



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

22–23 September 2008

by

HM Inspectorate of Prisons and

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1. Introduction

This is the fifth 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 response to its international obligation to ensure regular and independent inspection of all places of detention.¹ The inspections look at force-wide strategies, treatment and conditions, individual rights and healthcare.

Durham Constabulary covers County Durham and Darlington Borough, a predominantly rural area of 860 square miles but with 12 main towns and over 260 smaller towns and villages. The force is divided into north and south basic command units (BCUs) and has six custody suites with 62 cells designated for the reception of detainees under the Police and Criminal Evidence Act, 1984 (PACE). There are a further 47 non-designated cells. All suites were visited, but the inspection focused on those in Bishop Auckland, Darlington, Durham and Peterlee. All four took adults, juveniles and immigration detainees. A survey was also undertaken of prisoners at HMP Holme House who had previously been in police custody in the force's busiest suite, Durham.

Senior managers and the Police Authority were beginning to take a more strategic approach to the oversight of custody, including exploration of the possibility of centralising facilities in two large suites, one in each BCU. A chief inspector at headquarters was responsible for the development and promulgation of policies and procedures, but these demonstrated limited recognition of the needs of particular groups, such as women and juveniles. There was some effective joint work with National Health Service partners to improve health services, but as yet no overall health strategy or adequate clinical governance arrangements.

The physical condition of the suites was far from ideal. Most cells had integral sanitation but showers lacked privacy. Cells in Durham had little natural light, and ventilation was a problem in Darlington. Standards of cleanliness were generally good, with the exception of Peterlee. Detainees were provided with a mattress and blankets but not pillows. Food and drinks were provided, but often only on request. Staff were generally responsive to need and relationships with detainees were largely good. However, staff would benefit from improved training, including refresher training for experienced staff.

Improvements were required in the quality of information given to detainees and in aspects of the management of risk. For example, the use of cell bells was not routinely explained, not all were answered promptly and some of those in Darlington had been isolated to prevent misuse – which was patently unsafe. Similarly, there were inconsistencies in the use of paper suits. More positively, an exit assessment had recently been introduced across the force in an effort to safeguard the most vulnerable detainees.

We were satisfied that the PACE codes were generally applied consistently and legal rights observed. The central duty solicitor scheme worked well and appropriate medical advice was taken about fitness for interview. The force needed to liaise with the HM Court Service to seek more flexible cut-off times for court appearances and thus avoid detainees spending unnecessary time in police custody.

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

The level and quality of healthcare was inconsistent. Access to forensic medical examiners was not always timely, but a good 12-hour service was provided by emergency care practitioners. Support for substance users was consistently good, but mental health provision less so. Medicines management was an area of particular weakness across all suites. There was a recognition among senior managers that better strategic management of healthcare was required, based on a comprehensive needs analysis, improved clinical governance and more consistent service delivery.

This inspection of police custody suites of Durham Constabulary provides an important degree of independent assurance to the public that detention in police custody is generally well managed and of a satisfactory standard. However, we have identified areas where improvement is required, and we make a number of recommendations. We look forward to being able to record significant improvement when we return to re-inspect in due course.

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January 2009

2. Background and key findings

- 2.1 HM Inspectorates of Prisons and Constabulary have begun a programme of joint inspections of police custody suites as part of the UK's international obligation to ensure regular independent inspection of places of detention. These inspections do not look only at the implementation of the Police and Criminal Evidence Act (PACE) codes. They are also informed by *Expectations* about the appropriate treatment of detainees and conditions of detention, which have been developed by the two inspectorates to assist best custodial practice.
- 2.2 Durham Constabulary serves the area of County Durham and Darlington borough, which occupies an area of over 860 square miles. The area is predominantly rural, with 12 main towns and over 260 small towns and villages, many former mining communities. The population of around 600,000 is almost wholly white British, with just over 1% from minority ethnic groups, with a higher concentration in the south of the force area. A decline in large-scale industry has had a major impact on the local economy. County Durham is the most socially deprived county in England, with 30% of its population living in wards which are among the 10% most deprived in England. Darlington also has some significant pockets of deprivation. The force is divided into basic command units: north area and south area.
- 2.3 Durham Constabulary has six custody suites designated under the PACE Act 1984 for the reception of detainees. All six operate 24 hours a day and deal with detainees arrested as a result of mainstream policing. The total cell capacity for the force was 89, 62 in designated cells and 27 non-designated. The police cells at Chester-le-Street were set aside for Operation Safeguard (prison overcrowding) if required.
- 2.4 This inspection was conducted in four of the designated custody suites at Bishop Auckland, Darlington, Durham and Peterlee. The other two designated suites at Consett and Aycliffe were visited but not formally inspected, as were three of the non-designated suites. Inspectors examined force-wide custody strategies, as well as treatment and conditions, individual rights and healthcare in each suite inspected. A survey of prisoners at HMP Holme House who had formerly been detained in Durham custody suites was conducted to obtain additional evidence (see Appendix II).
- 2.5 The physical condition of the suites was far from ideal, but cleanliness and relationships between staff and detainees were generally good. While there were no immediately obvious ligature points in many cells a subsequent assessment by the Home Office General Property Technical Standards Unit found a number of ligature risks in all suites, which need to be minimised. Realistically many of the deficiencies in the accommodation could only be addressed by new accommodation being built.
- 2.6 Staffing in the custody suites consisted of a custody sergeant, not all of whom were specialists in this role, supported by custody officers.

Strategic overview

- 2.7 A more strategic approach to the oversight of custody matters was beginning to be developed. A custody project set up in May 2008 was examining the feasibility of centralising custody provision with two proposed large new custody suites in the north and south areas. The Police Authority was engaged in the process. A recently appointed assistant chief constable had portfolio responsibility for custody matters, although the management of custody policies and

procedures rested with a chief inspector in the headquarters Criminal Justice Department who was responsible for the introduction of the Safer Detention and Handling of Persons in Police Custody Guidance (SDHP) project, and operational responsibility was devolved to each area. There was some effective joint work with National Health Service partners to improve the delivery of health services but, as yet, no overall health strategy. Good relationships had been established with other criminal justice agencies. Some mechanisms for learning from adverse incidents had been established but there was little recognition in policies and procedures of the needs of specific groups of detainees such as juveniles and women.

Bishop Auckland

Treatment and conditions

- 2.8 Custody staff had all received the basic training course. Although some had been in post for a number of years, no refresher or additional training had been undertaken. The standards of care were good and staff were responsive to the individual needs of detainees. Food and drink were routinely offered and catered for a variety of diets. Most cells had toilets and the whole custody area was clean. Detainees were given a mattress and clean blankets.

Individual rights

- 2.9 All detentions were authorised and reviews were completed within the timescales specified under PACE. Detainees were given a copy of the notice of entitlement and someone concerned for their welfare was notified of their whereabouts. Staff had some awareness of the differential impact of custody on women and juveniles, and responded respectfully, but there were no formal policies or training. The central duty solicitors (CDS) scheme worked well and medical advice was taken about fitness for detention and/or interview. There was a need to investigate seemingly early court cut-off times which meant that some detainees spent longer in custody than desirable. Detainees were not told how to make a complaint. A pre-release detention exit plan had recently been introduced and was used appropriately.

Darlington

Treatment and conditions

- 2.10 Detainees were treated with respect. There was no seating area for those waiting to be booked in, and some delays. The environment was clean and had recently been decorated, but cells were hot and lacked ventilation. Some cell bells were isolated and their use was not routinely explained. The whole cell area was stark and little written information was given. Food and drink were available on request and catered for a variety of diets. Detainees were routinely provided with a mattress and blankets but not pillows. Paper suits, rather than more appropriate clothing, were routinely used when the detainee's clothing was taken. Detainees were not routinely informed of what was available to them during their time in custody.

Individual rights

- 2.11 Detention was authorised and reviews took place in line with PACE guidelines. Detainees were not routinely allowed a telephone call but one was made on their behalf. Staff did not routinely ask about childcare issues. Legal advice was easily obtained and interpreting services used

when needed. Subject to availability, juveniles and females were allocated to specific cells, and young people were not interviewed without an appropriate adult being present. However, little else was different in the treatment of young people and females, and there were no policies about their specific needs in detention. Restraints were seldom used. There was a need to investigate seemingly early court cut-off times which meant that some detainees spent longer in custody than desirable. An exit risk assessment had recently been introduced for the most vulnerable detainees.

Durham

Treatment and conditions

- 2.12 Custody sergeants had all received the basic training course. However, a number had been in post for some time and had received no refresher or additional training. The standards of care were satisfactory but cell bells were not always answered promptly and not all detainees were given adequate information before being left in a cell. Most cells had toilets and were clean, but had no natural light. Showering facilities lacked privacy. Food and drink were available on request but not routinely offered. Detainees were regularly provided with a mattress and blankets, but not pillows or sheets.

Individual rights

- 2.13 All detentions were authorised and reviews were completed within the timescales specified under PACE. Detainees were informed of their entitlements. Detainees were not routinely allowed a telephone call but one was made on their behalf. Custody staff treated all detainees properly according to the PACE code of practice but there was little attention to the specific needs of female and juvenile detainees. The CDS scheme worked well and medical staff assessed detainees' fitness for detention and/or interview. Detainees were not always taken to courts promptly because of apparently early cut-off times. A pre-release detention exit plan had recently been introduced.

Peterlee

Treatment and conditions

- 2.14 Detainees were treated respectfully and the custody sergeant interacted well with new arrivals. The general environment was bright but the fabric was in poor repair, with remedial work planned. The cells were not properly cleaned. There was no information about routines or what was available to them during their time in custody. The women's shower lacked privacy. Food and drink were provided on request. Detainees were provided with a mattress and blankets but not pillows. Paper suits were routinely used when clothing was taken. One interview room was out of order but there was adequate provision.

Individual rights

- 2.15 Detention was authorised and reviews took place in line with PACE guidelines. Detainees were not routinely offered a free telephone call but staff made contact on their behalf. Staff did not routinely ask about childcare issues. Legal advice was easily obtained, as were interpreting services, although these were seldom required. When available, juveniles and females were

allocated to specific cells. Young people were not interviewed without appropriate adults. There was little distinction in the treatment of young people and women, and there were no specific policies for them. Restraints were seldom used. Detainees were not always taken to courts promptly because of apparently early cut-off times. Detainees were not told how to make a complaint. An exit risk assessment had recently been introduced for the most vulnerable detainees.

Healthcare

- 2.16 The level and quality of health services to detainees held in custody throughout the Durham Constabulary area were inconsistent. Health services were provided by forensic medical examiners (FMEs) and emergency care practitioners (ECPs). The ECPs provided a good 12-hour service but we had concerns about response times for FMEs.
- 2.17 There was no overall health strategy underpinning the healthcare needs of detainees. There were no robust governance arrangements and no healthcare policies or protocols. There was no evidence of any generic health needs analysis or mental health needs analysis being undertaken. However, senior police management had recognised the deficits and were putting in place plans to address the gaps in service delivery. Some work with local primary care trusts had begun to deliver improvements. We had significant concerns about medicines management.
- 2.18 Despite no specific funding for those with alcohol problems, there was good support for substance users from arrest referral workers in all police stations.
- 2.19 Except at Peterlee, there were good arrangements with local mental health trusts to meet the needs of detainees with mental health problems. There was no clear central information about the circumstances in which Section 136 detainees were held.

3. Strategy

- 3.1 Historically, there had been little strategic focus on custody but this was beginning to be developed, and the chief constable and the deputy and assistant chief constables set a good lead. A custody project set up in May 2008 was examining the feasibility of centralising custody provision, taking into account an existing safer detention project. The project had recommended the provision of two new large custody suites in the north and south areas with centralised professional custody teams. The Police Authority was supportive of future plans for the development of new custody suites and was fully engaged with the command team in the strategic decision-making process. A recently appointed assistant chief constable (ACC) had portfolio responsibility for custody matters, although the management of custody policies and procedures rested with a chief inspector in the headquarters Criminal Justice Department who was responsible for the introduction of the Safer Detention and Handling of Persons in Police Custody Guidance (SDHP) project, and operational responsibility was devolved to each area. There was some effective joint work with National Health Service (NHS) partners to improve the delivery of health services but as yet no overall health strategy or appropriate clinical governance arrangements. Good relationships had been established with other criminal justice agencies. Some mechanisms for learning from adverse incidents had been established but there was little recognition in policies and procedures of the needs of specific groups of detainees such as juveniles and women.

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 The ACC was the senior portfolio holder for custody issues within Durham Constabulary. He had recently been promoted into the post from another force and had taken an active interest in custodial matters, aiming to bring a more strategic focus to a custody users group, but there was little evidence of previous strategic priority in this area. Custody was not highlighted in force planning documents, which reflected national policing priorities. It was recognised that, historically, there had been an underinvestment in the custodial estate. A custody project had been established in May 2008 in recognition that the Durham Constabulary would be embarking on a major capital building programme and that a professional custody capability would be central to that. The need for custody suites to be compliant with SDHP guidance was also recognised. The project was to complete a feasibility study about the centralisation of custody provision as a stand-alone project within the force, to include both operational and strategic oversight of custody issues.
- 3.4 The project had recommended the provision of two new large custody suites in the north and south areas, with 50 cells in each, with centralised professional custody teams. The Police Authority was supportive of future plans for the development of new custody suites and was fully engaged with the command team in the strategic decision-making process and

recognised the risks inherent in an old estate. A cell capacity feasibility study had been completed as part of the project but we questioned the basis of some of the data. This contained figures for the use of non-designated police custody suites which the staff at those stations did not recognise and which seemed unlikely to reflect the actual position. No-one was able to explain to us the basis of the figures. There were indications that following the delivery of the feasibility study, senior managers were beginning to question how well two large centralised units, while likely to be efficient and provide better physical conditions than the current dispersed smaller suites, would meet the needs of a largely rural and far flung population and the force's commitment to citizen focus.

