Inspecting policing in the public interest

Report on an inspection visit to police custody suites in

Derbyshire

by HM Chief Inspector of Prisons

and HM Inspectorate of Constabulary

7-11 May 2013

Glossary of terms

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Contents

Section 1. Introduction

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

The inspection of Derbyshire police provision of custody revealed some concerns. We observed a high incidence of strip searching and use of safety clothing. The force told us this was to respond to detainee risks though, when asked, staff were unable to provide a cogent explanation as to why this was a proportionate response in some individual cases. Conversely their information system was unable to provide any performance data on their management of issues such as mental health, throughput in custody, incidences of use of force and we were not assured they could reasonably know whether their response to strategic risks was appropriate. The force did not have access to management information since the installation of the new system some 12 months earlier and we were surprised the situation remained unresolved. The force needed to address the over use of interventions with detainees and gain a reliable understanding of the higher level trends and patterns.

We were also concerned that detainees were being held in custody for unnecessary periods due to an inappropriate use of the threshold for drink driving as the test for fitness to interview. This test does not take into account other factors such as demeanour and individual tolerances. The drink drive limit is not the correct test for assessment for fitness to interview; the assessment should reflect a holistic understanding of the detainee's condition and ability to understand and participate in the proceedings.

We also found the force used a custody form (F142) which excluded the detainee from hearing the conversation between the arresting officer and the custody sergeant as to the reasons for arrest. It was reported to us before the end of our inspection that this form was being reviewed and was subsequently withdrawn.

Despite these concerns we observed good interactions between custody staff and detainees. Staff were polite and courteous and the general conditions of the suites were good. Healthcare was good and the force had a strategic lead officer for mental health and we were able to confirm, from other data sources, there had been a reduction in the use of police custody as a place of safety.

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June 2013

Section 2. Background and key findings

2.1 This report is one in a series relating to inspections of police custody carried out jointly by HM Inspectorates of Prisons and Constabulary. These inspections form part of the joint work programme of the criminal justice inspectorates and contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorates of Prisons and Constabulary are two of several bodies making up the NPM in the UK.

2.2 The inspections of police custody look beyond the implementation of the Police and Criminal Evidence Act 1984 (PACE) codes of practice and *Safer Detention and Handling of Persons in Police Custody* 2011 (SDHP) at force-wide strategies, treatment and conditions, individual rights and health care. They are also informed by a set of *Expectations for Police Custody*[1] about the appropriate treatment of detainees and conditions of detention, developed by the two inspectorates to assist best custodial practice.

2.3 Derbyshire had three full-time custody suites with a total cell capacity of 77.

Custody suites	**Cells**
Derby	44
Chesterfield	20
Buxton	13

Strategy

2.4 The force had a centralised custody function delivered through the criminal justice department. Detainees were generally conveyed to their local facility. Custody matters were discussed at the risk management board chaired by the chief constable.

2.5 There were significant concerns about the production of basic performance data from the 'GEM' custody IT system. Derbyshire had no structured means of monitoring performance on custody, detainee throughput, immigration detainees, detainees held under section 136 of the Mental Health Act[2] and the number of detainees subject to strip searching.

2.6 The IT system was subject to regular breakdown and interruption. The force told us this had been the case since the system had been installed 12 months previously. The

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1 http://www.justice.gov.uk/inspectorates/hmi-prisons/expectations.htm

2 Section 136 of the Mental Health Act 1983 enables a police officer to remove someone from a public place and take them to a place of safety – for example, a police station. It also states clearly that the purpose of being taken to the place of safety is to enable the person to be examined by a doctor and interviewed by an approved social worker, and for the making of any necessary arrangements for treatment or care.

breakdowns had become less frequent but the integrity of the system was compromised, and a risk to detainees and the organisation.

2.7 The force had a thorough quality assurance process completed on a corporate template. Five custody records a month were checked for each suite, although more could have been reviewed for the busier suites.

Treatment and conditions

2.8 Staff engaged with detainees in a professional and respectful manner. The Derby suite was a busy environment, sometimes with many police and non-police personnel in the area, and the custody sergeants were not always in control of the area. We saw non-custody staff freely accessing cell keys and taking detainees for interviews. This environment made it difficult to provide privacy for detainees being booked in.

2.9 The force routinely used breathalysers for people detained on non-motoring offences. We saw high use of rip-proof clothing and excessive strip searching, which were symptomatic of a risk-averse approach to detainee care. The rationale for these measures was often lacking.

2.10 Staff considered specific diversity issues and asked questions accordingly, providing translated materials or interpreters as necessary.

2.11 We observed a good level of questioning and interaction on pre-release risk assessments, although there was poor recording of the risks discussed. All detainees being released were given a leaflet with telephone numbers of support agencies.

2.12 We observed detainees subject to a range of observations and checks. Some staff misunderstood or lacked training about the correct application of the standard required for level three (CCTV) observations. Approved Professional Practice (APP) requires such observations to be a constant and uninterrupted watch by camera tasked to one person; staff mistakenly believed that as long as detainees were on screen, and observed intermittently, this would suffice. Only staff at Buxton complied with the standard required in APP.

2.13 The physical condition of the suites was generally good.

Individual rights

2.14 Custody sergeants told us they would refuse detention. Restorative justice and voluntary attendance were thought to be well used, although this could not be evidenced due to the lack of management information.

2.15 We observed use of a pro forma, F142, which was completed by the arresting officer and then discussed with the custody sergeant without the detainee present. It was not clear to us why these forms were required, although by the end of the inspection we saw an email informing staff that they were being reviewed. In the interim, detainees should be present when the reasons for arrest are explained to the sergeant.

2.16 The force was complying with the April 2013 High Court decision that the PACE definition of an adult was incompatible with human rights law (in which17-year-olds

are treated as children), and was seeking consent from 17-year-old detainees to provide them with an appropriate adult.

2.17 Rights and entitlements were available to detainees in 38 languages, and the force used a professional interpreting service, with access to interpreters by phone and face to face. Staff reported difficulties in finding face-to-face interpreters in some languages.

2.18 We were unable to confirm how quickly Home Office Immigration Enforcement collected foreign national detainees when a notification to detain them (IS91) was issued due to the lack of management information available.

2.19 There were copies of the current PACE codes in all suites, but not enough for the number of cells in Derby. Detainees were offered out-of date copies in some suites. We observed some PACE reviews, required to review detention, which were thorough, and a good proportion were done face to face.

2.20 There was a good standard of complaints handling, and lessons learned were disseminated to staff.

Health care

2.21 Derbyshire police was an 'early adopter' for NHS commissioning of health services. At the time of inspection, Derbyshire Healthcare United provided health services in the custody suites, but the contract was due to change within three weeks of our visit. There was a governance meeting structure but custody issues were not a standing item, which caused concerns that serious incidents were not identified and acted upon.

2.22 Not all detainees got the same level of direct patient care, but we were told by detainees that the care provided was good. DHU staff were available at different times across the suites. In Buxton there was no nurse, but a forensic medical examiner (FME) covered the suite. Unusually, nurses did not assess a detainee's fitness to be interviewed or released, and an FME was required to assess this.

2.23 There was excellent joint working between the police, arrest referral workers (supporting detainees to access local drugs and alcohol services), and health services to obtain medications for detainees, including opiate substitution therapy to maintain continuity of treatment.

2.24 The force had a new strategic lead staff member for mental health care. Derbyshire Health NHS Foundation Trust provided a criminal justice mental health team during working hours for the three custody suites, and the team reported good working relationships with custody staff. There were two section 136 suites in the force area, and data indicated that the use of police custody suites as a place of safety was reducing.

Main recommendations

2.25 As a priority, chief officers should resolve the inadequacies of the custody IT system to ensure outcomes for detainees are not adversely affected.

2.26 Custody staff should only use safety clothing following a risk assessment, and its use should be monitored for rationale and justification and to identify any staff training needs.

2.27 Strip searching needs to be authorised and justified. Custody staff should be monitored for rationale and justification and to identify any staff training needs.

