and their use explained to detainees. (4.107)
- 7.41 Clothing offered to detainees should include underwear. (4.108)
- 7.42 Detainees whose clothing has been taken should be given proper replacements rather than paper suits. (4.109)
- 7.43 Visits for detainees should be facilitated. (4.110)
- 7.44 All reading material should be appropriate and routinely offered. (4.111)
- 7.45 Fire evacuation procedures should be practised regularly. (4.112)

Individual rights

- 7.46 Detainees should be asked if they wish to see a doctor and this should be logged on custody records. (5.115)
- 7.47 Detainees should be asked about their dependency and childcare obligations and this should be logged and any action taken as appropriate. (5.116)
- 7.48 Arrangements should be made with the courts to ensure that those ready for court are listed at the earliest opportunity. (5.117)
- 7.49 Leaflets and posters should be available in languages most commonly used by detainees. (5.118)
- 7.50 A record should be made of when professional interpreting services are used during the booking in procedure. (5.119)
- 7.51 Appropriate adults should be accessible and able to attend the police station 24 hours a day, and should be allowed to wait with juveniles in areas other than their cells. (5.120)
- 7.52 The system for identifying vulnerable adults should be more robust and appropriate adults should automatically be called when a detainee is identified as vulnerable. (5.121)
- 7.53 All custody staff should be aware of the differing needs of juveniles and women in detention and all policies should reflect their particular needs. (5.122)

- 7.54 Female detainees should have access to female staff. (5.123)
- 7.55 All female detainees should routinely be offered a hygiene pack that incorporates a range of suitable sanitary items. (5.124)
- 7.56 Detainees should be able to make telephone calls to legal representatives in private. (5.125)
- 7.57 The duty solicitor service should incorporate solicitors with an ability to provide specialist advice on immigration to immigration detainees. (5.126)
- 7.58 Detainees should routinely be given clear and simple instructions on how to make a complaint, including racial complaints, and staff should not discourage them from doing so if they so wish. (5.127)
- 7.59 Clear criteria for producing a pre-release plan should be developed and applied consistently in respect of vulnerable detainees. (5.128)
- 7.60 Formal protocols should be put in place to ensure pre-release risk management is conducted on all vulnerable detainees being released and appropriate measures should be implemented based on the risk assessment and detailed on the custody records. (5.129)
- 7.61 All interview rooms should be fit for purpose and confidential information should not be left lying around. (5.130)
- 7.62 The force should urgently review how it takes, stores, tracks and submits all DNA and forensic samples taken from detainees, volunteers and victims. Robust monitoring of performance should be overseen by a senior officer. (5.131)

Healthcare

- 7.63 The Constabulary should monitor all aspects of the health services contract, including response times, professional training and registration of staff. (6.47)
- 7.64 Healthcare professionals contracted for police work should not have any other contractual obligations at the same time that could lead to a conflict of time allocated to police work. (6.48)
- 7.65 Detainees should have access to a relevant healthcare professional of their own gender. (6.49)
- 7.66 There should be clear lines of accountability for the checking of resuscitation equipment and first aid kits and such checks should be documented. (6.50)
- 7.67 There should be a full range of resuscitation equipment, including an automated external defibrillator and oxygen, available in each suite. The kit should be the same in each suite. (6.51)
- 7.68 All staff should have annual training in resuscitation, including the use of an external automated defibrillator. (6.52)
- 7.69 There should be a formalised cleaning contract for the clinical rooms and formalised infection control guidelines. (6.53)

- 7.70 All detainees should be offered the services of a drugs or alcohol arrest referral worker where appropriate and be referred to relevant services if required. (6.54)
- 7.71 There should be a liaison and/or diversion scheme to enable mentally disordered offenders to be identified and diverted into appropriate mental health services. (6.55)
- 7.72 Police custody suites should not be used as a place of safety for section 136 assessments. (6.56)
- 7.73 Patient group directions should be introduced to ensure the safe prescribing of medications. (6.57)