- 3.5 The ACC was supported by a project team, led by a chief inspector, who was responsible for implementing the guidance on SDHP and who provided policies and standard operating procedures (SOPs) for custody suites in each area. These covered protocols and guidance to custody staff with regard to mitigating risk. The custody users group and its experience was utilised in strategic meetings to inform decision making. The SDHP policy had been recently ratified at a full management group meeting in September 2008, although it was unclear where ownership would lie at the completion of the project.
- 3.6 The SOPs were designed to assist areas to deliver safe and consistent levels of service, although responsibility and accountability rested with the area commanders (chief superintendents) in the north and south of the constabulary, and ultimately with the ACC. Senior management oversight was progressive, although there was insufficient intrusive supervision into custodial matters at inspector rank level to include consistent audit trails of findings, observations and follow-up action.
- 3.7 Approved custody training for custody officers was delivered corporately. Most, but not all custody sergeants and detention officers (DOs) had received nationally approved custody training before their deployment in custody suites, and some had been delivered some years previously. The need for refresher training had been identified and was due to be delivered as part of a package beginning in 2009.
- 3.8 Durham Constabulary was actively committed to healthcare issues at chief officer level, with NHS partners, but there was not yet any overall health strategy or appropriate clinical governance arrangements. Until recently, there had been little strategic focus on the provision of health services to detainees but there were signs that improvements were beginning to be made. There was a shortfall in forensic medical examiner (FME) services and no clear operating frameworks for FMEs. Emergency cover for FMEs in the northern area of the force relied on Cleveland Police Constabulary, which had outsourced its FME provision to a private contractor. The force was looking to outsource the provision of FME services in 2009. The local primary care trust had recently won a tender to provide nursing services, and well-qualified nurses acted as emergency care practitioners (ECPs) and provided a good and responsive service.
- 3.9 Addaction (the substance misuse charity) workers were available in all the custody suites we inspected. This provided the force with a responsive substance misuse service, with follow-up services where necessary. However, there was no alcohol support and referral service anywhere in the county.
- 3.10 The force had a positive relationship with the Crown Prosecution Service (CPS). The chief crown prosecutor and chief constable had a good working relationship, with ongoing partnership work being developed at Local Criminal Justice Board (LCJB) level. There were no criticisms put forward to the inspection team with regard to the quality of CPS cover. However, each of the custody suites we visited indicated that some detainees remained in custody too

long because court cut-off times were too early. It was not apparent that this had been raised with the Court Services representative at the LCJB.

Expectation

- 3.11 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

- 3.12 The Custody Project brief recognised that Durham Constabulary had struggled for many years to define how custody would be managed and overseen from a holistic perspective. It noted that there was a custody user group with operational ownership carried out through the operational support chief inspectors in the north and south areas. Policy issues related to custody were addressed either through the Administration of Justice Department or the Corporate Development Department, depending on the issue.
- 3.13 With operational responsibility devolved to each area, there were different working practices in staffing custody suites between the northern and southern areas. 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 many found the lines of accountability confusing. Some staff expressed frustration at this lack of clarity, as it impacted on the resolution of ongoing problems. This issue was of particular note in some non-designated custody suites, which one police inspector described as 'a shambles'.
- 3.14 There was no formal force policy covering cell bell usage and dealing with how staff reacted to cell bells, and we found that some audible cell bells had been turned off because staff found them 'intrusive'. The current working practice presented a risk to detainees, who would have been unable to summon assistance, and it increased the risk to the force in terms of suffering a serious adverse incident.
- 3.15 We identified a need to interrogate the National Strategy for Police Information Systems (NSPIS) custody system to obtain a broader overview of the management information contained within it, with a view to identifying more readily the profile of detainees entering the custody suites. This should include how many detainees are held for more than 24 hours and how many are juveniles, females and UK Border Agency (UKBA) detainees.
- 3.16 There were no specific policies dealing with the needs of juveniles, females and UKBA detainees detained beyond 24 hours, or any guidance to custody staff about the different impact of custody on juvenile and female detainees. Despite this, some individual staff showed good awareness of specific needs.
- 3.17 The force had no intranet site for custody staff to help to provide sound information and timely advice on detainee supervision and identify health and safety learning points from investigations into adverse incidents. Such a site would have enabled a link to the 'Lessons Learned' newsletters from the Independent Police Complaints Commission and allow policies and protocols to be updated through the site and alert staff to relevant updates.
- 3.18 No information was provided to detainees about how they could make a complaint while they were in custody. While those detained at the police stations did not raise any concerns about their treatment when we spoke to them, we witnessed some working practices which could

have led to complaints. Although we found no evidence in records to support them, a different picture emerged when we spoke to detainees in the local prison, who had many complaints about their detention in custody suites in Durham. There was no clear mechanism to learn from complaints or issues raised by detainees.

- 3.19 Policies and audit trails for processing DNA, blood and urine samples were not explicit in terms of when and where samples should be stored and who had responsibility for ensuring that they were dealt with expeditiously. We found DNA stored alongside milk in a fridge. Old DNA, urine and blood samples were found stored in freezers, and the dates on the samples led us to conclude that they had been completely forgotten. A custody sergeant admitted to 'discarding' old samples which had been left behind. The situation was unsatisfactory and raised questions about systemic failings to manage samples, which could have adverse impacts for bringing offenders to justice.

Expectation

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

Findings

- 3.21 Due to the age and limited capacity of cell provision within Durham Constabulary, maintenance work was completed when facilities were open.

Recommendations

- 3.22 A clear strategy for the future of custodial provision should be agreed and custody matters should be routinely included in relevant force planning documents.
- 3.23 A health strategy based on a needs analysis should be agreed utilising National Health Service (NHS) support. The strategy should ensure that sufficient health services, including forensic medical examiner (FME) cover, are provided and outline an effective working framework for FMEs and emergency care practitioners (ECP).
- 3.24 Staffing of custody suites should be managed to ensure consistent working practices across all custody suites in the north and south of the force and to reflect the pressures faced by busier custody suites.
- 3.25 An effective system of intrusive supervision into custodial matters should be introduced at inspector rank, with consistent audit trails detailing their findings, observations and follow-up action.
- 3.26 A formal force-wide policy should be developed which deals with cell bell usage and staff responses.
- 3.27 Greater effort should be made to utilise management information within the National Strategy for Police Information Systems (NSPIS) custody system to achieve a better understanding of the profile of detainees.
- 3.28 Specific policies in relation to the treatment of young people, women and immigration detainees should be introduced.

- 3.29 The force should develop a custody intranet site, which should include all relevant policies and be linked to the 'Lessons Learned' newsletters from the Independent Police Complaints Commission.
- 3.30 A clear complaints policy should be advertised in custody suites and the number and nature of complaints should be analysed centrally so that underlying causes of complaints can be identified with a view to solving any problems.
- 3.31 The force should urgently review how it stores, tracks and submits all DNA and forensic samples taken from detainees. A robust series of control mechanisms should be introduced which facilitate intrusive monitoring of performance in this area. Performance should be reviewed by a senior officer who has responsibility for ensuring its delivery.

4. Treatment and conditions

Bishop Auckland custody suite

- 4.1 Custody staff had all received basic training. Although some had been in post for a number of years, no refresher or additional training had been undertaken. The standards of care were good and staff were responsive to the individual needs of each detainee, although there was little differentiation in systems. Facilities were routinely offered or provided on request. Most cells had toilets and the whole custody area was clean. Food and drink were provided regularly and on request, and catered for a variety of diets. Detainees were given a mattress and clean blankets.

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

- 4.3 The booking-in process included a generic risk assessment used for all detainees, which was inadequate for female and juvenile detainees. However, staff made efforts to obtain additional information, beyond that which was contained in the assessment. The assessment covered the risks of suicide, drugs and alcohol use, medical conditions and medications. Information was gathered from the detainee, escorting staff and the prisoner escort record. The booking-in desk was high and located in the open area, giving inadequate privacy for those being booked in. We observed two prisoners being booked in while other detainees were present in the waiting area.
- 4.4 Custody staff had all attended the basic training course. Although some had been in post for a number of years, no refresher or additional training had been undertaken. Custody staff were aware of the signs to look out for that would indicate that a person was at risk of self-harm, and explained in some detail their systems and protocols to manage different levels of risk. One woman on a constant watch was given good care, but we also saw a young girl who was visibly distressed sometimes being left alone in the holding area.
- 4.5 A doctor was requested when deemed necessary and a mental health nurse was present daily.
- 4.6 Handovers took place at each shift change and were recorded on the National Strategy for Police Information Systems (NSPIS) system. Comments made at handover regarding risk were recorded in individual custody records.

- 4.7 Regular custody staff carried keys and anti-ligature knives. A spare set of keys was kept in the office for other staff, but a spare anti-ligature knife had gone missing and not been replaced. All general areas were monitored by closed-circuit television (CCTV).

Expectation

- 4.8 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

- 4.9 Detainees did not routinely share cells. Custody staff indicated that detainees who requested to share a cell (such as family members) would be allowed to do so during the day, after a thorough risk assessment, but would be placed in a single cell at night.

Expectation

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

Findings

- 4.11 All cells had a cell call bell with an integral intercom. We observed call bells being responded to promptly. The system was explained to all detainees, both verbally and in writing.

Expectation

- 4.12 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

- 4.13 The main waiting area was clean and opened out onto the station yard, giving it adequate natural light. The two interview rooms were austere decorated, poorly ventilated and had no natural light.
- 4.14 The two juvenile detention cells were clean and in a separate spur, away from the staff office, so could not easily be monitored. The door observation panels were high, and it was necessary to stand on a stool to see into the cells.

- 4.15 There was one female cell and six male cells, all of which were clean, although lacked natural light and were poorly ventilated. The female cell was in a separate area.
- 4.16 The exercise area was small, austere, dirty and littered with cigarette ends and other rubbish.

Expectation

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

Findings

- 4.18 The entire custody suite was a no smoking area, including the exercise yard. However, detainees could smoke in the exercise yard if this had been approved by the medical officer. Alternatives to smoking, such as nicotine patches, were not routinely offered but available on request.

Expectation

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

Findings

- 4.20 Microwave meals, catering for most dietary requirements, were provided, and we observed detainees being offered meals routinely and given them on request between mealtimes. Drinks were offered at frequent intervals. Visitors were permitted to bring in food for detainees. Information about when food and drink were taken was recorded in custody records.

Expectation

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

Findings

- 4.22 Detainees were given a mattress and clean blankets.

Expectation

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

Findings

- 4.24 The juvenile cells had no in-cell sanitation and young people had to use a separate toilet on request. However, staff told us that juveniles would usually be held in the cells with the door open, so access to the toilet was not a problem.

- 4.25 All the adult cells had in-cell sanitation, but the toilets were clearly visible from the cell door and offered little privacy. Detainees were able to flush their own toilets, but no cells had washbasins. Toilet paper was provided in all cells. The female cell had its own shower and sink, and provided adequate privacy. There was one shower for men, which was clean and adequately screened, and a hand washbasin.

Expectation

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

Findings

- 4.27 Detainees who had their clothing removed, or who required clean clothing, were offered blue tracksuits, t-shirts and underwear. Detainees were asked to remove the cord from tracksuits, and if they did not want them removed they were offered paper forensic suits. We were told that if these were refused they remained in their underwear, with their clothes left outside the cell door so that they could wear these when moving around the custody suite. This was automatic, without any regard to the individual level of risk.

Expectation

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

Findings

- 4.29 Detainees could take a shower or have exercise on request and were offered the chance for both at regular intervals.

Expectation

- 4.30 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

- 4.31 A selection of books and magazines was available, as well as paper and pens. Visits were facilitated and visitors were able to bring in clothing, reading materials and food. Good efforts were made to make those who were likely to go to prison following a court appearance aware of this, so that they could make arrangements for their families to bring in items they needed.

Expectation

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

Findings

- 4.33 Staff reported that they had recently received fire safety training. The fire system was tested weekly but no evacuation exercises had taken place in the previous six months.

Darlington custody suite

- 4.34 Detainees were treated with respect but there was no seating area for those waiting to be booked in. There were delays in admitting detainees to the custody suite, as only one person could be dealt with at a time. The environment was clean and had recently been decorated, although some graffiti still showed through. Detainees complained that they found the cells stuffy and overheated. Some cell bells were isolated and their use was not routinely explained. The whole cell area was stark and there was little written information. Food and drink were available on request and catered for a variety of diets. Detainees were routinely provided with a mattress and blankets but not pillows. Paper suits were customarily used when clothing was taken for evidence or the individual was perceived to be at risk of self-harm. Detainees were not routinely informed of what was available to them during their time in custody.

Expectation

- 4.35 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

- 4.36 Custody suite staff we spoke to were aware of the risks to those in custody of self-harm and suicide, drugs ingestion, medical conditions and alcohol. The risks presented were identified by the custody sergeant at initial reception and were based on what the detainee was prepared to disclose, as well as the custody sergeant's view of how the individual presented. When it was deemed necessary to seek medical advice, an immediate call was made to the forensic medical examiner (FME), but it could be several hours before a doctor attended. The detention officer at Darlington had been specifically recruited and trained to work in the custodial setting, but the custody sergeant worked relief shifts and relied on the experience and knowledge gained in the course of his work. All staff we observed carried anti-ligature knives, which were routinely used to cut cords from tracksuit bottoms.
- 4.37 We did not observe a handover, but were told that matters of concern were passed verbally at the change of shifts. The electronic log of who was in custody also contained relevant information for incoming staff. The detention officer we observed was rigorous in his checks of all people held in custody, particularly of a detainee who had drunk a large amount of alcohol. The management of the risks presented was routine and risk averse. One cell was designated

as the alcohol cell (mainly because there was a drain in the floor, to allow the cells to be easily washed out). However, the drain presented a ligature point.