2.28 Custody staff should review the use of a breathalyser as the only determining factor for assessing someone's suitability for interview. Risk assessments should consider the detainee's demeanour and understanding.

2.29 The meaning and standard of level three observations should be explained to all custody staff.

2.30 The use of form F142 should be reviewed, and the detainee should be present when the arresting officer explains the reason for their arrest to the custody sergeant.

Section 3. Strategy

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

Strategic management

3.1 An assistant chief constable (ACC) provided strategic leadership on custody issues, with a centralised custody function delivered through the criminal justice department (CJD). A superintendent, head of CJD, line-managed the chief inspector, head of custody.

3.2 The force estates strategy had led to the reduction to the current three full-time custody suites. There was one standby custody suite and two non-designated suites that, we were advised, were rarely used

3.3 Detainees were generally conveyed to their area facility. Use of the force-specific form, F142 during the booking-in process added a further layer to the procedure, which we observed inhibiting dialogue between custody sergeant and detainee (see paragraph 5.1 and main recommendation 2.30).

3.4 Staffing levels in custody suites were adequate, and comprised permanent custody sergeants and police staff civilian detention officers (CDOs), employed by Derbyshire Constabulary.

3.5 Custody sergeants line-managed CDOs who looked after the care and welfare of detainees. CDOs also undertook booking-in duties, although this was not consistent across the three suites. CDOs had specific roles and worked effectively to provide a good standard of care. There was effective team working, such as in the shift handover process.

3.6 Custody matters were discussed and reviewed at a risk management board, and at weekly and monthly chief officer group meetings. There were regular custody-specific meetings, ranging in attendance from senior police managers and custody staff.

3.7 Performance information reviewed at meetings consisted of qualitative performance data from the custody audit processes. However, there were significant problems with the production of basic quantitative data from the GEM custody (IT) system. Derbyshire Constabulary had no structured means to monitor and evaluate accurately areas of performance, such as total detainee throughput, the throughput of immigration detainees, detainees held under section 136 of the Mental Health Act 1984, and the number of detainees subject to strip searching. The IT system was also subject to regular breakdown and interruption. Chief officers said that there had been ongoing dialogue with the IT provider since implementation of the system 12 months previously, but the problems had still not been resolved. We felt that the integrity of the custody IT system was compromised, presented a risk to detainees and the organisation, was not sustainable and needed to be resolved as a priority (see main recommendation 2.25).

Partnerships

3.8 We were told that voluntary attendance by arrested people at police stations was used where appropriate, but due to the limitations of the custody IT system, there was no management information to support this. We were told that local authority provision of secure and non-secure accommodation for young people refused bail was non-existent. The new Association of Chief Police Officers (ACPO) guidance on treatment of arrested 17-year-olds had been implemented and was being monitored.

3.9 There was an independent custody visitors (ICV) coordinator in the Police and Crime Commissioner's (PCC) office. The ICV scheme consisted of two panels and provided a regular schedule of visits. ICVs told us that they were generally admitted to custody suites quickly and felt able to raise any concerns with custody staff. They had not identified any particular trends or problems, and ad hoc issues were dealt with and communicated effectively through quarterly meetings. There was regular and consistent police representation at ICV meetings.

Recommendation

3.10 The Police and Crime Commissioner or chief officer group should discuss with local authority partners at a strategic level how to address the lack of local authority accommodation for children and young people refused bail at police stations.

Learning and development

3.11 All custody sergeants and CDOs had undergone an initial three-week custody-specific training course before undertaking custody duties. The course was linked to the national custody officer learning programme (NCOLP) of the College of Policing. The initial training was supplemented by a period of on-the-job mentoring and the completion of a portfolio before accreditation. This was a good process.

3.12 There was a three-day annual refresher training event for custody sergeants and CDOs. The training was informed by the quality assurance of sampling, adverse incidents, complaints and use of force monitoring. Again, this was an effective programme of training.

3.13 The force used the College of Policing authorised professional practice (APP) as its custody policy, which was accessible on the custody intranet. There was a comprehensive weekly custody publication for custody sergeants to brief all staff, although some staff said they had not received such briefings.

3.14 The adverse incident process was clear and any immediate issues were dealt with by email with any later time learning disseminated through a weekly briefing document. Adverse incidents were also the subject of analysis in the monthly performance package and were reviewed at custody management meetings.

3.15 There was a robust quality assurance process for sampling custody records. The PACE inspector and custody support sergeant were required to sample five custody records a month per suite, although more could have been reviewed for the busier suites. This process was thorough and auditable, scrutinised by the head of custody. There was cross-referencing to CCTV, and the person escort record (PER) was included in the quality checking. Each month, one handover per suite was quality

assured by reviewing the CCTV recording of the process. Trends and themes from this process were fed into the weekly custody briefing and custody refresher training.

Recommendation

3.16 The sample of custody records quality assured at the busier suites should be increased.

Housekeeping points

3.17 The force should review custody procedures against the College of Policing authorised professional practice (APP) custody policy.

3.18 Senior managers in custody should reinforce the weekly briefing with staff.

Section 4. Treatment and conditions

Expected outcomes:
Detainees are held in a clean and decent environment in which their safety is protected and their multiple and diverse needs are met.

Respect

4.1 Staff engaged with detainees in a professional and polite manner. The custody detention officers (CDOs) responded appropriately to detainees' needs and were confident in their role. Custody sergeants' overall response to detainees varied between suites. At the less busy custody suite of Buxton, they could spend time engaging with detainees and reassuring those who required it. However, at the busy Derby custody suite they sometimes paid less attention to detainees' individual needs, and gave priority to booking in the detainee as swiftly as possible.

4.2 The booking-in areas varied greatly between Buxton, Chesterfield and Derby, but all three offered privacy. Buxton, the smallest of the three suites, had two booking-in terminals, but we were told and observed only one being used. At Chesterfield, we saw detainees booked in individually, and the small booking-in area was well managed by custody staff who promptly returned detainees to their cells or the holding room so that other detainees could be booked-in in privacy. The booking-in area at Derby was reasonably large and the three booking-in terminals had privacy screens, but the overall management of the area was poor. We observed 18 people in the booking-in area, including detainees, legal representatives, appropriate adults and non-custody police staff. There was no active management to remove those who did not need to be in the area while detainees were booked in.

4.3 Staff showed a reasonable awareness of diversity, and the CDO initial training included some input on the subject. Custody staff booking in female detainees asked if they might be pregnant. We observed a CDO booking in a female detainee and informing her that hygiene products were available, although the custody sergeants we observed did not offer this information, even though it was a set question on the GEM custody system. Custody staff asked all detainees, both male and female, whether they had dependants, in a thorough and clear way.

4.4 All the suites had designated cells for young people located in their own corridor with toilet and washing facilities. This enabled young people to be kept separately from adult detainees. We saw three young people booked in at Buxton. Custody staff spoke to them in a patient and age-appropriate manner.

4.5 We observed several foreign national detainees being booked in. Custody staff correctly used the professional telephone interpreting service for those who could not speak English. At Derby, we observed a CDO using this service to ensure that a foreign national detainee being transferred to court understood what was happening, and to complete a pre-release assessment. The process was thoroughly conducted.

4.6 Detainees being booked in were asked if they had any religious needs. We were told that there was little use of the religious artefacts held at the three suites. Prayer mats, a Qur'an and several Bibles were available.

4.7 There were no adapted cells for older detainees or those with disabilities at any of the suites. Chesterfield and Buxton had step-free access but Derby did not. Only Chesterfield had an adapted toilet. There were no hearing loops or Braille material at any suite.

4.8 Custody sergeants and CDOs were aware of the needs of transgender detainees when they were searched.

Recommendations

4.9 Custody sergeants at Derby should maintain better control of the number of staff waiting in the booking-in area.

4.10 Custody suites should be accessible to detainees with disabilities, and booking-in areas should be fitted with hearing loops and custody staff know how to use them.