Housekeeping points

- 7.74 Detainees should be told the job title of the healthcare professional with whom they are consulting. (6.58)
- 7.75 All the examination couches should have paper roll to cover them. (6.59)
- 7.76 The time a healthcare professional is called should be recorded by custody staff on the paper custody record as well as the electronic record. (6.60)
- 7.77 Detainees should be told that they can obtain a copy of their clinical records. (6.61)

Good practice

- 7.78 The management of clinical records was good and records were kept securely in line with Caldicott principles. It was a system that could be emulated by other custody suites. (6.62)

Appendix 1 : Inspection team

Hindpal Singh Bhui	-	HMIP team leader
Paddy Craig	-	HMIC inspector
Karen Dillon	-	HMIP inspector
Hayley Folland	-	HMIP inspector
Ian Macfadyen	-	HMIP inspector
Martin Owens	-	HMIP inspector
Susan Fenwick	-	HMIP inspector
Elizabeth Tysoe	-	Healthcare inspector
Jan Fookes-Bale	-	CQC Inspector
Catherine Nichols-		HMIP researcher

Appendix 2 : Police custody survey

Section 1: About You

Total number of surveys completed: 38

Q1	What police station were you last held at?

Q2	What type of detainee were you?	
	Police detainee.....	82%
	Prison lock-out (i.e. you were in custody in a prison before coming here).....	3%
	Immigration detainee.....	3%
	I don't know.....	8%

Q3	How old are you?		
	16 years or younger.....	0%	40-49 years..... 21%
	17-21 years.....	5%	50-59 years..... 11%
	22-29 years.....	26%	60 years or older..... 0%
	30-39 years.....	37%	

Q4	Are you:	
	Male.....	82%
	Female.....	0%
	Transgender/Transsexual.....	5%

Q5	What is your ethnic origin?	
	White - British.....	18%
	White - Irish.....	5%
	White - Other.....	5%
	Black or Black British - Caribbean.....	26%
	Black or Black British - African.....	16%
	Black or Black British - Other.....	0%
	Asian or Asian British - Indian.....	0%
	Asian or Asian British - Pakistani.....	0%
	Asian or Asian British - Bangladeshi.....	5%
	Asian or Asian British - Other.....	0%
	Mixed Race - White and Black Caribbean.....	0%
	Mixed Race - White and Black African.....	3%
	Mixed Race - White and Asian.....	3%
	Mixed Race - Other.....	11%
	Chinese.....	0%
	Other ethnic group.....	3%
	Please specify:	

Q6	Are you a foreign national (i.e. you do not hold a British passport, or you are not eligible for one)?	
	Yes.....	18%
	No.....	71%

Q7	What, if any, would you classify as your religious group?	
	None.....	11%

	Church of England.....	32%
	Catholic	29%
	Protestant.....	0%
	Other Christian denomination.....	8%
	Buddhist	0%
	Hindu.....	0%
	Jewish	0%
	Muslim.....	13%
	Sikh	0%
	Any other religion, please specify	

Q8	How would you describe your sexual orientation?	
	Straight / Heterosexual.....	79%
	Gay / Lesbian / Homosexual	8%
	Bisexual.....	0%
	Other (please specify):	

Q9	Do you consider yourself to have a disability?	
	Yes.....	18%
	No.....	71%
	Don't know.....	5%

Q10	Have you ever been held in police custody before?	
	Yes.....	82%
	No.....	13%

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.