Expectation

- 4.38 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

- 4.39 There were no detainees in shared cells at the time of the inspection. Sharing was rare, and those considered for sharing would first undergo a thorough risk assessment.

Expectation

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

Findings

- 4.41 All cells were equipped with call bell systems. However, we found that the call bell buttons for three out of the bank of four adult cells, including the designated alcohol cell, were isolated, so the bell did not sound at the custody desk on the first day of the inspection. One call bell button was isolated on the second day of the inspection. We were told that this was done when persistently rung and causing a nuisance, but the cells were empty on our arrival. There was a danger that isolated bells could have remained switched off when detainees were subsequently allocated to these cells. The purpose of the call bell was not routinely explained to detainees, but those we asked understood how to use them. We observed them being answered reasonably quickly.

Expectation

- 4.42 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

- 4.43 There was no seating area for those waiting. The area which had originally been designed as a holding area was now used for 'safe water' screening and was rightly deemed inappropriate to hold those awaiting booking in, as it lacked privacy. The cells and detention rooms, although

old and stark, were clean, recently decorated and in good repair. Graffiti in the cells had been painted over, although some of the scoring meant that text was still discernible. We were told that some detainees had been prosecuted for criminal damage for graffiti in cells, but were unable to source records for this. One cell was out of use for repair work. The cells were warm and some detainees complained that they were stuffy. There was no natural light, and some cells were particularly dark and had no strip lighting. There were no obvious ligature points apart from floor drain covers in cells designated for intoxicated detainees. The door to the exercise yard was covered in graffiti. The whole cell area was stark and there was little written information, either in booklet or poster form.

Expectation

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

Findings

- 4.45 The custody suite operated a complete no-smoking policy. We were told that the FME could authorise a detainee to smoke in the exercise area if nicotine withdrawal symptoms were excessive. Staff said that nicotine patches were available from the medical team but had not seen them supplied.

Expectation

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

Findings

- 4.47 Boxed microwave meals were available and catered for a variety of diets, including vegetarian and halal. There were no set meal or drink times but food and drink were provided on request and we saw detainees regularly being given hot and cold drinks. Pre-packed hot drinks all had milk incorporated, so one detention officer used his own coffee if someone requested a hot drink without milk. Detainees could have food brought in by family and friends, provided that it was sealed.

Expectation

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

Findings

- 4.49 All detainees were given a mattress and clean blankets. Laundry arrangements for anti-ligature blankets for those at risk of self-harm were less clear than for normal blankets. Clean towels were available but not issued unless requested. Pillows were not provided.

Expectation

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

Findings

- 4.51 The toilet arrangements were unsatisfactory. Detainees were able to use the toilet in relative privacy, given the safety constraints. The cells for adults contained toilets but juveniles had to use their cell call bell to be let out. There were no hand washing facilities in cells. Toilet paper was not routinely supplied but given on request and then only in small amounts. The detention officer said that at his discretion he would give a toilet roll to someone who would not misuse it. Women had to request sanitary products. In several of the cells, detainees could not flush the toilet, as the handle was outside, and had to request staff to do so.

Expectation

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

Findings

- 4.53 Paper suits were routinely given to detainees to wear in cells when their clothes were taken. There were no tracksuit bottoms available for detainees at the time of the inspection. Clean t-shirts were available and were given to those who needed them on release or transfer. We were told that families and friends were allowed to provide fresh clothing, but did not see this happen.

Expectation

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

Findings

- 4.55 Showers or time in the open air were not routinely offered and had to be requested. We did not observe anyone taking a shower or using the exercise area during the inspection, but when these took place they were recorded on the electronic custody record. The men's shower was in the thoroughfare between cell areas, and lacked privacy.

Expectation

- 4.56 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

- 4.57 We were told that all detainee requests for reading material, visits or a change of clothes were facilitated but they were not routinely informed that these were possible. A box containing a limited number of books and newspapers was held in the staff rest area. The visits area was immediately adjacent to the custody desk, so availability of staff was not a factor in determining whether a visit could take place. The visiting area was small and entirely non-contact.

Expectation

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

Findings

- 4.59 Fire safety training had not been undertaken by all custody suite staff, and the relief staff, in particular, were unlikely to have had recent training. Fire evacuation procedures were not practised frequently.

Other findings

- 4.60 There were sometimes delays in admitting detainees to the custody suite, as only one person could be processed at a time and there was no area in which to hold people who were waiting. This could lead to considerable lengths of time waiting on transport outside, both for staff and for those coming into custody.
- 4.61 The treatment of those entering and exiting custody was generally respectful. We observed good use of first names or titles. However, treatment varied depending on the custody sergeant, and we saw one man being searched at the same time that he was being asked questions, which was distracting and disrespectful.
- 4.62 When detainees' property was booked in, the individuals were asked to sign to say that they had been told that the police had retained their property and that it would be returned to them when they left. What they were in fact signing was a statement agreeing that what was listed was a true record of their property. However, from their side of the screen, detainees were unable to see what had been listed.

Durham custody suite

- 4.63 Custody sergeants had all received the basic training. However, a number had been in post for some time and had received no refresher or additional training. The standards of care were mostly good, although cell bells were not always answered promptly and not all detainees were given adequate information before being left in a cell. Most cells had toilets and were clean, although had little natural light. Showering facilities lacked privacy. Food and drink were available but meals were not routinely offered. Detainees were provided with a mattress and blankets, but not pillows. Most facilities had to be requested.

4.64 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

- 4.65 Custody sergeants had all received the basic training. However, a number had been in post for some time and had received no refresher or additional training. A generic reception risk assessment was used for all detainees, irrespective of gender, age or other differences. The assessment covered the risks of suicide, drugs and alcohol use, medical conditions and medications. Information was gathered from the detainee, escorting staff and the prisoner escort record. In some cases, it was based on prior knowledge of the detainee. Interviews were carried out in a separate private area. A doctor was called when necessary and a mental health nurse attended daily.
- 4.66 Custody sergeants were not always as thorough in the risk assessment process when the detainee was known to them, when some assumptions were made. Custody staff were aware of the signs to look out for that might indicate that a detainee was at risk of self-harm and had a good knowledge of the systems and protocols to put in place when a higher risk was presented. However, staff told us that if a detainee was, for example, kicking their cell door and generally being noisy, they would not be checked until they quietened down, as the noise meant that they were okay. This suggested too much emphasis on physical rather than psychological well-being. One detainee was placed on 15-minute observations, as it was suspected that he had taken drugs but he had refused a blood test to confirm this. An additional member of staff was drafted in specifically to carry out those checks.
- 4.67 Handovers took place at each shift change and were recorded on the NSPIS system and a vision and sound recording CCTV, so that there was a full record of what was said. Handovers included matters relating to risk.
- 4.68 Regular custody staff carried keys and anti-ligature knives. A spare set of keys and a spare anti-ligature knife were kept in the office for other staff; but this could lead to delays in an emergency. We observed visiting officers routinely being given cell keys to access detainees, without reasons being given or asked for. All general areas were monitored by CCTV.
- 4.69 During the weekend, which was the busiest time, the staffing complement was doubled and a second custody booking-in room, which was private and located off the holding area, was used.

Expectation

- 4.70 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

- 4.71 We observed several detainees in the waiting area together, one of whom was wandering into the cell area without any supervision. Custody staff told us that young detainees would be held in the general waiting area until it was determined whether or not they were juveniles.
- 4.72 Detainees were not routinely expected to share cells and would be moved to other custody suites when Durham was full. We found no record of cell sharing in recent months.

Expectation

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

Findings

- 4.74 All cells had working call bells but the system had been silenced in the staff office, as staff thought it intrusive. We saw at least one call bell not answered for approximately 20 minutes. Detainees we spoke to said that the use of the call bell had not been explained to them, although they needed to use it to make routine requests.

Expectation

- 4.75 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

- 4.76 All three interview rooms were sound proofed, cramped and austere decorated, and had no natural light. The waiting area was bright and airy, although there was little natural light.
- 4.77 There were three juvenile holding cells, 10 adult male cells and two female cells. The juvenile and female cells were in separate areas. All the cells were reasonably clean but had little natural light and were inadequately ventilated.
- 4.78 Detainees were expected to clean up after themselves if they soiled the cells, and spillage kits were available. Cells were cleaned and checked by custody staff between uses.
- 4.79 The two booking-in areas both had high desks, which made it difficult for staff and detainees to interact.

- 4.80 The exercise area was small and austere, with overhead netting.

Expectation

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

Findings

- 4.82 The custody suite operated a complete no-smoking policy. We were told that the FME could authorise a detainee to smoke in the exercise area if nicotine withdrawal symptoms were excessive. We were also told that nicotine patches were available from the medical team.

Expectation

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

Findings

- 4.84 Microwave meals, catering for all dietary requirements, were stocked, but during the inspection we did not observe any detainees being offered or given food, although drinks were given. Few of the custody records we checked showed that food had been given to any detainees. One detainee we spoke to had been in custody for over 18 hours without a meal. Custody staff said that food was not always given if they were busy, and was not routinely offered or given during the night, as the custody suite was 'not a kebab shop where meals could be served on request'.

Expectation

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

Findings

- 4.86 Detainees were given a mattress and clean blankets, but there were no pillows. Dirty and clean blankets were stored separately and we were told that they were regularly laundered. There was a good supply of blankets, including anti-ligature blankets.

Expectation

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

Findings

- 4.88 The holding rooms for juveniles had no integral sanitation. Juveniles used a toilet next to the staff office. This was inadequately screened and also gave a clear view of the electronic whiteboard used to record details of all detainees.

- 4.89 All the male and female cells had in-cell toilets, but these provided little privacy. Detainees were able to flush their own toilets but no cells had washbasins. Toilet paper was available in some cells, while others had none. There was a shower and a sink on each of the adult corridors, but these were inadequately screened.

Expectation

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

Findings

- 4.91 Detainees whose clothing had been taken and who were being released or transferred to court were given tracksuits, t-shirts and black plimsolls. Paper forensic suits were also available. No underwear was stocked but visitors could bring in clothing for detainees.

Expectation

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

Findings

- 4.93 Detainees could have showers and take exercise upon request, but neither was offered routinely.

Expectation

- 4.94 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

- 4.95 There was no reading material. Visits were officially allowed and families could bring in clothes, but in practice the visits facility was rarely used. The visiting area was small and entirely non-contact.

Expectation

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

Findings

- 4.97 Staff had recently received fire safety training. There had been no recent evacuation practices.

Other findings

- 4.98 We observed two occasions when detainees were informed of whether or not they would be charged in the general waiting area, with other detainees present. This was an unnecessary breach of privacy, as suitable private rooms were available.

Peterlee custody suite

- 4.99 Detainees were treated respectfully and the custody sergeant engaged with them well. The general environment was bright but the fabric was in a poor state of repair, although remedial work was planned. The cells were dirty. Written information about legal rights was available, but there was no information about routines or what was available to them during their time in custody. The shower for women lacked privacy. Food and drink were available on request and catered for a variety of diets. Detainees were provided with a mattress and blankets but not pillows. Paper suits were routinely used when clothing had been taken, rather than the good range of tracksuit bottoms and t-shirts available. One interview room was out of order, but the remaining three were adequate.

Expectation

- 4.100 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

- 4.101 The custody staff we spoke to were aware of the risks to those in custody of self-harm and suicide, drugs ingestion, medical conditions and alcohol. They had received no specialist training in any of these areas but used 'common sense'. Their concern about their lack of specialist knowledge contributed to the risk-averse way in which they treated detainees. The risk assessment was based on the questions prompted at initial reception, but staff also used their discretion when their view of a person was in conflict with what that person was telling them. The custody sergeant engaged well with those coming into custody, who were consistently treated respectfully and with understanding. The custody sergeant had received two weeks' custody training as part of his sergeant's course four and a half years previously. The detention officer had received NSPIS training, so understood the computer elements of the role, but had not received any training around managing people in custody. All staff we observed carried anti-ligature knives. Handovers were given verbally at exchanges of shifts, and staff used the electronic custody log to check details of individuals in custody.

Expectation

- 4.102 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

- 4.103 There were no detainees in shared cells at the time of the inspection. Sharing was rare and those considered for sharing would first undergo a thorough risk assessment.

Expectation

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

Findings

- 4.105 All cells were equipped with call bell systems. The fabric of the cell areas was checked weekly and any need for repairs reported immediately. Requests for remedial work were not confined to the weekly check, and any problems discovered in between were dealt with. We did not observe anyone being admitted to a cell, but some of the detainees we spoke to said that the use of the cell bell had not been explained to them, although they were aware of how to summon assistance. We saw cell call bells answered reasonably promptly.

Expectation

- 4.106 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

- 4.107 The cells and detention rooms were equipped with a bench, running the length of the cell. Despite the suite only being around seven years old, the fabric was in a poor state of repair. Of the four interview rooms, one was out of commission owing to a flood, and the plaster was damaged in areas around the door frames. The remaining interview rooms offered sufficient provision. We were told that a substantial reorganisation and refurbishment of the custody suite was planned. The cells were reasonably well decorated, free from graffiti and at a suitable temperature. Detainees were actively pursued for charges of criminal damage if found to have put graffiti in their cells. The cells had no natural light, and one detainee was in semi-

darkness, as the light had not been switched on since the night before, and he had no way to control it himself. The detention officer switched it on when asked, but lights were not switched on routinely. There were no obvious ligature points. The cells were dirty, particularly around the toilet areas, where there was ingrained dirt. The cells were cleaned by contract cleaners on Monday to Friday, but not if they were occupied. Detention officers cleaned at weekends and when a detainee was discharged after the regular cleaners had been in, but the standard was poor.