Housekeeping point

4.11 Hygiene packs should be routinely offered to female detainees.

Safety

4.12 Staff undertook systematic risk assessments with detainees on arrival, working through questions prompted by the GEM custody system. The GEM system was very slow and frustrating for many staff. The system broke down during the inspection, which resulted in the temporary loss of some information on the custody records, and staff had to resort to a paper-based system. We were informed that this was not uncommon. We were concerned about safety issues if the system failed during a busy period (see main recommendation 2.25).

4.13 Both custody sergeants and CDOs booked in detainees. The risk assessment process was explained to detainees. We observed CDOs being more thorough than sergeants in explaining the purpose of the risk assessment and in its subsequent completion. Staff followed the GEM script but sometimes also asked detainees comprehensive supplementary questions about their health and feelings, especially when there were indications of self-harm. We observed checks of police national computer details, with warning markers duly noted on the custody record. The 30 custody records we analysed confirmed that risk assessments were reasonably well completed.

4.14 Custody sergeants did not always manage risk proportionately, and routinely removed detainees' shoes or clothes with cords attached. We observed custody sergeants breathalysing detainees to confirm that they had been drinking or who they suspected were under the influence of alcohol. Signs displayed in all three custody suites informed detainees that they could be breathalysed to determine when they would be fit for interview (see also paragraph 5.5 and main recommendation 2.28). Detainees had been subject to breath testing in 13 of the 30 custody records we analysed. One of these cases concerned a 15-year-old with no appropriate adult present, which was poor practice. Custody staff did not have the authority to breathalyse detainees, and an arbitrary cut-off level (35 μg) did not take account of individual risk factors.

4.15 We observed more detainees in safety clothing than we usually see. They were placed in safety clothing if they had current or historical self-harming warning markers, or expressed feelings of vulnerability during booking in. There appeared to be little consideration of whether detainees were at immediate risk of harming themselves. Once detainees were placed in safety clothing, this was not reviewed (see main recommendation 2.26).

4.16 We observed CDOs diligently visiting cells and recording this. Detainees were placed on a range of observations, but some custody staff were confused about the expectation of level three CCTV observations for vulnerable detainees. APP requires such observations to be a constant and uninterrupted watch via camera by a member of staff. We saw several examples of detainees on CCTV monitors that could be seen in the back office or the custody bridge, but little evidence of anyone watching these detainees, other than a cursory glance. Custody staff at Derby and Chesterfield believed that as long as the detainee was clearly displayed on the CCTV monitor and was watched intermittently, this would suffice as level three observation, but this was incorrect. Only Buxton custody suite confirmed that a CDO or officer would be tasked with constantly watching the CCTV monitor for a level three observation (see main recommendation 2.29).

4.17 Staff had a good understanding of rousing procedures for detainees who were intoxicated, and this was confirmed in our custody record analysis. There was an aide-memoire on rousing detainees behind the custody desk in all suites. Anti-ligature knives were not personal issue but affixed to all sets of cell keys. There was the potential for staff not to have a set of keys readily accessible to them (see paragraph 4.28). All cells and communal areas were monitored by CCTV, which included an audio capability in the communal areas.

4.18 Custody staff handovers were thorough. The handover we observed at Derby involved the whole team of incoming and outgoing custody staff. The booking-in area was cleared and there were no interruptions. The handover was led by the night shift custody sergeants, and CDOs contributed information. All detainees were discussed and relevant information was shared, with a focus on risk assessments and detainees' physical and mental health. We observed the incoming CDO assigned to cell visits attend each cell to check on detainees after the handover.

4.19 The custody record system incorporated a pre-release risk assessment (PRRA) prompt for custody sergeants to respond to before the record could be closed. There was sufficient attention to preparation for release. A leaflet with information about support agencies was regularly given to those leaving custody, but was only available in English. Staff at Buxton and Derby said they contacted someone at the detainee's home, if necessary, and police took the most vulnerable people home. We observed detainees being released from custody and each were asked how they felt and if they had any immediate thoughts of harming themselves. The quality of PPRA in the record analysis was mixed. There were gaps in information about how some vulnerable individuals, mainly young people and women, had travelled home in the early hours of the morning. In one case, a woman who had left rehabilitation three days previously and who was released at 3.49am with no record of how she travelled home. She had been breathalysed at midnight, and found to be very intoxicated before she was released four hours later.

Recommendation

4.20 Staff should carry anti-ligature knives at all time.

Housekeeping point

4.21 Custody staff should record on the pre-release risk assessment all information considered and action taken before releasing a detainee.

Use of force

4.22 Many detainees arrived at the custody suites in handcuffs. At Chesterfield we saw these removed promptly once the detainee was in the holding area, and we also saw detainees arriving at this suite without handcuffs. Arresting officers demonstrated a clear understanding of the need for their use to be justified, necessary and proportionate. This was not the case at Buxton and Derby, where we saw detainees wait in handcuffs for up to 25 minutes in the holding area before they were brought before the custody sergeant. Most were calm and compliant while in the holding area, so it was unclear why their handcuffs could not have been removed sooner. Custody sergeants told us that they were not averse to officers removing handcuffs when detainees were in the holding area.

4.23 All custody staff were aware of the use of force form and the circumstances in which it should be submitted. At Derby, we observed custody staff completing the forms after force had to be used on two fractious detainees. Data about use of force in custody were collated and analysed. Staff had been trained in approved personal safety techniques and received annual refresher training.

4.24 During the inspection, we saw detainees being strip searched for reasons not in accordance with PACE code C. For example, on several occasions we observed detainees admitting to having used drugs in the last 24 hours and then being told by custody staff that they would need to be strip searched because of this. This was in contravention of PACE code C, which specifies that strip searching should be conducted only if the officer reasonably considers that the detainee might have concealed a non-permitted article. The strip searches at Derby and Chesterfield also took place in a cell monitored by CCTV and therefore visible on the monitor behind the custody desk. This should have been turned off, and this action was taken when we brought this to the custody sergeants' attention (see main recommendation 2.27).

Recommendation

4.25 Detainees should only be handcuffed in holding areas when a risk assessment indicates this is necessary for the safety of staff and others.

Physical conditions

4.26 The condition of the custody estate was very good. All suites were kept clean and well maintained, and graffiti was minimal. Many cells had been repainted in the previous 12 months. However, natural light in some cells was poor.

4.27 There was an effective process for regular health and safety checks. CDOs checked their facilities once a day and records were completed consistently. Custody sergeants completed monthly checks. Cells were checked after each occupation to identify any unauthorised items left behind or any damage. A helpful notice in the cell corridors of all three custody suites reminded CDOs about how to conduct cell

checks. We observed CDOs at Derby checking cells, including cell call bells, the quality of mattresses and pillows, lighting and ligature points.

4.28 Cell call bells were responded to promptly at all three custody suites. We saw civilian detention officers taking detainees to the cells and explaining how call bells and toilet flushes work. There was poor supervision of cell keys at Chesterfield and Derby. We saw cell keys handed to non-custody staff to collect detainees for interview or take them to the custody desk for charging or release.

4.29 All suites had a fire evacuation box containing handcuffs. Staff indicated that they had received a fire evacuation drill, either table top or full exercise, in the previous 12 months.

Recommendation

4.30 Only custody staff should visit cells or, if necessary, accompany such visits.

Detainee care

4.31 Detainee care was reasonable overall. All cells had mattresses and pillows and most were clean and in a reasonable condition, but some at Derby were heavily stained due, we were told, to a reaction to the paint used in the cells. Some detainees thought this staining was dirt and refused to lie on them. There were good supplies of clean blankets.

4.32 Most cells in all three custody suites had integral sanitation. At Chesterfield, toilet paper was available only on request. At Derby and Buxton we were told that detainees were given toilet paper before they were located in a cell if no concerns were highlighted in their risk assessment. Images of toilet areas on CCTV monitors were appropriately obscured.