Q11	How long were you held at the police station?	
	1 hour or less.....	0%
	More than 1 hour, but less than 6 hours.....	5%
	More than 6 hours, but less than 12 hours.....	8%
	More than 12 hours, but less than 24 hours.....	29%
	More than 24 hours, but less than 48 hours (2 days).....	24%
	More than 48 hours (2 days), but less than 72 hours (3 days).....	5%
	72 hours (3 days) or more	26%

Q12	Were you given information about your arrest and your entitlements when you arrived there?	
	Yes.....	76%
	No.....	16%
	Don't know/Can't remember	5%

Q13	Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')?	
	Yes.....	61%
	No.....	24%
	I don't know what this is/I don't remember.....	13%

Q14	If your clothes were taken away, were you offered different clothing to wear?	
	My clothes were not taken.....	66%
	I was offered a tracksuit to wear.....	5%

	I was offered an evidence suit to wear	13%
	I was offered a blanket	3%

Q15	Could you use a toilet when you needed to?	
	Yes.....	76%
	No.....	18%
	Don't know.....	3%

Q16	If you have used the toilet there, were these things provided?		
		Yes	No
	Toilet paper	57%	38%
	Sanitary protection	11%	34%
	Other (please specify):		

Q17	Did you share a cell at the police station?	
	Yes.....	3%
	No.....	87%

Q18	How would you rate the condition of your cell:			
		Good	Neither	Bad
	Cleanliness	32%	21%	39%
	Ventilation /Air Quality	16%	21%	47%
	Temperature	13%	23%	49%
	Lighting	54%	10%	23%

Q19	Was there any graffiti in your cell when you arrived?	
	Yes.....	50%
	No.....	45%

Q20	Did staff explain to you the correct use of the cell bell?	
	Yes.....	29%
	No.....	66%

Q21	Were you held overnight?	
	Yes.....	84%
	No.....	13%

Q22	If you were held overnight, which items of clean bedding were you given?	
	Not held overnight	8%
	Pillow.....	22%
	Blanket	39%
	Nothing.....	27%

Q23	Were you offered a shower at the police station?	
	Yes.....	8%
	No.....	87%

Q24	Were you offered any period of outside exercise while there?	
	Yes.....	5%
	No.....	92%

Q25	Were you offered anything to:		
		Yes	No
	Eat?	74%	24%
	Drink?	68%	24%

Q26	Was the food/drink you received suitable for your dietary requirements?		
	I did not have any food or drink		13%
	Yes.....		34%
	No.....		45%

Q27	If you smoke, were you offered anything to help you cope with the smoking ban there?		
	I do not smoke.....		11%
	I was allowed to smoke		5%
	I was not offered anything to cope with not smoking.....		74%
	I was offered nicotine gum		0%
	I was offered nicotine patches.....		3%
	I was offered nicotine lozenges		0%

Q28	Were you offered anything to read?		
	Yes.....		13%
	No.....		84%

Q29	Was someone informed of your arrest?		
	Yes.....		58%
	No.....		29%
	I don't know		5%
	I didn't want to inform anyone		5%

Q30	Were you offered a free telephone call?		
	Yes.....		74%
	No.....		21%

Q31	If you were denied a free telephone call, was a reason for this offered?		
	My phone call was not denied.....		47%
	Yes.....		3%
	No.....		24%

Q32	Did you have any concerns about the following, while you were in police custody:		
		Yes	No
	Who was taking care of your children	26%	36%
	Contacting your partner, relative or friend	45%	29%
	Contacting your employer	18%	39%
	Where you were going once released	16%	42%

Q33	Were you interviewed by police officials about your case?		
	Yes.....	82%	
	No.....	16%	If No, go to Q35

Q34	Were any of the following people present when you were interviewed?			
		Yes	No	Not needed
	Solicitor	60%	21%	11%
	Appropriate Adult	11%	18%	26%
	Interpreter	5%	11%	34%

Q35	How long did you have to wait for your solicitor?	
	I did not requested a solicitor.....	24%
	2 hours or less.....	18%
	Over 2 hours but less than 4 hours	3%
	4 hours or more.....	45%