Expectation

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

Findings

- 4.109 The custody suite operated a complete no-smoking policy. We were told that the FME could authorise a detainee to smoke in the exercise area if nicotine withdrawal symptoms were excessive. Nicotine patches were available, but it was not clear when or how often.

Expectation

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

Findings

- 4.111 Boxed microwave meals were available and catered for a variety of diets, including vegetarian and halal. There were no set meal or drink times, but food and drink were available on request. We saw lunch being given at 1.30pm on one day during the inspection. The food provided was bland and lacked variety for anyone being detained for longer periods. There was no fridge for storing food or milk. Detainees could have food brought in by family and friends, provided that it was sealed.

Expectation

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

Findings

- 4.113 All detainees were given a mattress and clean blankets. Laundry arrangements for anti-ligature blankets for those at risk of self-harm were less clear than for normal blankets. Clean towels were available but not issued unless requested. No pillows were ever provided. Mattresses were removed from cells during the day, which left detainees either sitting or lying on hard benches for long periods. New mattresses had just been received.

Expectation

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

Findings

- 4.115 All detainees were able to use the toilet in relative privacy, given safety constraints. Adult men and women had toilets in their cells. Children, or those held in the juvenile cells, had to use their cell bells to access a toilet. Adult men and women would then have to use their cell call bell to be let out to wash their hands. Toilet paper had to be requested.

Expectation

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

Findings

- 4.117 Of the five people in custody on the second day of the inspection, none had had their clothes taken for evidence, but two were in paper suits. One had refused the clothing offered and was wearing only his shorts. The remaining two were in their own clothes. A 17-year-old was in a paper suit because his tracksuit bottoms had been taken from him, as they contained a cord, but he was still wearing his own t-shirt. An older man receiving a caution for a criminal damage charge was at the front desk in a paper suit and socks. Material clothing was not usually given until release or transfer, although there was a good range of tracksuit bottoms and t-shirts. Families and friends were allowed to provide fresh clothing.

Expectation

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

Findings

- 4.119 We were told that anyone who requested a shower or time in the open air would be allowed it, but neither was offered routinely. We did not see anyone using the showers or the exercise area during the inspection, but there was a record of the exercise yard being used the previous day. The men's shower provided appropriate privacy, but not the women's shower, which was located between two cells on the main cell area. The women's shower door had fallen on its hinges. We were told that there was never a problem supervising, and that if the detention officer was male, the regular custody sergeant, who was female, would supervise and hold the door to the shower closed. One detainee we spoke to said that he had been held at Peterlee for two days on a previous occasion, but had not been offered a shower or exercise.

Expectation

- 4.120 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

- 4.121 Reading material, visits or a change of clothes had to be requested. Visits were only facilitated when a member of staff was available to supervise, and rarely happened. The visiting area was small and entirely non-contact. Detainees were not routinely informed of what was available to them, despite the onus being on them to ask for these things. One detainee we spoke to said that he was unaware that visits were allowed at all, and that although he would have liked to have some reading matter to pass the time, none had been offered and he had not known that he could ask for this.

Expectation

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

Findings

- 4.123 Fire safety training had not been undertaken by all custody suite staff, and the relief staff, in particular, were unlikely to have had recent training. There had been a fire evacuation practice just before the inspection, but this had been the first in some years.

Recommendations

- 4.124 Booking in and discharge arrangements should be improved so that detainees are dealt with at a desk of an appropriate height and which allows sufficient privacy for confidential information to be passed.
- 4.125 Appropriate supervised seating areas should be provided for detainees waiting to be booked in, who should not have to wait for prolonged periods in vans.
- 4.126 Holding facilities, interview rooms and the exercise yard area should be made less austere and all cell areas kept clean.
- 4.127 Risk assessments should be based on individual risk and take into account the needs of specific groups such as women and children.
- 4.128 All custody staff should carry personal cell keys and anti-ligature knives.
- 4.129 An entry in the custody record should be kept of all occasions and the reasons when a member of staff has access to a detainee held in the custody suite.
- 4.130 All staff working in custody suites should be up to date with training which includes the management of detainees, risk assessment, mental health awareness training and gender- and child-specific issues.
- 4.131 Basic information about what to expect in custody and what facilities can be requested should be explained to detainees and available in booklets and/or posters.
- 4.132 Detainees should be offered meals at appropriate intervals and this should be recorded in custody records.

- 4.133 All showers should provide appropriate privacy.
- 4.134 Items to meet basic needs, such as pillows, toilet paper, sanitary products, and reading materials should be routinely available unless their removal can be justified by an individual risk assessment.
- 4.135 Staff should explain the use of the call bell to detainees and this should be recorded.
- 4.136 Detainees should be held in suitable ventilated and heated cells with natural light, sanitation and washing facilities which can be used independently and in suitable privacy.
- 4.137 When required, detainees should be provided with appropriate alternative clothing and paper suits used only when absolutely necessary.
- 4.138 Young people under 18 should be held in well supervised accommodation and dealt with taking into account their legal status and vulnerabilities as children, including an awareness of child protection issues.
- 4.139 Fire evacuation plans should be practised regularly.

5. Individual rights

Bishop Auckland custody suite

- 5.1 All detentions were authorised and reviews were completed within the timescales specified under the Police and Criminal Evidence Act (PACE). Detainees were given a copy of the notice of entitlement and someone concerned for their welfare was notified of their whereabouts. Staff were sufficiently attuned to the differential impact of custody on women and juveniles, and responded respectfully. Staff were not trained in child welfare or child protection and the booking-in process was not age appropriate. Female detainees were not told that hygiene products were available to them. The central duty solicitors (CDS) scheme worked well and medical staff were consulted regarding detainees' fitness for detention and/or interview. Detainees were not taken to courts promptly owing to courts' reluctance to receive them beyond a specified hour; this resulted in detainees spending longer periods in custody than was necessary. Detainees were not told how to make a complaint. A pre-release risk management plan had recently been introduced and was used appropriately by custody staff.

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

- 5.3 Reviews were carried out by an inspector and records indicated that they were completed within the timescales specified under PACE and covered the necessary legal requirements.

Expectation

- 5.4 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

- 5.5 A notice of entitlements was located at the custody desk and copies were given to detainees to take away and read. The information was taken from the PACE code of practice and was useful. It outlined their general entitlements, how interviews were conducted, the purpose of appropriate adults and information for foreign national detainees. There was also an audio version; however, the audio equipment was only available at the front desk, so detainees would have had to listen to it in the holding area.
- 5.6 We observed a number of detainees being booked in and in all cases they were asked if they wanted to have someone informed of their whereabouts. If appropriate, custody staff allowed detainees to make a telephone call, but if not they notified someone on behalf of the detainee.

- 5.7 Detainees were not always asked if they wished to see a doctor. Detainees saw a doctor either on request or if the custody sergeant dealing with the admission had any concerns.

Expectation

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

Findings

- 5.9 The notice of entitlement was translated into a number of languages, but other than that there was limited translated material in the custody suite – mainly information about legal advice. A telephone interpreting service was used for detainees who did not speak English, and this was evidenced in the custody records we saw.

Expectation

- 5.10 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

- 5.11 There was no separate policy for detained young people under 18 but custody staff had some awareness of the relevant issues. None of the custody staff had received specific training in child welfare or child protection. Custody staff we spoke to said that during booking-in procedures they held juveniles separately in one of the detention rooms if there were adult detainees in the holding area.
- 5.12 There were two juvenile detention cells, which were close to the custody desk. However, when these were full, juveniles were located in any available cells. Exercise and access to showers and toilets were conducted separately from adult detainees.
- 5.13 Although we did not observe it, we were told that juveniles and their appropriate adults would be permitted to wait in the detention room with the door open. An appropriate adult scheme was provided by the local Youth Offending Service during working hours on Monday to Friday. A PACE-trained member of staff was placed on a rota to undertake PACE duties in the custody suite, and staff from the Youth Offending Service and the custody suite said that the service was effective. Outside office hours and during the weekend, an appropriate adult scheme was provided by the social services emergency duty team, but we noted in one case of a 16-year-old that this team was not contacted when the parents could not be found, and after some wait the boy was bailed to return later.

Expectation

- 5.14 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

- 5.15 We observed a female custody officer dealing well with a female detainee who was distressed. All detention staff were briefed about some of the issues pertaining to this detainee and it was sensitively handled by all the staff.
- 5.16 Custody staff showed some understanding of the differential impact of detention on women, and we observed staff working to safeguard the welfare of a detainee's child, as well as her own well-being. Due to the domestic concerns in this case, the custody sergeant had devised an exit plan, and referrals were made to social services. If a female member of staff was not on duty, arrangements were made for a female officer to conduct the searches.
- 5.17 Hygiene products were available in the custody suite, but female detainees were not routinely informed of their availability and had to ask staff if they required them.

Expectation

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

Findings

- 5.19 Custody staff said that detainees were routinely asked if they had any dependency issues, and we observed staff taking details of detainees' personal circumstances during their detention and before releasing them.

Expectation

- 5.20 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

- 5.21 Access to duty solicitors was managed through the CDS scheme, and solicitors attended promptly. However, there were only two interview rooms, and during busy periods they experienced delays. Solicitors said that custody staff were professional and provided them with the information they needed. Juveniles were not interviewed unless a relative, guardian or appropriate adult was present.

Expectation

- 5.22 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 the Police and Criminal Evidence Act, 1984 (PACE).

Findings

- 5.23 Custody records confirmed that consideration was given to whether detainees were fit to be interviewed. We saw one detainee being assessed by a mental health practitioner to assess whether he was fit to be detained and/or interviewed. During the inspection, several detainees who had been under the influence of alcohol when arrested were checked regularly to establish whether they were fit to be interviewed.

Expectation

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

Findings

- 5.25 Solicitors were provided through the CDS scheme to all detainees who requested it. Custody staff were unsure if there were solicitors available who were specialists in immigration matters.

Expectation

- 5.26 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

- 5.27 Detainees were provided with at least an eight-hour continuous break from interviewing in a 24-hour period. Interview rooms were appropriate and sound-proofed. Solicitors we spoke to did not express any concerns about their clients' treatment.

Expectation

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

Findings

- 5.29 Custody records indicated whether or not detainees were brought into the custody suite in handcuffs. In the majority of the records we reviewed, detainees were handcuffed at the front, and handcuffs were removed once in the holding area of the custody suite. All detainees, including juveniles, were restrained according to the risk they posed. During the inspection, no detainees in the custody suite were handcuffed or otherwise restrained.

Expectation

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

Findings

- 5.31 Global Solutions Limited (GSL) was the main escort contractor. Difficulties were experienced in getting detainees to court after the morning collection. The custody sergeant told us that the local court refused to accept detainees after 12.45pm, and if detainees were not at court by this time, they would remain in custody until the next day.

Expectation

- 5.32 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

- 5.33 Detainees were not told how to make a complaint. Detainees in custody long enough to have their detention reviewed by an inspector were routinely asked if they had any complaints, but the process for making complaints was not publicised. Staff said that if detainees wanted to make a complaint they would be referred to the duty inspector. However, we observed one detainee requesting an independent police complaints commission form and the custody sergeant was able to locate this form with ease and offered it to the detainee. Custody staff were also aware that they could deal with more immediate low-level complaints.

Expectation

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

Findings

- 5.35 There was no formal system for detainees to report racist incidents, which were dealt with in the same manner as any other complaint (see expectation 5.32).

Expectation

- 5.36 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

- 5.37 An up to date PACE Code of Practice C was held, and all newly arrived detainees were told that it was available on request for them to read. We were told by police staff that detainees or

their legal representatives could obtain a copy of the custody record on release, or at any time within the 12 months following detention, and this was confirmed by the solicitors we met.

Expectation

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

Findings

- 5.39 A pre-release risk management plan had recently been introduced for detainees for whom significant concerns about their well-being while in custody had been flagged. We saw one female detainee being helped to find alternative accommodation before being released, and appropriate referrals to social services were made. Detainees who had alcohol concerns were asked if they wanted to be seen by a drug and alcohol worker.
- 5.40 We observed custody staff booking in a 13-year-old girl. It was her first time in a custody suite, and although staff dealt with her courteously and attempted to allay some of her fears, the booking-in process was not age appropriate. The girl informed custody staff that she had a burn on her shoulder. The custody sergeant on duty ensured that a female police officer looked at the burn before making a decision about whether it was appropriate for medical staff to attend the station. The custody suite was empty and they allowed the juvenile to remain in the holding area instead of being placed in one of the juvenile cells. However, she was left alone on occasions and appeared frightened. Staff made attempts to respond to her needs and showed an awareness of the fact that she was a juvenile, and promptly contacted her parents to attend the custody suite.

Darlington custody suite

- 5.41 Detention was authorised and reviews took place in line with PACE guidelines. Detainees were not routinely offered a free telephone call, but staff contacted family, friends, legal representatives and other third parties on their behalf. Medical and legal advice was freely available, and interpreting services were used when needed. Subject to availability, juveniles and females were allocated to specific cells, and young people were not interviewed without an appropriate adult being present. However, little else was different in the treatment of young people and females, and there were no policies to guide how the specific needs of these groups while in detention could best be met. Use of restraints was minimal and proportionate, and detainees could gain access to their custody record. Court appearances were sometimes delayed. Detainees were not told how to make a complaint, and custody staff did not routinely ask about childcare issues. A pre-release risk management plan had recently been introduced for use with the most vulnerable detainees.

Expectation

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

Findings

- 5.43 Reviews of custody records and discussions with relevant staff indicated that detention was authorised and was overseen by regular reviews at inspector level. We also observed custody sergeants taking steps to expedite bail for detainees when deemed appropriate.