4.33 Toiletries such as soap and toothpaste were available but we did not observe any detainees use them. There were private, clean shower facilities, which operated correctly. Of the 30 detainees in our sample, only one was recorded as offered the opportunity to shower or wash. This male detainee was held at Buxton for over 37 hours and had been able to have two showers.

4.34 Chesterfield and Buxton had sufficient supplies of boilersuits that detainees could wear in the custody suite if their clothes had been seized or soiled. Footwear and paper underwear were also available. There was some second-hand clothing from staff and lost property for people going to court or on release.

4.35 At Derby, the management of the boilersuits and safety clothing was poor, and on one day during the inspection none was available for detainees. We observed a woman who had been given only a rip-proof top to wear and a blanket to cover her lower half, which was undignified. Custody staff allowed her to put on pyjama trousers for her interview. Additional supplies of clothing were eventually obtained from another custody suite. The availability of replacement footwear was also a problem at Derby, which only had very small or very large sizes. Consequently, detainees were left in cells and in some cases walked around the custody suite barefooted. The other two suites had sufficient supplies.

4.36 There was a wide variety of microwave meals. These met a range of dietary and religious needs but were of low calorific value. In Derby, meals were mainly offered at standard meal times but could be offered more regularly at the two smaller suites. Detainees were offered drinks at regular intervals.

4.37 All suites had an exercise yard covered by CCTV, but they were infrequently used. We observed only one detainee (who had claustrophobia) using the exercise yard during the inspection. Only one detainee in our custody record analysis had been offered exercise. He had been held in custody for almost 26 hours, but one detainee held for over 37 hours did not appear to have been offered outside exercise.

4.38 All suites provided some reading materials, and at Derby we saw this actively given out. However, they were mostly old magazines, with nothing in foreign languages or age-related. There were no closed visits room at any of the custody suites to facilitate visits for vulnerable detainees.

Recommendations

4.39 Suitable alternative clothing for detainees should be available in all the custody suites at all times.

4.40 Detainees, particularly those held for more than 24 hours, should be offered exercise and a shower.

Housekeeping points

4.41 Stained mattresses and pillows should be replaced.

4.42 Toilet paper should be routinely provided in each cell.

4.43 There should be a suitable range of reading material for detainees, including young people, non-English speakers and those with limited literacy.

Section 5. Individual rights

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

Rights relating to detention

5.1 On arrival at a custody suite, arresting officers completed a form F142, which summarised the full circumstances of the arrest, offence details and grounds for detention. Custody sergeants used the information recorded on the form to create a custody record for the detainee before booking them in. This not only delayed the booking-in process, but we observed the use of this form inhibiting custody sergeants, particularly at Derby, from checking the reasons for detention with arresting officers in the presence of detainees, to ensure there were appropriate grounds. We often heard detainees asked the rhetorical question, 'You know why you have been arrested?', but sergeants did not attempt to confirm whether or not they really had understood the full reason for arrest. This was not a transparent or open process, although after we highlighted our concerns we were made aware of steps to remind staff of their responsibilities when accepting a detention, and the use and purpose of the form was under review (see main recommendation 2.30).

5.2 Custody sergeants told us they were confident in refusing detention when the circumstances did not merit arrest, and were able to give us some historical details of such cases.

5.3 Alternatives to custody were available, such as restorative justice and voluntary attendance, which staff believed were responsible for reducing the throughput in the custody suites. However, the force was unable to provide any performance statistics to evidence increasing use of these disposals. Sergeants told us they had seen an increase in officers seeking advice before making an arrest, and we observed this taking place on several occasions.

5.4 Custody sergeants were clear about their obligations to ensure that cases proceeded quickly. At Derby, when staffing levels permitted, one of the three custody sergeants on duty monitored detention periods and contacted investigating officers to ensure cases were progressed without delay.

5.5 We were concerned that the routine practice of breath-testing any detainee who might be intoxicated could potentially lead to unnecessarily long stays in custody (see main recommendation 2.28). The questionable formula used to predict when a detainee would be sober did not take into account their demeanour.

5.6 We observed staff giving detainees being booked-in a four-page leaflet summarising their rights and entitlements. This document was out of date, originating in July 2009, and did not contain standard information that had been agreed in August 2011 between the Home Office, Legal Services Commission and the Law Society. For example, it did not advise detainees how long they could be detained in custody or how to make a complaint. When this was pointed out to staff, the document was immediately withdrawn and replaced across all three custody suites.

5.7 We were assured that the custody suites were never used as a place of safety for children under section 46 of the Children Act 1989[3]. Custody staff told us that they contacted social services to confirm the availability of PACE beds for young people held overnight who could not be bailed, but that such beds were never available.

5.8 The force adhered to the PACE definition of a child instead of that in the Children Act 1989, which meant those aged 17 were not provided with an appropriate adult (AA) unless they were otherwise deemed vulnerable.[4] However, following the judicial review of 25 April 2013, which deemed this practice 'incompatible' with human rights law, the force had begun to offer 17-year-olds, with their consent, the support of an AA. We observed this taking place several times during the inspection. Relatives or friends were usually contacted in the first instance to act as an AA. When this was not possible, the force had access to two AA schemes – The Appropriate Adult Service (TAAS) provided a 24-hour service for young people in Derby city only, and the Derby Appropriate Adult Service (DAAS) provided cover for vulnerable adults force-wide and for young people outside Derby city between 9am and midnight, seven days a week. We observed AAs arriving at the custody suites within an hour of being requested, and were impressed by the competence and commitment of those with whom we spoke.

5.9 We were told that staff had a good relationship with Home Office Immigration Enforcement staff based at their liaison point of East Midlands Airport, and the majority of immigration detainees were collected within a short period. We were unable to confirm this with the force due to the lack of information available.

5.10 Staff were aware of where they could download and print off a document for non-English speaking detainees in 38 languages. We observed several that were printed off in different languages to meet detainee needs, although the foreign rights and entitlements were not offered to one Lithuanian national. Commendably, all suites had copies of rights and entitlements information in easy-read pictorial format.

5.11 A professional telephone interpreting service was used during the booking-in process. Derby had one double-handset telephone, which facilitated a three-way conversation, and we observed this used to good effect several times. But with only one double-handset, only one non-English speaking detainee could be booked-in at a time. At Chesterfield, custody staff had to use a speaker phone to facilitate a three-way conversation, and the custody suite had to be cleared when a non-English speaker was booked-in to allow the conversation to be clearly heard. Staff said this could result in delays for other detainees being booked-in. At Buxton, staff could plug a remote microphone and headset into the telephone to enable a three-way conversation. Staff told us that there was a good face-to-face interpreter service for interviews, but there were sometimes delays in finding interpreters for some languages.

Housekeeping points

5.12 Information about detainees' rights and entitlements should always be offered to all detainees, and be available in a range of formats to meet specific needs.

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[3] Section 46(1) of the Children Act 1989 empowers a police officer, who has reasonable cause to believe that a child would otherwise be likely to suffer significant harm, to remove the child to suitable accommodation and keep him/her there.
[4] In all other UK law and international treaty obligations, 17-year-olds are treated as children.

5.13 There should be sufficient double-handset telephones in all suites to facilitate telephone interpreting for non-English speaking detainees.

Rights relating to PACE

5.14 We observed detainees being told they could read the PACE codes of practice during the booking-in process. The new version of PACE code C was available in all the custody suites, although we observed detainees offered the out-of-date 2006 version throughout the force, and there were not enough copies of the codes at Derby. A poster displayed at Derby in several languages advised detainees of their right to free legal advice, but there were no such posters at Chesterfield or Buxton. Solicitors told us that they believed custody staff adhered to PACE, and were positive about how they and their clients were dealt with. They voiced some concerns over gaining physical access to the custody suite at Derby, and delays during busy periods in accessing one of the seven interview rooms. We observed solicitors routinely offered either the front sheet or full printout of their clients' custody record.