Q36	Were you officially charged?	
	Yes.....	74%
	No.....	11%
	Don't know.....	8%

Q37	How long were you in police custody after being charged?	
	I have not been charged yet.....	8%
	1 hour or less.....	0%
	More than 1 hour, but less than 6 hours.....	18%
	More than 6 hours, but less than 12 hours.....	18%
	12 hours or more.....	50%

Section 3: Safety

Q39	Did you feel safe there?	
	Yes.....	50%
	No.....	37%

Q40	Had another detainee or a member of staff victimised (insulted or assaulted) you there?	
	Yes.....	18%
	No.....	71%

Q41	If you have felt victimised, what did the incident involve? (Please tick all that apply)			
	I have not been victimised.....	21%	Because of your crime.....	9%
	Insulting remarks (about you, your family or friends).....	18%	Because of your sexuality.....	2%
	Physical abuse (being hit, kicked or assaulted).....	5%	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.....	2%
	Drugs.....	11%		

Q42	Were you handcuffed or restrained while in the police custody suite?	
	Yes.....	39%
	No.....	50%

Q43	Were you injured while in police custody, in a way that you feel was not your fault?	
	Yes.....	21%
	No.....	68%

Q44	Were you told how to make a complaint about your treatment here, if you needed to?	
	Yes.....	11%
	No.....	82%

Section 4: Healthcare

Q46	When you were in police custody, were you on any medication?	
	Yes.....	50%
	No.....	45%

Q47	Were you able to continue taking your medication while there?	
	Not taking medication.....	29%
	Yes.....	18%
	No.....	34%

Q48	Did someone explain your entitlements to see a healthcare professional, if you needed to?	
	Yes.....	45%
	No.....	42%
	Don't know.....	8%

Q49	Were you seen by the following healthcare professionals during your time there?		
		Yes	No
	Doctor	66%	26%
	Nurse	0%	50%
	Paramedic	0%	50%
	Psychiatrist	0%	47%

Q50	Were you able to see a healthcare professional of your own gender?	
	Yes.....	29%
	No.....	42%
	Don't know.....	13%

Q51	Did you have any drug or alcohol problems?	
	Yes.....	55%
	No.....	34%

Q52	Did you see, or were you offered the chance to see, a drug or alcohol support worker?	
	I didn't have any drug/alcohol problems	13%
	Yes.....	42%
	No.....	37%

Q53	Were you offered relief or medication for your immediate symptoms?	
	I didn't have any drug/alcohol problems	21%
	Yes.....	21%
	No.....	47%

Q54	Please rate the quality of your healthcare while in police custody:						
		<i>I was not seen by healthcare</i>	Very Good	Good	Neither	Bad	Very Bad
	Quality of healthcare	11%	0%	16%	21%	24%	16%

Q55	Did you have any specific physical healthcare needs?	
	No.....	61%
	Yes.....	26%

Q56	Did you have any specific <u>mental</u> healthcare needs?	
	No.....	68%
	Yes.....	16%

Section 5: Prison Lock-Out Information

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

Q58	Were you told that you would be held in a police station, rather than a prison, before you arrived there?	
	Yes.....	16%
	No.....	39%

Q59	How long did you spend in the escort van before arriving there?	
	Less than 1 hour.....	32%
	More than 1 hour, but less than 2 hours.....	8%
	More than 2 hours, but less than 3 hours.....	5%
	More than 3 hours, but less than 4 hours.....	3%
	More than 4 hours.....	3%

Q60	Were you offered the chance to let family/friends know where you were?	
	Yes.....	24%
	No.....	26%

Q61	Did your property come with you to the police station?	
	Yes.....	24%
	No.....	16%
	I don't know.....	5%

Q62	On average, how much time were you able to spend out of your police cell each day?	
	I was not able to spend any time out of my police cell.....	39%
	Less than 1 hour.....	3%
	More than 1 hour, but less than 2 hours.....	0%
	More than 2 hours, but less than 3 hours.....	0%
	More than 3 hours, but less than 4 hours.....	0%
	More than 4 hours.....	0%