Expectation

- 5.44 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

- 5.45 Booking-in procedures for a number of detainees were observed, and in all cases they were asked if they wanted someone informed of their whereabouts. However, custody staff routinely made a call on their behalf, rather than detainees making the call themselves.
- 5.46 Detainees were not always asked if they wished to see a doctor. Detainees saw a doctor either on request or if the custody sergeant dealing with the admission had any concerns.

Expectation

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

Findings

- 5.48 Detention staff told us that detainees only occasionally required translation services. They used a telephone interpreting service during booking-in procedures, and face-to-face interpreters for interviews with police and solicitors. Solicitors we talked to confirmed that interpreters were provided when needed.

Expectation

- 5.49 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

- 5.50 Whenever possible, juveniles were located in the single designated detention cell, but otherwise juveniles were placed in any spare cell.
- 5.51 There was no policy outlining the management and treatment of young people under 18, and we observed no differences in the way they were dealt with on entry to custody, or in their ongoing management. Custody staff treated juveniles in the same manner as any other detainee with regard to the use of restraints, conduct of strip searching and provision of showers, and they had had no specific training in dealing with them or in child protection matters.
- 5.52 A 15-year-old girl was held in the custody suite, with her mother present as the appropriate adult. The mother requested that she be allowed to stay in the detention room with her daughter while she waited for interview, but this was not allowed. The custody sergeant told us that, regardless of the circumstances, and any risk assessment, they would not allow a relative, guardian or appropriate adult to wait with a detainee in a detention room.
- 5.53 An appropriate adult scheme operated. During working hours on Monday to Friday, this scheme was effective, quickly providing trained and vetted people to take on this role. Out-of-hours and weekend cover was provided by social services, and resources were shared with the Middlesbrough area. Custody staff said that it was usual for juveniles arrested at night to be left without support until the following day, or to be bailed until an appropriate adult could be provided.

Expectation

- 5.54 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

- 5.55 There was no policy for dealing with female detainees. Custody staff did not indicate any awareness of the differential impact of detention on women, and told us that they would be treated similarly to men, apart from being allocated to the one designated female cell when possible.
- 5.56 On one day during the inspection, there were no female staff on duty in the custody suite and other women officers were used to search new female detainees. Although hygiene products were available, women were not routinely informed of this.

Expectation

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

Findings

- 5.58 Custody staff did not routinely ask newly arrived detainees whether they had any childcare issues resulting from their detention. Staff said that if they were made aware of any issues, appropriate action would be taken to ensure the welfare of children.

Expectation

- 5.59 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

- 5.60 Custody staff proactively facilitated contact with legal advisers, and solicitors were provided for newly arrived detainees without undue delay. Detainees were routinely informed that they could have a solicitor present when being interviewed by police officers. Meetings with legal advisers were held in one of the interview rooms, which were adequate. Solicitors we spoke to confirmed this generally positive picture. Custody records and our observations indicated that juveniles were not interviewed unless a relative, guardian or appropriate adult was present.

Expectation

- 5.61 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

- 5.62 We observed cases of detainees who had arrived in the custody suite under the influence of alcohol, and who had been judged by the forensic medical examiner (FME) to be unfit for interview. They would not be interviewed under PACE until the FME deemed them fit.

Expectation

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

Findings

- 5.64 Newly arrived detainees were told about their legal rights. Solicitors were provided through the CDS scheme to all detainees who requested it, although staff were unsure about whether lawyers were available with specific expertise in immigration matters.

Expectation

- 5.65 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

- 5.66 Custody records confirmed that detainees were provided with at least an eight-hour continuous break from interviewing in a 24-hour period, but it was rare for detainees to be held for as long as 24 hours.

Expectation

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

Findings

- 5.68 Custody staff did not use handcuffs in the custody suite unless it was absolutely necessary for the safety of detainees and staff. During the inspection, no detainees in the custody suite were handcuffed or otherwise restrained.

Expectation

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

Findings

- 5.70 GSL was the main escort contractor. The police station was in the same building complex as the magistrates' court, which meant that movements to and from this court were easily facilitated. However, custody staff said that the court closed their lists at around 2pm each day, which they believed could lead to some detainees spending longer periods of time in custody than was necessary.

Expectation

- 5.71 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

- 5.72 Detainees were not told how to make a complaint. Staff told us that if complaints were received, they would be logged in the custody record, and that the duty inspector would be informed. The duty inspector interviewed the complainant in more serious cases.

Expectation

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

Findings

- 5.74 There was no formal system for detainees to report racist incidents, which were dealt with in the same manner as any other complaint (see expectation 5.71).

Expectation

- 5.75 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

- 5.76 An up to date PACE Code of Practice C was held, and all newly arrived detainees were told that it was available on request for them to read. We saw one detainee taking the code of practice to read in his cell. We were told by police staff that detainees or their legal representatives could obtain a copy of the custody record on release, or at any time within the 12 months following detention, and this was confirmed by the solicitors we met.

Expectation

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

Findings

- 5.78 A pre-release risk management plan had recently been introduced for detainees for whom significant concerns about their well-being while in custody had been flagged. Custody staff told us that they would take steps to ensure that a vulnerable person was assisted on release from custody – for example, by arranging for them to have a lift home. We saw care and consideration being shown to detainees leaving custody, and there were three exit plans for which the care offered post-release had been planned for and documented.

Durham custody suite

- 5.79 All detentions were authorised and reviews were completed within the timescales specified under PACE. Detainees were informed of their entitlements and were routinely asked if they wanted to have someone concerned for their welfare informed of their whereabouts. Custody staff treated all detainees according to the PACE code of practice, without paying attention to the specific needs of female and juvenile detainees. Staff had not been trained in child welfare or protection, and female detainees were not told that hygiene products were available. The

CDS scheme worked well and medical staff assessed detainees' fitness for detention and/or interview. Detainees were not taken to courts promptly owing to courts' reluctance to receive them beyond a specified hour. This resulted in detainees spending longer periods in custody than was necessary. A pre-release risk management plan had recently been introduced.

Expectation

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

Findings

- 5.81 All the custody records reviewed detailed the reason for the detention. Records indicated that they were completed within the timescales specified under PACE and covered the necessary legal requirements. Detainees who were under the influence of alcohol and arrested during the night were usually held overnight or until they were sufficiently lucid to be interviewed by police staff. In cases where no further action was taken, the process was completed quickly.

Expectation

- 5.82 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

- 5.83 A notice of entitlements was located at the custody desk and these were pointed out to detainees to read, but they were not given a copy.
- 5.84 We observed a number of detainees being booked in and in all cases they were asked if they wanted to have someone informed of their whereabouts. Usually, custody staff made the calls, but we noted in some custody records that family members had telephoned the custody suite and detainees had been able to speak to them.
- 5.85 Staff were clear about the procedures and the circumstances (for example, to preserve evidence) for which detainees might not be permitted to notify others of their whereabouts and when authorisation was required.
- 5.86 Detainees were not always asked if they wished to see a doctor. Detainees saw a doctor either on request or if the custody sergeant dealing with the admission had any concerns.

Expectation

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

Findings

- 5.88 There was limited translated material in the custody suite, and mainly information about legal advice. A telephone interpreting service was used for detainees who did not speak English, and this was evidenced in custody records we saw.

Expectation

- 5.89 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

- 5.90 There was no separate policy for the detention of juveniles and their treatment, and custody staff told us that all detainees were treated in the same manner and in accordance with PACE. Juveniles were kept in the same holding area as adults until their age was determined, at which point they were held in a detention room. When we enquired about the potential risk that this posed for juveniles, we were told that all detainees in the holding room were accompanied by at least one officer, but we saw the holding area unsupervised.
- 5.91 There were two juvenile detention cells, which were close to the custody desk. However, when these were full, juveniles were located in any available cells. The juvenile detention rooms were not visible from the custody desk, although they were located along the same corridor, so could be easily accessed. Exercise and access to showers and toilets were conducted separately from adult detainees.
- 5.92 Custody staff had not received any specific child welfare or child protection training. One detention custody officer we spoke to knew who to contact if there were child protection concerns and understood the need for sensitivity in conducting strip searches on juveniles.
- 5.93 We were told that juveniles and their appropriate adults would be permitted to wait in the detention room with the door open, or ideally in one of the three interview rooms, if available, but did not witness this.
- 5.94 An appropriate adult scheme was provided by the local Youth Offending Service during working hours on Monday to Friday. A PACE-trained member of staff was placed on a rota to undertake PACE duties in the custody suite, and staff from the Youth Offending Service and the custody suite said that the service was effective. Outside office hours and during the weekend, an appropriate adult scheme was provided by the social services emergency duty team. Custody staff raised no concerns about these arrangements, and in the custody records we reviewed the appropriate adult scheme was rarely needed, as in most cases parents or carers attended.

Expectation

- 5.95 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

- 5.96 During the inspection, there were no female staff in the custody suite. However, we were informed, and custody records indicated, that, when necessary, appropriate arrangements were made for women officers to be present.
- 5.97 Detention custody staff said that, aside from female members of staff dealing with female detainees (and this was largely limited to searching), they treated women no differently. Staff were not aware of the differential impact of detention on women.
- 5.98 Hygiene products were available in the custody suite, but female detainees were not routinely informed of their availability and had to ask staff if they required them.

Expectation

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

Findings

- 5.100 Custody staff did not routinely ask detainees if they had childcare responsibilities, and the generic risk assessment used did not provide any prompts for custody staff to enquire about possible childcare arrangements that might need to be made. We were told that women detainees in particular would usually alert staff to any childcare issues so that appropriate arrangements could be made.

Expectation

- 5.101 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

- 5.102 Custody records clearly indicated whether or not detainees had requested a solicitor. When they declined legal representation, the reasons were sometimes recorded. Detainees were informed that they could request legal representation at any point during their detention if they had initially declined seeing a solicitor. Duty solicitors were contacted through the CDS scheme and attended promptly. Solicitors we spoke to told us that they found custody staff to be professional. There were three interview rooms and access was generally good, but there were sometimes delays when all were in use.

- 5.103 Custody records and our observations indicated that juveniles were not interviewed unless a relative, guardian or appropriate adult was present.

Expectation

- 5.104 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

- 5.105 We observed two detainees under the influence of alcohol and other substances being assessed by the FME for their fitness for detention and/or interview, and the custody sergeant acted on the advice given by the FME. Custody records also showed that staff completed full risk assessments when detainees were able to engage in the process. Detention staff ensured that detainees were not interviewed until fit.

Expectation

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

Findings

- 5.107 Solicitors were provided through the CDS scheme to all detainees who requested it. Custody staff were unsure if there were solicitors available who were specialists in immigration matters.

Expectation

- 5.108 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

- 5.109 Detainees were provided with at least an eight-hour continuous break from interviewing in a 24-hour period. Interview rooms were appropriate and sound-proofed. Solicitors we spoke to did not express any concerns about their clients' treatment.

Expectation

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

Findings

- 5.111 Custody records indicated whether or not detainees were brought into the custody suite in handcuffs. In the majority of the records we reviewed, detainees were handcuffed at the front, and handcuffs were removed once in the holding area of the custody suite. All detainees, including juveniles, were restrained according to the risk they posed. During the inspection, no detainees in the custody suite were handcuffed or otherwise restrained.

Expectation

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

Findings

- 5.113 GSL was the main escort contractor. Custody staff said that the service provided was adequate, and detainees were normally collected for court between 7am and 7.30am. On one day, custody staff had to remind GSL about a detainee, who was eventually collected at 11.15am.
- 5.114 The custody sergeant told us that the local court refused to accept detainees beyond 12.45pm. and otherwise remained in custody until the next day.

Expectation

- 5.115 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

- 5.116 Detainees were not told how to make a complaint. Detainees in custody long enough to have their detention reviewed by an inspector were routinely asked if they had any complaints, but the process for making complaints was not publicised. Staff said that if detainees wanted to make a complaint they would be referred to the duty inspector. There was no process for custody staff to manage low-level complaints.

Expectation

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

Findings

- 5.118 There was no formal system for detainees to report racist incidents, which were dealt with in the same manner as any other complaint (see expectation 5.115).

Expectation

- 5.119 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

- 5.120 An up to date PACE Code of Practice C was held, and all newly arrived detainees were told that it was available on request for them to read. We were told by police staff that detainees or

their legal representatives could obtain a copy of the custody record on release, or at any time within the 12 months following detention, and this was confirmed by the solicitors we met.

Expectation

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

Findings

- 5.122 A pre-release risk management plan had recently been introduced for detainees for whom significant concerns about their well-being while in custody had been flagged. We observed an older detainee being taken home, as he was assessed as vulnerable owing to the impact of his arrest and also because of the level of alcohol still in his system. Detainees who had alcohol concerns were asked if they wanted to be seen by a drug and alcohol worker. However, there was no signposting to services that might be relevant to vulnerable detainees or advice given.

Peterlee custody suite

- 5.123 Detention was authorised and reviews took place in line with PACE guidelines. Detainees were not routinely offered a free telephone call, but staff contacted family, friends, legal representatives and other third parties on their behalf. Medical and legal advice was freely available, and interpreting services were used when needed, although this was rare. Subject to availability, juveniles and females were allocated to specific cells, and young people were not interviewed without an appropriate adult being present. However, little else was different in the treatment of young people and females, and there were no policies to guide how the specific needs of these groups while in detention could best be met. Use of restraints was minimal and proportionate, and detainees could gain access to their custody record. Court appearances were sometimes delayed. Detainees were not told how to make a complaint, and custody staff did not routinely ask about childcare issues. A pre-release risk management plan had recently been introduced for use with the most vulnerable detainees.

Expectation

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

Findings

- 5.125 Reviews of custody records and discussions with relevant staff indicated that detention was authorised and was overseen by regular reviews at inspector level. We also observed custody sergeants taking steps to expedite bail for detainees when deemed appropriate.