5.15 Reviews of detainees in custody were undertaken by custody inspectors, one of whom covered Derby (south) and one Chesterfield and Buxton (north). The majority of reviews we observed were done face-to-face, and were reasonably thorough. The custody records we read failed to note whether detainees who were reviewed when sleeping were informed of the review on waking. In our analysis, 23 detainees were in custody long enough to require a review – 15 were conducted on time, four were early and four were late. When a third review was required, it was not recorded if it was carried out by a superintendent.

5.16 Staff reported that there were sometimes delays when duty solicitors were not readily available, due to the high volume of detainees requesting their services, and that this lengthened stays in custody.

5.17 We observed detainees being told they could inform someone of their arrest.

5.18 All DNA samples were handled effectively, with regular collection from custody. Freezers were clearly labelled for their purpose.

5.19 Detainees were transported to court in a timely manner with court cut-off times between 2pm and 3pm on weekdays, with some flexibility day to day. A prisoner escort contractor was available for transportation to morning and afternoon courts, but staff at Chesterfield said that they did not contact the contractor for afternoon courts as they felt it was quicker to convey detainees in police vehicles to ensure they did not remain longer than necessary in custody.

Housekeeping points

5.20 The reasons why detainees decline the offer of legal advice should be recorded in the custody record.

5.21 During reviews, detainees should be asked if they want to make any representations.

5.22 Detainees whose continued detention is reviewed while they are asleep should be told of the review on waking.

Rights relating to treatment

5.23 Custody staff reported that if a detainee wished to make a complaint, they would immediately advise the custody or duty inspector. Inspectors confirmed they would note complaints from detainees while they were still in custody or make an appointment to see them at a later date. Staff did not have access to any Independent Police Complaints Commission (IPCC) literature to give to detainees. The force collected data on complaints and analysed patterns and trends. We were impressed by the provisions to disseminate learning from complaints to custody staff through the weekly custody bulletin.

Good practice

5.24 *Lessons learned from the investigation of complaints about treatment in custody were disseminated to staff through a regular custody bulletin.*

Section 6. Health care

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

Governance

6.1 Derbyshire Police Force was an 'early adopter' for NHS commissioning of health services for police custody. At the time of the inspection, Derbyshire Healthcare United (DHU) were providing health services in the custody suites, but the contract was due to change within three weeks of our visit. Some health services staff were concerned by the imminent change. Contract monitoring information provided by DHU was basic; the force had regular contract monitoring meetings with DHU, but had not enacted 'service credits' for underperformance. A separate project board involving NHS commissioners was progressing work with a new provider of health services.

6.2 While DHU had a clinical governance meeting structure, custody issues were not a standing agenda item and we had some concerns that serious untoward incidents were not identified and acted upon. Nurses and doctors (forensic medical examiners, FMEs) who worked in custody each had monthly meetings, but these were not always minuted. Staff training was reasonable but there was no clinical supervision for nursing staff.

6.3 The treatment rooms in each custody suite were of an acceptable standard and needed only minor alterations to meet current infection control guidance. The force had this in hand as part of the NHS commissioning arrangements.

6.4 Each suite had two automated external defibrillators (AEDs). We were told that one was for use by the police and the other was the property of DHU and for the use of DHU staff only. Neither was checked correctly. DHU staff told us that they checked their AED weekly, although a policy clearly stated they should carry out daily checks. Custody staff in Derby checked their AED monthly, but staff in the other two suites thought that the DHU staff checked the police AED, which they did not. Other resuscitation equipment included oxygen and pulse oximetry which was good to see. All staff we spoke to said that they had received resuscitation training in the previous 12 months.

Recommendations

6.5 All staff should have access to clinical supervision.

6.6 All medical equipment should be checked regularly.

Patient care

6.7 Not all detainees got the same level of patient care because of the allocation of DHU staff across the force area. There was always a nurse based at Derby for 22 hours a day (7am until 5am). At Chesterfield, a nurse was based in the suite for 22 hours a

day on Thursday until Sunday, and during the day on Monday to Wednesday; there was sometimes also a night nurse, but only when the rota allowed. There was no nurse at Buxton. An FME covered Buxton and was on call for the other suites as required, at the same time as being on call for the sexual assault referral centre and the child abuse unit.

6.8 Unusually, nurses often called on FMEs to assess a detainee as 'fit to interview' and 'fit to release', as they seemed to lack training in these areas. Minutes of meetings dating back to 2006 had highlighted this as an issue, but it appeared that little had been done to alter the situation. The decision on who should undertake a 'fit to interview' assessment also seemed to be linked to the results of the breathalyser test taken during booking in (see paragraph 4.14 and main recommendation 2.28).

6.9 We observed detainees receiving a reasonable service. In our survey, 33% of prisoners who had been through Derbyshire police custody said the quality of care was good, which was similar to other forces. In our custody record analysis, eight records indicated that a detainee had wished to see a health professional (all at Derby or Chesterfield), and that five were seen. The longest wait was three hours 23 minutes, the shortest 27 minutes and the average was one hour 43 minutes.

6.10 Most DHU staff used a handwritten assessment tool when they saw a detainee, and then transferred the information on to the DHU IT system, which appeared to be designed for an out-of-hours service. Health services staff also entered relevant data on to the police custody record. It was not clear how detainee consent was recorded, or how they could obtain a copy of their clinical record.

6.11 DHU staff used a telephone interpreting service for patients who could not speak English, but they did not have access to a three-way phone in any of the clinical rooms. Detainees were not told that they could request to see a health professional of their own gender.

6.12 Efforts were made to obtain detainees' medication, including opiate substitution, and this was a well-established practice. We saw examples of police staff collecting medications for detainees from their home address, and of substance misuse arrest referral workers working closely with DHU and custody staff to ensure that a detainee's opiate substitution medication was obtained from a local pharmacy.

6.13 Medications were stored appropriately. The list of medications that could be administered using a patient group direction (allowing appropriate health care professionals to supply and administer prescription-only medicine) was limited and did not include symptomatic relief for substance withdrawal, for which an FME had to be called. There was a good system for the storage and administration of medications by CDOs in the absence of a nurse. The FME could prescribe a small range of medications that were on the custody record without having to be present in the custody suite; CDOs then administered the medication to the detainee and recorded this on the custody record and in a designated record book.

Recommendation

6.14 Detainees' documented consent should be obtained for all clinical interventions.

Housekeeping point

6.15 There should be a three-way phone in the clinical rooms for health care staff to use for interpreting with detainees who do not speak English.

Good practice

6.16 *The joint working between the police, arrest referral workers and health services staff to obtain detainees medications, including opiate substitution therapy, to maintain continuity of treatment was excellent and should continue.*

Substance misuse

6.17 Substance misuse services for the county were provided by Derbyshire substance misuse services, part of Derbyshire Healthcare NHS Foundation Trust (the Trust). Workers were based in the suites at Derby and Chesterfield, but there were no on-site services at Buxton (although this was due to change shortly after our inspection). Services for Derby city were provided by Arch Initiatives, who had a worker in the Derby custody suite. The workers in Derby covered for each other during periods of absence. The workers had a presence in the two suites between 9am and 4pm, Monday to Friday and 7am to 11am at weekends. At other times and in Buxton there were systems for the team to receive referrals. The team reported good relationships with custody staff and good systems of referral to community services.

6.18 It was not clear from our custody record analysis whether an arrest referral worker was always offered to detainees, and the worker was only mentioned in four instances. Of these, one declined, one was offered but did not see anyone while in custody, one saw a worker and the other record stated that the service was offered but did not make it clear whether anyone saw them.

6.19 Arrest workers had access to the custody system and Trust databases. Staff took referrals direct from custody staff but also cross-checked custody and court lists to identify people who might require drug or alcohol services. They saw and signposted children and young people in custody, which was helpful.

6.20 Detainees who chose to engage were referred to appropriate services and appointments made for when they left custody. Appointments were followed up and reminders sent to people if they failed to attend. For detainees who were sentenced or remanded in custody, referrals were made to prison drug teams.