Expectation

- 5.126 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

- 5.127 We observed the booking-in procedures for a number of detainees, and in all cases they were asked if they wanted someone to be informed of their whereabouts. However, custody staff routinely made a call on their behalf, rather than detainees making the call themselves.
- 5.128 Detainees were not always asked if they wished to see a doctor. Detainees saw a doctor either on request or if the custody sergeant dealing with the admission had any concerns.

Expectation

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

Findings

- 5.130 Detainees rarely required translation services, but where necessary a telephone translation service was used during booking-in procedures, and face-to-face interpreters for interviews with police staff and solicitors. Solicitors we spoke to confirmed that interpreters were provided when needed.

Expectation

- 5.131 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

- 5.132 Whenever possible, juveniles were located in four designated detention cells, which were located opposite the custody desk for easier monitoring of the occupants. When these cells were full, as was the case on one day during the inspection, juveniles were placed in any spare cell available.
- 5.133 There was no policy outlining the management and treatment of young people under 18, and we observed no differences in the way they were dealt with on entry to custody, or in their ongoing management. Custody staff treated juveniles in the same manner as any other detainee with regard to the use of restraints, conduct of strip searching and provision of showers, and they had had no specific training in dealing with them or in child protection

matters. Custody staff told us that, regardless of the circumstances, and any risk assessment, they would not allow a relative, guardian or appropriate adult to wait with a detainee in a detention room.

- 5.134 An appropriate adult scheme operated. During working hours on Monday to Friday, this scheme was effective, quickly providing trained and vetted people. Out-of-hours and weekend cover was provided by the social services emergency duty team. Custody staff said that it was usual for juveniles arrested at night to be left without support until the following day, or to be bailed until an appropriate adult could be provided.

Expectation

- 5.135 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

- 5.136 There was no policy for dealing with female detainees. Custody staff did not indicate any awareness of the differential impact of detention on women, and told us that they would be treated similarly to men, apart from being allocated to one of the designated female cells.
- 5.137 Newly arrived female detainees were searched by female police staff. However, they were not routinely informed that hygiene products were available.

Expectation

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

Findings

- 5.139 Custody staff did not routinely ask newly arrived detainees about childcare issues. Staff said that if they were made aware of any issues, appropriate action would be taken to ensure the welfare of children.

Expectation

- 5.140 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

- 5.141 Custody staff proactively facilitated contact with legal advisers, and solicitors were provided for newly arrived detainees without undue delay. Detainees were routinely informed that they could have a solicitor present when being interviewed by police officers. Meetings with legal advisers were held in one of the interview rooms, which were adequate. Solicitors we spoke to

confirmed this generally positive picture. Custody records and our observations indicated that juveniles were not interviewed unless a relative, guardian or appropriate adult was present.

Expectation

- 5.142 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

- 5.143 We observed cases of detainees who had arrived in the custody suite under the influence of alcohol, and who had been judged by the FME to be unfit for interview. They would not be interviewed under PACE until the FME deemed them fit.

Expectation

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

Findings

- 5.145 Newly arrived detainees were told about their legal rights. Solicitors were provided through the CDS scheme to all detainees who requested it, although staff were unsure about whether lawyers were available with specific expertise in immigration matters.

Expectation

- 5.146 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

- 5.147 Custody records confirmed that detainees were provided with at least an eight-hour continuous break from interviewing in a 24-hour period, but it was rare for detainees to be held for as long as 24 hours.

Expectation

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

Findings

- 5.149 Custody staff did not use handcuffs in the custody suite unless it was absolutely necessary for the safety of detainees and staff. During the inspection, no detainees in the custody suite were handcuffed or otherwise restrained.

- 5.150 In a recent case, leg restraints had been used with a particularly violent detainee. This had been recorded in the custody record, and indicated that he had been held under such restraint for only a short period of time, until he calmed down.

Expectation

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

Findings

- 5.152 GSL was the main escort contractor and relationships with them were described as good. The police station was in the same building complex as the magistrates' court, which meant that movements to and from this court were easily facilitated. However, custody staff complained that the court closed their lists at around 2pm each day, which they believed could lead to some detainees spending longer periods of time in custody than was necessary.

Expectation

- 5.153 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

- 5.154 Detainees were not told how to make a complaint. Staff told us that if complaints were received, they would be logged in the custody record, and that the duty inspector would be informed. The duty inspector interviewed the complainant in more serious cases.

Expectation

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

Findings

- 5.156 There was no formal system for detainees to report racist incidents, which were dealt with in the same manner as any other complaint (see expectation 5.153).

Expectation

- 5.157 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

- 5.158 An up to date PACE Code of Practice C was held, and all newly arrived detainees were told that it was available on request for them to read. We saw one detainee taking the code of practice to read in his cell. We were told by police staff that detainees or their legal

representatives could obtain a copy of the custody record on release, or at any time within the 12 months following detention, and this was confirmed by the solicitors we met.

Expectation

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

Findings

- 5.160 A pre-release risk management plan had recently been introduced for detainees for whom significant concerns about their well-being while in custody had been flagged. We saw some completed examples of these plans. Custody staff said that they would take steps to ensure that a vulnerable person was assisted on release from custody – for example, by arranging for them to have a lift home.

Recommendations

- 5.161 On admission, detainees should be routinely asked if they need to see a doctor, asked about any childcare issues and offered the opportunity to make a personal telephone call to inform someone of their whereabouts unless there are clear contrary indications.
- 5.162 Custody staff should receive training on the differential impact of custody on different groups of detainees, particularly juveniles (including child protection awareness), women and carers.
- 5.163 The availability of appropriate adults out of normal office hours should be improved.
- 5.164 Subject to individual risk assessment, relatives, guardians or appropriate adults should be allowed to remain with juveniles in detention rooms.
- 5.165 Discussions should be held with the Court Service to ensure that cut-off points for accepting detainees are not too early and thus result in people spending too long in police custody.
- 5.166 Detainees should be given information about how to complain about treatment in custody.
- 5.167 A specific procedure for handling racist incidents and complaints should be introduced.
- 5.168 A strategy should be introduced to ensure the consistency of exit plans, which should recognise the vulnerability of children.

6. Healthcare

- 6.1 There was no overall health strategy underpinning the healthcare needs of detainees, no robust governance arrangements based on current national guidelines and healthcare legislation, and no healthcare policies or protocols. No generic health needs analysis or mental health needs analysis had been undertaken. Senior police management had recognised this and were putting in place plans to address the deficits in service delivery. Recent work with Durham Primary Care Trust (PCT) and The Tees, Esk and Wear Valley National Health Service (NHS) Trust had begun to make major progress to improve health services for detainees. The level and quality of care were inconsistent and we had significant concerns about response times, and in particular about the absence of any managerial process regarding medicines management.

Expectation

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

Findings

- 6.3 Detainees were treated respectfully and the majority of staff tried to ensure that the dignity and privacy of detainees was maintained. We observed good interactions between staff and detainees and there was evidence that staff often worked hard to ensure that detainees had their requests granted, such as specific dietary needs, within reasonable limits, and that they were held in reasonable conditions. Although the majority of forensic medical examiner (FME) rooms had portable screens, only Durham had a vacant/occupied sign outside the FME room, although this was not used. We saw custody staff entering FME rooms directly, without checking if an examination was taking place.

Expectation

- 6.4 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

- 6.5 It was evident that health professionals and drug treatment workers were conscientious and professional in their approach to detainees. The health professionals we met were courteous and proficient and quickly developed good relationships with the detainees. They had also established good working relationships with custody staff. When necessary, interpreting and translation services, including Language Line, were used without restriction.

Expectation

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

Findings

- 6.7 There were no clinical governance arrangements. The constabulary was not involved in any professional training or supervision of health staff. There was no overall comprehensive oversight of the clinical and work practices of FMEs, or of their professional training needs. The force had not undertaken any training needs analysis and there was no overarching policy on the contracted hours of work undertaken by individual FMEs. There was no evidence of systems to check the number of contracted hours worked and the number of hours that FMEs were on call. At times, this had a detrimental effect on optimal response times and on the timely discharge of FMEs' responsibilities towards the health needs of detainees. This, coupled with the recent resignations of experienced FMEs, had led to significant gaps in service, which sometimes resulted in unmet health needs for detainees. Sometimes, FMEs from a neighbouring constabulary were called in to provide emergency cover. As Durham Constabulary had no means of verifying the professional registration, skills or experience of these FMEs, it meant that the quality of their practice was uncertain. In addition, FMEs worked on an individual basis, which meant that there was little or no consistency in their approach to managing detainees. Senior police management had identified this deficit and were putting in place plans to address the problems.
- 6.8 Following a successful pilot scheme, emergency care practitioners (ECPs) now worked alongside FMEs to provide healthcare to detainees. Currently, the ECPs only provided a daytime service, although the PCT was due to introduce 24-hour cover in October 2008. This cohort of ECPs were already in post at local NHS walk-in centres. This new arrangement provided more comprehensive and responsive healthcare delivery.

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 Healthcare was provided by independent FMEs and ECPs. Eleven FMEs, including three women, were on call for the Durham City, Peterlee, Bishop Auckland and Darlington custody suites. We were told that they were all registered with the General Medical Council, were all general practitioners (GPs) and were all approved under Section 12 of the Mental Health Act 1983. However, there was no evidence that Durham Constabulary checked to ensure that annual appraisals on FMEs were carried out, that supervision was provided and accessed, or that continuous professional development was undertaken. The constabulary did not provide any mandatory training for FMEs, although many FMEs had other NHS contracted posts and would therefore be able to access regular professional updating. One FME we spoke to had extensive forensic experience, particularly in relation to work in police custody settings. The professional experience of the FMEs was varied and included GPs working in the community and others who worked in other places of detention, such as prisons.
- 6.11 A team of 50 ECPs provided support to the majority of police stations from their bases, many of which were located in local walk-in centres. While there were limitations to their practice, all were qualified registered nurses, with additional appropriate qualifications in minor illness and accident and emergency nursing, and many were nurse prescribers. The PCT had set

standards for skills and competencies for all ECPs. This included the requirement for nurses to have experience in accident and emergency or minor illness nursing and the ability to suture and interpret X-rays. Before deployment, all nurses undertook a familiarisation course in 'Working in a Custody Suite'. Continuing professional development and clinical supervision was an individual responsibility and strongly supported by the PCT.

Expectation

- 6.12 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

- 6.13 The configuration of FME rooms and the overall standard of cleanliness found in all stations were of vastly differing standards. However, none that we inspected were of a satisfactory standard, either in terms of cleanliness or equipment. Hand washing facilities in all police stations were unsatisfactory, and the sinks were grubby and of the incorrect design. None met infection control criteria and could not be classed as clinically clean. Tops of cupboards were dusty and there was insufficient storage space, with boxes piled on the floor in some suites. In all cases, the layout of the rooms was not conducive to conducting physical examinations, and in some cases privacy was undermined by lack of effective screening and people entering the room when detainees were being assessed (see expectation 6.2). In Bishop Auckland, staff security was compromised owing to the treatment door being wrongly hinged to open away from the health worker, with the desk being between the door and the health worker. The emergency bell was poorly sited on the wall behind the health worker and could not be reached without leaving the desk.
- 6.14 In some custody suites, there was little or no ventilation or natural light. Clinical and domestic waste was often mixed and there did not appear to be a regular collection of clinical waste in any of the custody suites. Sharps bins were not used correctly and some were overflowing. In Peterlee and Bishop Auckland custody suites, there were numerous ligature points in the toilet area within the treatment room. There was no overall governance for the management of treatment rooms and drug cupboards.

Expectation

- 6.15 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

- 6.16 No resuscitation equipment was held in any of the four stations we visited, and there was no evidence that any staff were trained in resuscitation techniques.

Expectation

- 6.17 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

- 6.18 There was 24-hour health support for detainees, although in our detainee survey it was clear that many detainees were not aware of their entitlement to see a healthcare professional while in custody. Although this view was confirmed by custody officers, it did not appear that there was any reluctance on the part of custody staff to call for a healthcare professional. There were significant differences between the response times of FMEs and ECPs, especially between 9am and 5pm. Response times for FMEs ranged between less than an hour to over four hours, and often detainees had to wait until the FME had finished clinics in their own practices before attending the police station. All custody staff confirmed that they would send a detainee to hospital without hesitation if they had significant concerns about their health and an FME could not attend immediately. Conversely, officers told us that ECP response times were quick, usually within the hour. In the Peterlee custody suite, there were gaps in the FME rota due to unavailability of FMEs. Where necessary, detainees were sent to the local community hospital for assessment and advice on continuing management while in custody.
- 6.19 There were procedures to ensure that detainees received their medication while in custody. However, the times when detainees received their medication varied greatly and depended on what the medication was. Custody staff contacted FMEs when detainees declared their use of medication. Following verification of the medication with either the detainee's GP, family or drug treatment centre, the FME was contacted again and, with the approval of the FME, custody staff gave the detainee the medication. Under Police and Criminal Evidence Act (PACE) regulations, the administration of controlled drugs had to be undertaken by a qualified medical practitioner; this often led to significant delays, especially in the case of a detainee requiring methadone support. In an effort to resolve this, police, having verified the medication and taken further instructions from the FME, would take the detainee to the nearest pharmacy for the drug to be administered by the pharmacist.
- 6.20 None of the FME rooms contained a fax machine, and ECPs told us that they took verbal orders for medication from FMEs, without a written prescription. This did not meet the standards for practice of administration of medicines as defined by the Nursing and Midwifery Council.