6.21 There were no needle exchange schemes in the custody suites, but we were assured that such services were available locally for each suite

Mental health

6.22 There was a new strategic lead staff member for mental health in the force, who had plans to review mental health provision, partnership working and relevant protocols.

6.23 The Trust provided criminal justice mental health liaison teams during normal working hours for all three custody suites. The teams reported good working relationships with custody staff, particularly in sharing information. They visited

Chesterfield and Derby suites daily and when required. An FME saw all detainees before they were seen by the mental health team. The team did not see anyone considered to be intoxicated, and returned later in the day to see them.

6.24 Detainees were offered a signposting service to mental health or other relevant services in the county. Out of hours, custody staff referred detainees with mental health issues to the crisis resolution home treatment teams based in Chesterfield and Derby.

6.25 In Buxton, detainees were more likely to be from another health trust area. Derbyshire police force had worked closely with neighbouring forces and their health partners to ensure that there were protocols to address such issues.

6.26 There were two Mental Health Act section 136 suites[5] in the force area – in Chesterfield, for the north of the county, and Derby for the south. Data provided by the force indicated that the use of police custody suites as a place of safety was reducing. Staff in both suites told us that they relied on the police to breathalyse detainees – in Chesterfield they used the result as part of the assessment of the detainee; in Derby they were clear that they would only see and assess detainees who were below the drink/drive limit. The drink/drive limit should not be used as the sole threshold for assessment, but should be considered alongside a person's demeanour and understanding. The joint policy for the use of the suites stated that 'police should be allowed to leave the person in the care of the hospital as soon as soon as possible'; but we were told that in Derby police were expected to stay until the detainee was fully assessed and either admitted or discharged. Monthly meetings attended by representatives from the Trust and the police discussed section 136 issues.

[5] Section 136 enables a police officer to remove someone from a public place and take them to a place of safety – for example, a police station. It also states clearly that the purpose of being taken to the place of safety is to enable the person to be examined by a doctor and interviewed by an approved social worker, and for the making of any necessary arrangements for treatment or care.

Section 7. Summary of recommendations

Main recommendations

7.1 As a priority, chief officers should resolve the inadequacies of the custody IT system to ensure outcomes for detainees are not adversely affected. (2.25)

7.2 Custody staff should only use safety clothing following a risk assessment, and its use should be monitored for rationale and justification and to identify any staff training needs. (2.26)

7.3 Strip searching needs to be authorised and justified. Custody staff should be monitored for rationale and justification and to identify any staff training needs. (2.27)

7.4 Custody staff should review the use of a breathalyser as the only determining factor for assessing someone's suitability for interview. Risk assessments should consider the detainee's demeanour and understanding. (2.28)

7.5 The meaning and standard of level three observations should be explained to all custody staff. (2.29)

7.6 The use of form F142 should be reviewed, and the detainee should be present when the arresting officer explains the reason for their arrest to the custody sergeant. (2.30)

Recommendations

Strategy

7.7 The Police and Crime Commissioner or chief officer group should discuss with local authority partners at a strategic level how to address the lack of local authority accommodation for children and young people refused bail at police stations. (3.10)

7.8 The sample of custody records quality assured at the busier suites should be increased. (3.16)

Treatment and conditions

7.9 Custody sergeants at Derby should maintain better control of the number of staff waiting in the booking-in area. (4.9)

7.10 Custody suites should be accessible to detainees with disabilities, and booking-in areas should be fitted with hearing loops and custody staff know how to use them. (4.10)

7.11 Staff should carry anti-ligature knives at all time. (4.20)

7.12 Detainees should only be handcuffed in holding areas when a risk assessment indicates this is necessary for the safety of staff and others. (4.25)

7.13 Only custody staff should visit cells or, if necessary, accompany such visits. (4.30)

7.14 Suitable alternative clothing for detainees should be available in all the custody suites at all times. (4.39)

7.15 Detainees, particularly those held for more than 24 hours, should be offered exercise and a shower. (4.40)

Health care

7.16 All staff should have access to clinical supervision. (6.5)

7.17 All medical equipment should be checked regularly. (6.6)

7.18 Detainees' documented consent should be obtained for all clinical interventions. (6.14)

Housekeeping points

Strategy

7.19 The force should review custody procedures against the College of Policing authorised professional practice (APP) custody policy. (3.17)

7.20 Senior managers in custody should reinforce the weekly briefing with staff. (3.18)

Treatment and conditions

7.21 Hygiene packs should be routinely offered to female detainees. (4.11)

7.22 Custody staff should record on the pre-release risk assessment all information considered and action taken before releasing a detainee. (4.20)

7.23 Stained mattresses and pillows should be replaced. (4.41)

7.24 Toilet paper should be routinely provided in each cell. (4.42)

7.25 There should be a suitable range of reading material for detainees, including young people, non-English speakers and those with limited literacy. (4.43)

Individual rights

7.26 Information about detainees' rights and entitlements should always be offered to all detainees, and be available in a range of formats to meet specific needs. (5.12)

7.27 There should be sufficient double-handset telephones in all suites to facilitate telephone interpreting for non-English speaking detainees. (5.13)

7.28 The reasons why detainees decline the offer of legal advice should be recorded in the custody record. (5.20)

7.29 During reviews, detainees should be asked if they want to make any representations. (5.21)

7.30 Detainees whose continued detention is reviewed while they are asleep should be told of the review on waking. (5.22)

Health care

7.31 There should be a three-way phone in the clinical rooms for health care staff to use for interpreting with detainees who do not speak English. (6.15)

Good practice

7.32 *Lessons learned from the investigation of complaints about treatment in custody were disseminated to staff through a regular custody bulletin. (5.24)*

7.33 *The joint working between the police, arrest referral workers and health services staff to obtain detainees medications, including opiate substitution therapy, to maintain continuity of treatment was excellent and should continue.*

Section 8. Appendices

Appendix I: Inspection team

Maneer Afsar	HMIP team leader
Gary Boughen	HMIP inspector
Peter Dunn	HMIP inspector
Vinnett Pearcy	HMIP inspector
Fiona Shearlaw	HMIP inspector
Paul Davies	HMIC lead staff officer
Mark Ewan	HMIC staff officer
Elizabeth Tysoe	HMIP health services inspector
Dawn Wallace	Care Quality Commission inspector
Annie Crowley	HMIP researcher
Joe Simmonds	HMIP researcher

Appendix II: Summary of detainee questionnaires and interviews

Prisoner survey methodology

A voluntary, confidential and anonymous survey of the HMP Nottingham prisoner population who had been through a police station in the Derbyshire police force area was carried out for this inspection. The results of this survey formed part of the evidence-base for the inspection.

Choosing the sample size

The survey was conducted on 29 April 2013. A list of potential respondents who have passed through Buxton, Chesterfield or Derby police stations was created, listing all those who had arrived from Buxton, Chesterfield or Derby magistrates' court within the past two months.

Selecting the sample

In total, 61 respondents were approached. Six respondents reported being held in police stations outside of Derbyshire. On the day, the questionnaire was offered to 55 respondents; there were five refusals, and two questionnaires were not returned. All of those sampled had been in custody within the last two months.

Completion of the questionnaire was voluntary. Interviews were carried out with any respondents with literacy difficulties. Two respondents were interviewed.

Methodology

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

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

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

Response rates

In total, 48 (87%) respondents completed and returned their questionnaires.

Comparisons

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

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

The current survey responses were analysed against comparator figures for all prisoners surveyed in other police areas. This comparator is based on all responses from prisoner surveys carried out in 64 police areas since April 2008.

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

Summary

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

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

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

Survey results

Section 1: About you

Q2 Which police station were you last held at?

Buxton – 6
Chesterfield – 14
Derby – 26
Unknown – 2

Q3 How old are you?

16 years or younger	0 (0%)	*40-49 years*	2 (4%)
17-21 years	5 (10%)	*50-59 years*	1 (2%)
22-29 years	22 (46%)	*60 years or older*	0 (0%)
30-39 years	18 (38%)		

Q4 Are you:

Male	48 (100%)
Female	0 (0%)
Transgender/Transsexual	0 (0%)

Q5 What is your ethnic origin?