Expectation

- 6.21 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

- 6.22 We were not aware of any mental health needs assessment having been carried out for those held in police custody. From April 2008, the Tees, Esk and Wear Valley NHS Trust was responsible for providing mental health support to police stations in the Durham Constabulary,

as well as courts, probation services and community teams. Although relatively new, the service was highly regarded by police, who felt well supported by the criminal justice liaison nurse (CJLN). Only one of two CJLN posts had been filled at the time of the inspection. The present incumbent was very experienced. As part of a mental health trust, the CJLN had access to additional support and expertise, as well as supervision and training.

- 6.23 Response times to call-outs were good and support was available between 9am and 5pm Monday to Friday. Out-of-hours support was provided by FMEs and community crisis intervention teams. The CJLN phoned police stations every morning to check if there were any detainees needing support. If necessary, she visited detainees, assessed them and formulated a care plan for their time in custody. She advised custody staff in their management and wrote a synopsis of the case onto the National Strategy for Police Information Systems (NSPIS) system. Community mental health teams were informed of any assessment or treatments provided to their patients while in custody. Detainees released into the community who were not under the care of community mental health teams were offered the support of the CJLN for up to six weeks after release from police custody. The CJLN worked closely with arrest referral workers when there was evidence of dual diagnosis (detainees with drug and mental health needs).
- 6.24 The CJLN was able to instigate and participate in the mental health assessment and admission of detainees under section or voluntarily through the crisis intervention team. Where possible, the CJLN accompanied the detainee to hospital to provide continuing support and ensure that all relevant information was passed to the receiving healthcare professionals. Staff at the Peterlee police station, which was covered by a different mental health trust, told us that mental health support there was unsatisfactory, with significant delays in responding to requests for detainees to be seen. Staff there felt unsupported.
- 6.25 While custody officers provided as much support as possible to detainees, they had received no mental health awareness training and many felt that this was a significant gap in their training.
- 6.26 A Trust steering group was in place, with wide representation of standing members drawn from public health and social care agencies and Durham Constabulary. This ensured that there was a robust management and professional framework to support the CJLNs. It was reported that there were clear protocols in place for referral and terms of engagement with detainees, although we were not supplied with them.

Expectation

- 6.27 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

- 6.28 Despite no specific funding for alcohol issues, there was good support for substance users from arrest referral workers in all police stations. Generally, arrest referral workers were in police stations between 9am and 5pm Monday to Friday. As well as checking with custody staff, arrest referral workers had established the practice of visiting the cells at least every hour to offer advice and information, including signposting to community drug treatment and support services for those who wanted it. Many detainees had established alcohol problems. Those known to the worker were referred to the appropriate treatment centre and followed up there.

Detainees from out of area or unknown to them were referred to local drugs intervention programme (DIP) teams and appointments made for as soon as possible after release from the police stations. When a detainee with alcohol problems was remanded to prison, the arrest referral worker contacted the establishment concerned to advise staff there of what assessments and treatment, if any, had been carried out. Documentation was forwarded to that prison.

Expectation

- 6.29 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

- 6.30 In general, there were good arrangements in place with the local mental health trusts to ensure that detainees with mental health needs were taken either to the local accident and emergency department if physical treatments were required, or to a relevant psychiatric unit for assessment. It was only when the detainees needed to be controlled for their own safety or the safety of others that Section 136 was used. No police station kept a central register of details relating to the number of detainees subject to assessment under Section 136.²

Expectation

- 6.31 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

- 6.32 The records of all clinical examinations were kept by the professional making the entry. FMEs held their own individual records, which they stored either in their personal offices or homes. ECPs held their records at their work bases. We were told that records were kept in secure locations. No clinical records were left on site, so we were unable to evidence any standards of record keeping. Summarised entries onto custody records were made by health professionals, and those we checked were of an appropriate standard. The ethnicity of the detainee was entered by custody staff onto the custody records.

Expectation

- 6.33 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.

² 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.

Findings

- 6.34 Any contact with a health professional was entered onto the custody record; this included any medication given and the need for closer observation. Detainees were informed of examination results and asked to sign a consent form to allow their lawyer access to clinical records.

Expectation

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

Findings

- 6.36 We were told that detainees seen by health workers were asked for their permission to allow the attending health worker to share relevant health information with other appropriate health and social care agencies but we saw no protocols.

Expectation

- 6.37 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

- 6.38 The management of medicines at all custody suites was wholly unsatisfactory. There were no overarching policies on the procurement, receipt, storage, administration or disposal of medicines, including controlled drugs. Medicine cabinets were available in treatment rooms, although we were unable to access all of them because the FME had the keys. Those that we did access held a variety of drugs. In Bishop Auckland, we found a bottle of patient-named methadone liquid dated 4 June 2008. This was not recorded anywhere and no one knew where it came from. In Darlington, a pack that should have contained two containers of fluid for emergency eye baths had one container missing, while the other was 10 years out of date.
- 6.39 In Peterlee, it was the accepted practice that prescribed controlled drugs removed from the detainee on reception were placed in an unsecured plastic bag alongside other clothing and belongings. Under current medicines legislation, all controlled drugs should be locked in a cupboard within another locked cupboard. In Durham, staff showed us a cupboard that held over-the-counter remedies such as ibuprofen and paracetamol. However, the cupboard also held two types of bronchial inhaler, which were given to different detainees at different times. None of the custody suites had a central register of what was given to whom, by whom and when.
- 6.40 Pharmacy reference books and limited clinical policies were available in some police stations but the majority were out of date. There were no relevant medicine policies or protocols meeting current national guidance and legislation in any of the police stations in the constabulary area.

Recommendations

- 6.41 The force should commission a health-focused organisation, such as the primary care trust (PCT), to provide the expertise to identify, equip and manage medical facilities within custody suites. This should include an infection control audit.
- 6.42 Sharps bins should be managed appropriately and exchanged regularly. They should not be used for general waste.
- 6.43 Clinical governance arrangements should be established, to include the management, training, supervision and accountability of clinical staff. These arrangements should be informed by robust risk assessment, audit and monitoring systems, with appropriate learning from findings, action planning and timely implementation.
- 6.44 There should be sufficient health services professionals to provide timely, consistent and competent healthcare services.
- 6.45 Clinical examinations should be conducted with due regard for decency, privacy and dignity.
- 6.46 Protocols for sharing information with all appropriate partner agencies should be developed.
- 6.47 Health services staff should receive ongoing training, supervision and support to maintain their professional registration and development, and this should be evidenced.
- 6.48 Appropriate resuscitation equipment in a 'grab bag' or similar should be easily accessible by all staff (health services and custody), who should know where it is and how to use it effectively. There should be weekly documented checks of all resuscitation equipment.
- 6.49 All clinical records should be held in accordance with Caldicott guidelines, be contemporaneous and conform to professional guidance from the relevant regulatory body, such as the General Medical Council or Nurse/Midwifery Council.
- 6.50 Police and Criminal Evidence (PACE) regulations should be reviewed to allow registered nurses to administer prescribed controlled drugs to detainees.
- 6.51 Nurses should only accept verbal orders from FMEs for medicines in exceptional circumstances. Any verbal orders must be supported by the completed prescription in fax, text message or email format at the time of the administration.
- 6.52 All medications on site should be stored safely and securely, and unused medication disposed of safely.
- 6.53 The force should identify a robust system to ensure the safe management and use of all pharmaceutical items. This should include stock levels of all medicines held at all police stations.
- 6.54 Custody suites should provide appropriate accommodation for health services professionals to interview detainees in a confidential setting.

- 6.55 The emergency call bell in the FME room in the Bishop Auckland custody suite should be moved to a more appropriate site – for example, under the desk top.
- 6.56 The force should review the mental health support given to detainees held at Peterlee to ensure that they receive appropriate specialist care during detention.
- 6.57 The FME rooms should be fit for purpose. This should include a daily cleaning schedule and removal of waste.
- 6.58 All police stations should keep a detailed central register of the occasions when the station is used as a place of safety.

7. Summary of recommendations

Strategy

To Durham Constabulary

- 7.1 A clear strategy for the future of custodial provision should be agreed and custody matters should be routinely included in relevant force planning documents. (3.22)
- 7.2 A health strategy based on a needs analysis should be agreed utilising National Health Service (NHS) support. The strategy should ensure that sufficient health services, including forensic medical examiner (FME) cover, are provided and outline an effective working framework for FMEs and emergency care practitioners (ECP). (3.23)
- 7.3 Staffing of custody suites should be managed to ensure consistent working practices across all custody suites in the north and south of the force and to reflect the pressures faced by busier custody suites. (3.24)
- 7.4 An effective system of intrusive supervision into custodial matters should be introduced at inspector rank, with consistent audit trails detailing their findings, observations and follow-up action. (3.25)
- 7.5 A formal force-wide policy should be developed which deals with cell bell usage and staff responses. (3.26)
- 7.6 Greater effort should be made to utilise management information within the National Strategy for Police Information Systems (NSPIS) custody system to achieve a better understanding of the profile of detainees. (3.27)
- 7.7 Specific policies in relation to the treatment of young people, women and immigration detainees should be introduced. (3.28)
- 7.8 The force should develop a custody intranet site, which should include all relevant policies and be linked to the 'Lessons Learned' newsletters from the Independent Police Complaints Commission. (3.29)
- 7.9 A clear complaints policy should be advertised in custody suites and the number and nature of complaints should be analysed centrally so that underlying causes of complaints can be identified with a view to solving any problems. (3.30)
- 7.10 The force should urgently review how it stores, tracks and submits all DNA and forensic samples taken from detainees. A robust series of control mechanisms should be introduced which facilitate intrusive monitoring of performance in this area. Performance should be reviewed by a senior officer who has responsibility for ensuring its delivery. (3.31)

Treatment and conditions

To Durham Constabulary

- 7.11 Booking in and discharge arrangements should be improved so that detainees are dealt with at a desk of an appropriate height and which allows sufficient privacy for confidential information to be passed. (4.124)
- 7.12 Appropriate supervised seating areas should be provided for detainees waiting to be booked in, who should not have to wait for prolonged periods in vans. (4.125)
- 7.13 Holding facilities, interview rooms and the exercise yard area should be made less austere and all cell areas kept clean. (4.126)
- 7.14 Risk assessments should be based on individual risk and take into account the needs of specific groups such as women and children. (4.127)
- 7.15 All custody staff should carry personal cell keys and anti-ligature knives. (4.128)
- 7.16 An entry in the custody record should be kept of all occasions and the reasons when a member of staff has access to a detainee held in the custody suite. (4.129)
- 7.17 All staff working in custody suites should be up to date with training which includes the management of detainees, risk assessment, mental health awareness training and gender- and child-specific issues. (4.130)
- 7.18 Basic information about what to expect in custody and what facilities can be requested should be explained to detainees and available in booklets and/or posters. (4.131)
- 7.19 Detainees should be offered meals at appropriate intervals and this should be recorded in custody records. (4.132)
- 7.20 All showers should provide appropriate privacy. (4.133)
- 7.21 Items to meet basic needs, such as pillows, toilet paper, sanitary products, and reading materials should be routinely available unless their removal can be justified by an individual risk assessment. (4.134)
- 7.22 Staff should explain the use of the call bell to detainees and this should be recorded. (4.135)
- 7.23 Detainees should be held in suitable ventilated and heated cells with natural light, sanitation and washing facilities which can be used independently and in suitable privacy. (4.136)
- 7.24 When required, detainees should be provided with appropriate alternative clothing and paper suits used only when absolutely necessary. (4.137)
- 7.25 Young people under 18 should be held in well supervised accommodation and dealt with taking into account their legal status and vulnerabilities as children, including an awareness of child protection issues. (4.138)
- 7.26 Fire evacuation plans should be practised regularly. (4.139)

Individual rights

To Durham Constabulary

- 7.27 On admission, detainees should be routinely asked if they need to see a doctor, asked about any childcare issues and offered the opportunity to make a personal telephone call to inform someone of their whereabouts unless there are clear contrary indications. (5.161)
- 7.28 Custody staff should receive training on the differential impact of custody on different groups of detainees, particularly juveniles (including child protection awareness), women and carers. (5.162)
- 7.29 The availability of appropriate adults out of normal office hours should be improved. (5.163)
- 7.30 Subject to individual risk assessment, relatives, guardians or appropriate adults should be allowed to remain with juveniles in detention rooms. (5.164)
- 7.31 Discussions should be held with the Court Services to ensure that cut-off points for accepting detainees are not too early and thus result in people spending too long in police custody. (5.165)
- 7.32 Detainees should be given information about how to complain about treatment in custody. (5.166)
- 7.33 A specific procedure for handling racist incidents and complaints should be introduced. (5.167)
- 7.34 A strategy should be introduced to ensure the consistency of exit plans, which should recognise the vulnerability of children. (5.168)

Healthcare

To the Home Secretary

- 7.35 Police and Criminal Evidence (PACE) regulations should be reviewed to allow registered nurses to administer prescribed controlled drugs to detainees. (6.50)

To Durham Constabulary

- 7.36 The force should commission a health-focused organisation, such as the primary care trust, to provide the expertise to identify, equip and manage medical facilities within custody suites. This should include an infection control audit. (6.41)
- 7.37 Sharps bins should be managed appropriately and exchanged regularly. They should not be used for general waste. (6.42)
- 7.38 Clinical governance arrangements should be established, to include the management, training, supervision and accountability of clinical staff. These arrangements should be informed by

robust risk assessment, audit and monitoring systems, with appropriate learning from findings, action planning and timely implementation. (6.43)