White - British	40 (83%)
White - Irish	0 (0%)
White - other	2 (4%)
Black or black British - Caribbean	2 (4%)
Black or black British - African	1 (2%)
Black or black British - other	0 (0%)
Asian or Asian British - Indian	1 (2%)
Asian or Asian British - Pakistani	0 (0%)
Asian or Asian British - Bangladeshi	0 (0%)
Asian or Asian British - other	0 (0%)
Mixed heritage - white and black Caribbean	2 (4%)
Mixed heritage - white and black African	0 (0%)
Mixed heritage- white and Asian	0 (0%)
Mixed heritage - other	0 (0%)
Chinese	0 (0%)
Other ethnic group	0 (0%)

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

Yes	6 (13%)
No	41 (87%)

Q7 What, if any, is your religion?

None	13 (27%)
Church of England	22 (46%)
Catholic	8 (17%)
Protestant	0 (0%)
Other Christian denomination	1 (2%)
Buddhist	1 (2%)
Hindu	0 (0%)
Jewish	1 (2%)

	Muslim	1 (2%)
	Sikh	1 (2%)
Q8	**How would you describe your sexual orientation?**	
	Straight/heterosexual	47 (100%)
	Gay/lesbian/homosexual	0 (0%)
	Bisexual	0 (0%)
Q9	**Do you consider yourself to have a disability?**	
	Yes	16 (33%)
	No	32 (67%)
Q10	**Have you ever been held in police custody before?**	
	Yes	47 (98%)
	No	1 (2%)

Section 2: Your experience of the police custody suite

Q11	**How long were you held at the police station?**	
	Less than 24 hours	16 (34%)
	More than 24 hours, but less than 48 hours (2 days)	19 (40%)
	More than 48 hours (2 days), but less than 72 hours (3 days)	8 (17%)
	72 hours (3 days) or more	4 (9%)
Q12	**Were you told your rights when you first arrived there?**	
	Yes	41 (87%)
	No	2 (4%)
	Don't know/Can't remember	4 (9%)
Q13	**Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')?**	
	Yes	26 (54%)
	No	16 (33%)
	I don't know what this is/I don't remember	6 (13%)
Q14	**If your clothes were taken away, what were you offered instead?**	
	My clothes were not taken	26 (59%)
	I was offered a tracksuit to wear	3 (7%)
	I was offered an evidence/ paper suit to wear	7 (16%)
	*I was **only** offered a blanket*	4 (9%)
	Nothing	4 (9%)
Q15	**Could you use a toilet when you needed to?**	
	Yes	41 (85%)
	No	7 (15%)
	Don't know	0 (0%)
Q16	**If you used the toilet there, was toilet paper provided?**	
	Yes	16 (34%)
	No	31 (66%)

Q17 How would you rate the condition of your cell:

	Good	*Neither*	*Bad*
Cleanliness	17 (36%)	17 (36%)	13 (28%)
Ventilation/air quality	13 (28%)	11 (24%)	22 (48%)
Temperature	5 (11%)	8 (17%)	34 (72%)

Lighting	16 (34%)	9 (19%)	22 (47%)

Q18 Was there any graffiti in your cell when you arrived?

Yes	20 (43%)
No	27 (57%)

Q19 Did staff explain to you the correct use of the cell bell?

Yes	7 (15%)
No	41 (85%)

Q20 Were you held overnight?

Yes	41 (85%)
No	7 (15%)

Q21 If you were held overnight, which items of bedding were you given? (Please tick all that apply)

Not held overnight	7 (15%)
Pillow	9 (19%)
Blanket	37 (77%)
Nothing	4 (8%)

Q22 If you were given items of bedding, were these clean?

Not held overnight/ Did not get any bedding	11 (24%)
Yes	20 (43%)
No	15 (33%)

Q23 Were you offered a shower at the police station?

Yes	3 (6%)
No	45 (94%)

Q24 Were you offered any period of outside exercise while there?

Yes	2 (4%)
No	46 (96%)

Q25 Were you offered anything to:

	Yes	*No*
Eat?	41 (85%)	7 (15%)
Drink?	41 (89%)	5 (11%)

Q26 What was the food/drink like in the police custody suite?

Very good	*Good*	*Neither*	*Bad*	*Very bad*	*N/A*
0 (0%)	6 (13%)	5 (11%)	9 (19%)	19 (40%)	8 (17%)

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

I did not have any food or drink	8 (17%)
Yes	14 (29%)
No	26 (54%)

Q28 If you smoke, were you offered anything to help you cope with not being able to smoke? (Please tick all that apply)

I do not smoke	5 (10%)
I was allowed to smoke	0 (0%)
I was offered a nicotine substitute	0 (0%)
I was not offered anything to cope with not smoking	43 (90%)

Q29 Were you offered anything to read?

Yes	6 (13%)
No	41 (87%)

Q30 Was someone informed of your arrest?

Yes	17 (35%)
No	19 (40%)
I don't know	3 (6%)
I didn't want to inform anyone	9 (19%)

Q31 Were you offered a free telephone call?

Yes	16 (33%)
No	32 (67%)

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

My telephone call was not denied	16 (40%)
Yes	2 (5%)
No	22 (55%)

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

	Yes	*No*
Who was taking care of your children	2 (5%)	37 (95%)
Contacting your partner, relative or friend	22 (49%)	23 (51%)
Contacting your employer	4 (11%)	33 (89%)
Where you were going once released	10 (27%)	27 (73%)

Q34 Were you offered free legal advice?

Yes	43 (90%)
No	5 (10%)

Q35 Did you accept the offer of free legal advice?

Was not offered free legal advice	5 (11%)
Yes	29 (63%)
No	12 (26%)

Q36 Were you interviewed by police about your case?

Yes	37 (79%)
No	10 (21%)

Q37 Was a solicitor present when you were interviewed?

Did not ask for a solicitor/Was not interviewed	14 (30%)
Yes	27 (57%)
No	6 (13%)

Q38 Was an appropriate adult present when you were interviewed?

Did not need an appropriate adult/Was not interviewed	23 (49%)
Yes	7 (15%)
No	17 (36%)

Q39 Was an interpreter present when you were interviewed?

Did not need an interpreter/ Was not interviewed	31 (67%)
Yes	1 (2%)
No	14 (30%)

Section 3: Safety

Q41 Did you feel safe there?

Yes	27 (57%)
No	20 (43%)

Q42 Did a member of staff victimise (insulted or assaulted) you there?

Yes	18 (38%)
No	29 (62%)

Q43 If you were victimised by staff, what did the incident involve? (Please tick all that apply to you.)

I have not been victimised	29 (63%)	*Because of your crime*	6 (13%)
Insulting remarks (about you, your family or friends)	14 (30%)	*Because of your sexuality*	0 (0%)
Physical abuse (being hit, kicked or assaulted)	3 (7%)	*Because you have a disability*	1 (2%)
Sexual abuse	0 (0%)	*Because of your religion/religious beliefs*	0 (0%)
Your race or ethnic origin	0 (0%)	*Because you are from a different part of the country than others*	2 (4%)
Drugs	7 (15%)		

Q44 Were your handcuffs removed on arrival at the police station?

Yes	27 (56%)
No	14 (29%)
I wasn't handcuffed	7 (15%)

Q45 Were you restrained whilst in the police custody suite?

Yes	7 (15%)
No	40 (85%)

Q46 Were you injured while in police custody, in a way that was not your fault?

Yes	9 (19%)
No	39 (81%)

Q47 Were you told how to make a complaint about your treatment if you needed to?

Yes	4 (8%)
No	44 (92%)

Q48 How were you treated by staff in the police custody suite?

Very well	*Well*	*Neither*	*Badly*	*Very badly*	*Don't remember*
6 (13%)	8 (17%)	17 (37%)	7 (15%)	7 (15%)	1 (2%)

Section 4: Health care

Q50 Did someone explain your entitlements to see a health care professional, if you needed to?