- 7.39 There should be sufficient health services professionals to provide timely, consistent and competent healthcare services. (6.44)
- 7.40 Clinical examinations should be conducted with due regard for decency, privacy and dignity. (6.45)
- 7.41 Protocols for sharing information with all appropriate partner agencies should be developed. (6.46)
- 7.42 Health services staff should receive ongoing training, supervision and support to maintain their professional registration and development, and this should be evidenced. (6.47)
- 7.43 Appropriate resuscitation equipment in a 'grab bag' or similar should be easily accessible by all staff (health services and custody), who should know where it is and how to use it effectively. There should be weekly documented checks of all resuscitation equipment. (6.48)
- 7.44 All clinical records should be held in accordance with Caldicott guidelines, be contemporaneous and conform to professional guidance from the relevant regulatory body, such as the General Medical Council or Nurse/Midwifery Council. (6.49)
- 7.45 Nurses should only accept verbal orders from FMEs for medicines in exceptional circumstances. Any verbal orders must be supported by the completed prescription in fax, text message or email format at the time of the administration. (6.51)
- 7.46 All medications on site should be stored safely and securely, and unused medication disposed of safely. (6.52)
- 7.47 The force should identify a robust system to ensure the safe management and use of all pharmaceutical items. This should include stock levels of all medicines held at all police stations. (6.53)
- 7.48 Custody suites should provide appropriate accommodation for health services professionals to interview detainees in a confidential setting. (6.54)
- 7.49 The emergency call bell in the FME room in the Bishop Auckland custody suite should be moved to a more appropriate site – for example, under the desk top. (6.55)
- 7.50 The force should review the mental health support given to detainees held at Peterlee to ensure that they receive appropriate specialist care during detention. (6.56)
- 7.51 The FME rooms should be fit for purpose. This should include a daily cleaning schedule and removal of waste. (6.57)
- 7.52 All police stations should keep a detailed central register of the occasions when the station is used as a place of safety. (6.58)

Appendix I: Inspection team

Michael Loughlin	-	HMIP team leader
Paddy Craig	-	HMIC inspector
James Rampton		HMIC inspection support manager
Sara Snell	-	HMIP inspector
Sean Sullivan	-	HMIP inspector
Karen Dillon	-	HMIP inspector
Vinnett Percy	-	HMIP inspector
Bridget McEvilly	-	HMIP healthcare inspector
Marilyn Handsford	-	Lead assessor Health Care Commission
Rachel Murray	-	HMIP researcher

Appendix II: Detainee survey

Detainee survey methodology

A voluntary, confidential and anonymous survey of the detainee population 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 27 and 28 August 2008. Two lists of detainees who had been through Durham police stations were created. The first listed those from the county of Durham; the second listed those who had come from the Magistrates Courts of Darlington, Consett, Bishop Auckland, Peterlee or Durham Crown Court, which receive those charged at Durham stations.

Selecting the sample

Fifty-four prisoners were identified and approached from the list indicating contact with Durham Constabulary. The list of those from the county of Durham was very small and had no wing locations, so only a handful of these individuals were found. Three prisoners could not be found. From those approached, 21 prisoners reported being held in police stations outside of Durham, or outside of our one-month time period.

In total, 30 questionnaires were handed out. One prisoner refused to take a survey.

Completion of the questionnaire was voluntary. If a prisoner had literacy problems, they were offered a joint interview by the research team and HMIC. No prisoners required an interview.

Methodology

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

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

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

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

Response rates

In total, 29 (97%) respondents completed and returned their questionnaires.

One prisoner (3%) refused to accept a survey.

Section 1: About You

Q1	What police station were you last held at?	Peterlee (8), Darlington (7), Durham (7), Newton Aycliffe (2), Bishop Auckland (3) and Consett (2)	
Q2	What type of detainee were you?	<i>Police detainee</i> 83% <i>Prison lock-out (i.e. you were in custody in a prison before coming here)</i> 3% <i>Immigration detainee</i> 3% <i>I don't know</i> 7%	
Q3	How old are you?	<i>16 years or younger</i> 0% <i>40-49 years</i> 3% <i>17-21 years</i> 0% <i>50-59 years</i> 3% <i>22-29 years</i> 69% <i>60 years or older</i> 0% <i>30-39 years</i> 24%	
Q4	Are you:	<i>Male</i> 97% <i>Female</i> 0% <i>Transgender/Transsexual</i> 3%	
Q5	What is your ethnic origin?	<i>White - British</i> 90% <i>White - Irish</i> 0% <i>White - Other</i> 0% <i>Black or Black British - Caribbean</i> 3% <i>Black or Black British - African</i> 0% <i>Black or Black British - Other</i> 0% <i>Asian or Asian British - Indian</i> 0% <i>Asian or Asian British - Pakistani</i> 0% <i>Asian or Asian British - Bangladeshi</i> 0% <i>Asian or Asian British - Other</i> 0% <i>Mixed Race - White and Black Caribbean</i> 0% <i>Mixed Race - White and Black African</i> 0% <i>Mixed Race - White and Asian</i> 3% <i>Mixed Race - Other</i> 0% <i>Chinese</i> 0% <i>Other ethnic group</i> 3%	
Q6	Are you a foreign national (i.e. you do not hold a British passport, or you are not eligible for one)?	<i>Yes</i> 3% <i>No</i> 90%	
Q7	What, if any, would you classify as your religious group?	<i>None</i> 34% <i>Church of England</i> 52% <i>Catholic</i> 14% <i>Protestant</i> 0% <i>Other Christian denomination</i> 0% <i>Buddhist</i> 0% <i>Hindu</i> 0% <i>Jewish</i> 0% <i>Muslim</i> 0% <i>Sikh</i> 0%	
Q8	How would you describe your sexual orientation?	<i>Straight / Heterosexual</i> 93% <i>Gay / Lesbian / Homosexual</i> 0% <i>Bisexual</i> 3%	

Q9	Do you consider yourself to have a disability?	
	Yes.....	14%
	No.....	83%
	Don't know.....	0%
Q10	Have you ever been held in police custody before?	
	Yes.....	93%
	No.....	7%

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.....		3%	
	More than 1 hour, but less than 6 hours.....		3%	
	More than 6 hours, but less than 12 hours.....		7%	
	More than 12 hours, but less than 24 hours.....		14%	
	More than 24 hours, but less than 48 hours (2 days).....		31%	
	More than 48 hours (2 days), but less than 72 hours (3 days).....		21%	
	72 hours (3 days) or more		17%	
Q12	Were you given information about your arrest and your entitlements when you arrived there?			
	Yes.....		66%	
	No.....		21%	
	Don't know/Can't remember		14%	
Q13	Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')?			
	Yes.....		41%	
	No.....		41%	
	I don't know what this is/I don't remember.....		17%	
Q14	If your clothes were taken away, were you offered different clothing to wear?			
	My clothes were not taken.....		55%	
	I was offered a tracksuit to wear.....		10%	
	I was offered an evidence suit to wear		24%	
	I was offered a blanket		0%	
Q15	Could you use a toilet when you needed to?			
	Yes.....		83%	
	No.....		14%	
	Don't Know.....		3%	
Q16	If you have used the toilet there, were these things provided?			
		Yes	No	
	Toilet paper	45%	45%	
	Sanitary protection	0%	34%	
Q17	Did you share a cell at the police station?			
	Yes.....		10%	
	No.....		90%	
Q18	How would you rate the condition of your cell:			
		Good	Neither	Bad
	Cleanliness	31%	34%	34%
	Ventilation / Air Quality	14%	31%	52%

Temperature	14%	31%	52%
Lighting	45%	24%	17%

Q19	Was there any graffiti in your cell when you arrived?	
	Yes.....	59%
	No.....	41%
Q20	Did staff explain to you the correct use of the cell bell?	
	Yes.....	14%
	No.....	83%
Q21	Were you held overnight?	
	Yes.....	83%
	No.....	17%
Q22	If you were held overnight, which items of clean bedding were you given?	
	Not held overnight.....	17%
	Pillow.....	3%
	Blanket.....	33%
	Nothing.....	47%
Q23	Were you offered a shower at the police station?	
	Yes.....	10%
	No.....	90%
Q24	Were you offered any period of outside exercise whilst there?	
	Yes.....	10%
	No.....	90%
Q25	Were you offered anything to:	
		Yes No
	Eat?	72% 28%
	Drink?	76% 24%
Q26	Was the food/drink you received suitable for your dietary requirements?	
	I did not have any food or drink.....	14%
	Yes.....	21%
	No.....	59%
Q27	If you smoke, were you offered anything to help you cope with the smoking ban there?	
	I do not smoke.....	14%
	I was allowed to smoke.....	0%
	I was not offered anything to cope with not smoking.....	62%
	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.....	7%
	No.....	72%
Q29	Was someone informed of your arrest?	
	Yes.....	34%
	No.....	34%
	I don't know.....	7%
	I didn't want to inform anyone.....	3%
Q30	Were you offered a free telephone call?	
	Yes.....	38%
	No.....	41%

Q31	If you were denied a free phone call, was a reason for this offered?		
	<i>My phone call was not denied</i>		38%
	Yes.....		0%
	No.....		38%
Q32	Did you have any concerns about the following, whilst you were in police custody:		
		Yes	No
	Who was taking care of your children	10%	34%
	Contacting your partner, relative or friend	41%	21%
	Contacting your employer	17%	28%
Q33	Where you were going once released		
		31%	31%
Q34	Were you interviewed by police officials about your case?		
	Yes.....		66%
	No.....		14%
Q35	Were any of the following people present when you were interviewed?		
		Yes	No
	Solicitor	48%	21%
	Appropriate Adult	3%	7%
	Interpreter	3%	7%
Q36	Not needed		
		7%	28%
		24%	
Q37	How long did you have to wait for your solicitor?		
	<i>I did not requested a solicitor</i>		21%
	2 hours or less.....		10%
	Over 2 hours but less than 4 hours		14%
	4 hours or more.....		45%
Q38	Were you officially charged?		
	Yes.....		69%
	No.....		21%
	Don't Know.....		7%
Q39	How long were you in police custody <u>after</u> being charged?		
	<i>I have not been charged yet</i>		21%
	1 hour or less.....		7%
	More than 1 hour, but less than 6 hours.....		7%
	More than 6 hours, but less than 12 hours.....		7%
	12 hours or more.....		55%

Section 3: Safety

Q38	Did you feel safe there?		
	Yes.....		48%
	No.....		48%
Q39	Had another detainee or a member of staff victimised (insulted or assaulted) you there?		
	Yes.....		41%
	No.....		55%
Q40	If you have felt victimised, what did the incident involve? (Please tick all that apply)		
	<i>I have not been victimised</i>		36%
	<i>Because of your crime</i>		11%
	<i>Insulting remarks (about you, your family or friends)</i>		18%
	<i>Because of your sexuality</i>		0%
	<i>Physical abuse (being hit, kicked or assaulted)..</i>		11%
Q41	<i>Because you have a disability</i>		0%
	<i>Sexual abuse</i>		2%
Q42	<i>Because of your religion/religious beliefs</i>		2%

Your race or ethnic origin	2%	Because you are from a different part of the country than others.....	0%
Drugs.....	14%		

- Q41** Were you handcuffed or restrained whilst in the police custody suite?
Yes 48%
No 45%
- Q42** Were you injured whilst in police custody, in a way that you feel was not your fault?
Yes 24%
No 72%
- Q43** Were you told how to make a complaint about your treatment here, if you needed to?
Yes 10%
No 86%

Section 4: Healthcare

- Q44** When you were in police custody were you on any medication?
Yes 41%
No 55%
- Q45** Were you able to continue taking your medication whilst there?
Not taking medication 55%
Yes 10%
No 31%
- Q46** Did someone explain your entitlements to see a healthcare professional, if you needed to?
Yes 21%
No 66%
Don't know 10%
- Q47** Were you seen by the following healthcare professionals during your time there?
- | | Yes | No |
|--------------|-----|-----|
| Doctor | 28% | 62% |
| Nurse | 3% | 69% |
| Paramedic | 0% | 69% |
| Psychiatrist | 7% | 62% |
- Q48** Were you able to see a healthcare professional of your own gender?
Yes 17%
No 52%
Don't know 24%
- Q49** Did you have any drug or alcohol problems?
Yes 69%
No 31%
- Q50** Did you see, or were offered the chance to see a drug or alcohol support worker?
I didn't have any drug/alcohol problems 31%
Yes 10%
No 59%
- Q51** Were you offered relief or medication for your immediate symptoms?
I didn't have any drug/alcohol problems 31%

Yes..... 14%
No..... 52%

- Q52 Please rate the quality of your healthcare whilst in police custody:**
- | | I was not
seen by
health -care | <i>Very Good</i> | <i>Good</i> | <i>Neither</i> | <i>Bad</i> | <i>Very Bad</i> |
|-----------------------|---|------------------|-------------|----------------|------------|-----------------|
| Quality of Healthcare | 34% | 7% | 7% | 7% | 17% | 24% |
- Q53 Did you have any specific physical healthcare needs?**
- No..... 52%
Yes..... 45%
- Q54 Did you have any specific mental healthcare needs?**
- No..... 69%
Yes..... 31%
Please specify: Peterlee:
'Paranoia and depression'

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.

- Q55 Were you told that you would be held in a police station, rather than a prison, before you arrived there?**
- Yes..... 28%
No..... 38%
- Q56 How long did you spend in the escort van before arriving there?**
- Less than 1 hour..... 34%
More than 1 hour, but less than 2 hours..... 17%
More than 2 hours, but less than 3 hours..... 10%
More than 3 hours, but less than 4 hours..... 3%
More than 4 hours..... 0%
- Q57 Were you offered the chance to let family/friends know where you were?**
- Yes..... 45%
No..... 21%
- Q58 Did your property come with you to the police station?**
- Yes..... 38%
No..... 24%
I don't know 3%
- Q59 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***..... 48%
Less than 1 hour..... 7%
More than 1 hour, but less than 2 hours..... 3%
More than 2 hours, but less than 3 hours..... 0%
More than 3 hours, but less than 4 hours..... 0%
More than 4 hours..... 3%

Thank you for your time.