Yes	10 (22%)
No	35 (76%)
Don't know	1 (2%)

Q51 Were you seen by the following health care professionals during your time there?

	Yes	*No*
Doctor	15 (34%)	29 (66%)
Nurse	12 (29%)	29 (71%)

	Paramedic	1 (3%)	32 (97%)

Q52 Were you able to see a health care professional of your own gender?

Yes	8 (18%)
No	22 (49%)
Don't know	15 (33%)

Q53 Did you need to take any prescribed medication when you were in police custody?

Yes	26 (57%)
No	20 (43%)

Q54 Were you able to continue taking your prescribed medication while there?

Not taking medication	20 (44%)
Yes	4 (9%)
No	21 (47%)

Q55 Did you have any drug or alcohol problems?

Yes	28 (60%)
No	19 (40%)

Q56 Did you see, or were you offered the chance to see a drug or alcohol support worker?

I didn't have any drug/alcohol problems	19 (42%)
Yes	14 (31%)
No	12 (27%)

Q57 Were you offered relief or medication for your immediate withdrawal symptoms?

I didn't have any drug/alcohol problems	19 (42%)
Yes	4 (9%)
No	22 (49%)

Q58 Please rate the quality of your health care while in police custody:

I was not seen by health care	*Very good*	*Good*	*Neither*	*Bad*	*Very bad*
27 (60%)	2 (4%)	4 (9%)	5 (11%)	1 (2%)	6 (13%)

Q59 Did you have any specific <u>physical</u> health care needs?

Yes	17 (38%)
No	28 (62%)

Q60 Did you have any specific <u>mental</u> health care needs?

Yes	21 (45%)
No	26 (55%)

Q61 If you had any mental health care needs, were you seen by a mental health nurse/psychiatrist?

I didn't have any mental health care needs	26 (57%)
Yes	0 (0%)
No	20 (43%)

Prisoner survey responses for Derbyshire Police 2013

Prisoner survey responses (missing data have been excluded for each question). Please note: where there are apparently large differences, which are not indicated as statistically significant, this is likely to be due to chance.

Key to tables

		Derbyshire Police 2013	Police custody comparator
	Any percentage highlighted in green is significantly better		
	Any percentage highlighted in blue is significantly worse		
	Any percentage highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
Number of completed questionnaires returned		48	2411
SECTION 1: General information			
3	Are you under 21 years of age?	**10%**	**10%**
4	Are you transgender/transsexual?	**0%**	**0%**
5	Are you from a minority ethnic group? (Including all those who did not tick white British, white Irish or white other categories)	**12%**	**29%**
6	Are you a foreign national?	**12%**	**15%**
7	Are you Muslim?	**2%**	**10%**
8	Are you homosexual/gay or bisexual?	**0%**	**2%**
9	Do you consider yourself to have a disability?	**34%**	**20%**
10	Have you been in police custody before?	**98%**	**92%**
SECTION 2: Your experience of this custody suite			
11	Were you held at the police station for over 24 hours?	**65%**	**68%**
12	Were you told your rights when you first arrived?	**88%**	**80%**
13	Were you told about PACE?	**54%**	**52%**
For those who had their clothing taken away:			
14	Were you given a tracksuit to wear?	**16%**	**41%**
15	Could you use a toilet when you needed to?	**86%**	**91%**
16	If you used the toilet, was toilet paper provided?	**35%**	**48%**
17	Would you rate the condition of your cell, as 'good' for:		
17a	Cleanliness?	**37%**	**34%**
17b	Ventilation/air quality?	**29%**	**23%**
17c	Temperature?	**10%**	**17%**
17d	Lighting?	**35%**	**45%**
18	Was there any graffiti in your cell when you arrived?	**43%**	**54%**
19	Did staff explain the correct use of the cell bell?	**14%**	**24%**
20	Were you held overnight?	**86%**	**92%**
For those who were held overnight:			
21	Were you given any items of bedding?	**91%**	**87%**
For those who were held overnight and were given items of bedding:			
22	Were these clean?	**57%**	**61%**
23	Were you offered a shower?	**6%**	**10%**
24	Were you offered a period of outside exercise?	**4%**	**6%**
25a	Were you offered anything to eat?	**86%**	**81%**
25b	Were you offered anything to drink?	**90%**	**84%**
For those who had food/drink:			
26	Was the quality of the food and drink you received good/very good?	**15%**	**13%**
27	Was the food/drink you received suitable for your dietary requirements?	**36%**	**44%**

Key to tables

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For those who smoke:			
28	Were you offered anything to help you cope with not being able to smoke?	0%	6%
29	Were you offered anything to read?	12%	14%
30	Was someone informed of your arrest?	36%	45%
31	Were you offered a free telephone call?	34%	51%
If you were denied a free telephone call:			
32	Was a reason given?	8%	15%
33	Did you have any concerns about:		
33a	Who was taking care of your children?	5%	13%
33b	Contacting your partner, relative or friend?	49%	52%
33c	Contacting your employer?	11%	18%
33d	Where you were going once released?	26%	30%
34	Were you offered free legal advice?	90%	88%
For those who were offered free legal advice:			
35	Did you accept the offer of free legal advice?	71%	70%
For those who were were interviewed and needed them:			
37	Was a solicitor present when you were interviewed?	82%	80%
38	Was an appropriate adult present when you were interviewed?	28%	29%
39	Was an interpreter present when you were interviewed?	6%	11%
SECTION 3: Safety			
41	Did you feel unsafe?	57%	62%
42	Has another detainee or a member of staff victimised you?	39%	33%
43	If you have felt victimised, what did the incident involve?		
43a	Insulting remarks (about you, your family or friends)	31%	16%
43b	Physical abuse (being hit, kicked or assaulted)	6%	11%
43c	Sexual abuse	0%	2%
43d	Your race or ethnic origin	0%	2%
43e	Drugs	14%	10%
43f	Because of your crime	12%	12%
43g	Because of your sexuality	0%	1%
43h	Because you have a disability	2%	3%
43i	Because of your religion/religious beliefs	0%	1%
43j	Because you are from a different part of the country than others	4%	3%
44	Were your handcuffs removed on arrival at the police station?	65%	73%
45	Were you restrained while in the police custody suite?	14%	19%
46	Were you injured whilst in police custody, in a way that was not your fault?	18%	23%
47	Were you told how to make a complaint about your treatment?	8%	13%
48	Were you treated well/very well by staff in the police custody suite?	31%	36%

Key to tables

		Derbyshire Police 2013	Police custody comparator
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	Any percentage highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
SECTION 4: Health care			
50	Did someone explain your entitlements to see a health care professional, if you needed to?	**21%**	**35%**
51	Were you seen by the following health care professionals during your time in police custody?		
51a	Doctor	**35%**	**42%**
51b	Nurse	**29%**	**22%**
	Percentage seen by either a doctor or a nurse	**39%**	**50%**
51c	Paramedic	**3%**	**4%**
52	Were you able to see a health care professional of your own gender?	**17%**	**25%**
53	Did you need to take any prescribed medication when you were in police custody?	**56%**	**42%**
For those who were on medication:			
54	Were you able to continue taking your medication while in police custody?	**15%**	**32%**
55	Did you have any drug or alcohol problems?	**59%**	**52%**
For those who had drug or alcohol problems:			
56	Did you see, or were offered the chance to see a drug or alcohol support worker?	**56%**	**42%**
57	Were you offered relief or medication for your immediate withdrawal symptoms?	**15%**	**25%**
For those who were seen by health care:			
58	Would you rate the quality as good/very good?	**33%**	**31%**
59	Did you have any specific physical health care needs?	**38%**	**31%**
60	Did you have any specific mental health care needs?	**45%**	**24%**
For those who had any mental health care needs:			
61	Were you seen by a mental health nurse/psychiatrist?	**0%**	**13%**