



Inspecting policing  
in the public interest

# Report on an inspection visit to police custody suites in Leicestershire Constabulary

24 – 26 August 2009

by

HM Inspectorate of Prisons and

HM Inspectorate of Constabulary

Crown copyright 2010

Printed and published by:  
Her Majesty's Inspectorate of Prisons  
and Her Majesty's Inspectorate of Constabulary

Ashley House  
2 Monck Street  
London SW1P 2BQ  
England

# Contents

1. Introduction	5
2. Background and key findings	7
3. Strategy	11
4. Treatment and conditions	15
5. <b>Individual rights</b>	21
6. Healthcare	25
7. Summary of recommendations	31

## Appendices

---

I Inspection team	35
II Custody record analysis	36
III Summary of detainee questionnaires and interviews	38



# 1. Introduction

This inspection of police custody suites in Leicestershire is part of a programme of work by HM Inspectorate of Constabulary and HM Inspectorate of Prisons. These inspections form part of a wider programme of joint work by the chief inspectors of criminal justice. They also contribute to the United Kingdom's compliance with its international obligation to ensure regular independent inspection of all places of custody<sup>1</sup>. Each inspection examines force-wide strategies, treatment and conditions, individual rights and healthcare.

At the time of the inspection, Leicestershire Constabulary had five custody suites designated under the Police and Criminal Evidence Act (PACE) for the reception of detainees. Those at Beaumont Leys, Keyham Lane, Loughborough and Wigston operated 24 hours a day, while that in Coalville only opened at weekends. The largest suite, Euston Street in Leicester, was closed for refurbishment. In addition, inspectors visited two non-designated suites at Melton Mowbray and Oakham. In 2008–09, 27,810 detainees were held in Leicestershire's custody suites, for an average of eight hours and 47 minutes each.

Management structures were sound and all staff working in custody were permanent. However, there were a number of detention officer vacancies and some staff, particularly at Keyham Lane, were stretched. There was a positive working relationship with the Police Authority, and independent custody visitors reported excellent relationships with the force and a willingness to act on their feedback. There was also good partnership working with the Crown Prosecution Service, but staff expressed frustration at the slowness of the UK Border Agency in dealing with immigration detainees.

Detainees were generally treated respectfully, although the condition of some accommodation was poor and we welcomed the intention to take the worst out of use once Euston Street reopened. Better privacy arrangements were required for toilets and showers. The provision of food and drinks was satisfactory. Insufficient attention was paid to the particular needs of women, juveniles and detainees with disabilities. While there was an appropriate focus on risk assessment, too many cells had ligature points and not all had camera cover. Use of force was not well recorded and this inhibited monitoring of trends and patterns by managers.

Custody sergeants rigorously applied PACE codes of practice and ensured that detainees received their entitlements. However, children aged 17 were not given access to an appropriate adult. Detainees were not told how to complain and there was no system to manage racist complaints. As reported in a number of other forces, there were serious deficiencies in the storage and management of DNA and forensic samples.

Healthcare arrangements were generally good and ensured that the physical health, mental health and substance use needs of detainees were met. Indeed, services for those with drug and alcohol problems were among the best we have seen. There was scope to further develop clinical governance and oversight of service provision. In particular, the response times of health professionals required better monitoring. Clinical rooms needed to be better maintained and cleaned.

This inspection of Leicestershire Constabulary police custody suites has identified much good practice, but also some areas of concern, a number of which are common across other forces that we have visited. We hope that, by reinforcing good practice and pointing to areas for

---

<sup>1</sup> Optional Protocol to the United Nations Convention on the Prevention of Torture and Inhumane or Degrading Treatment.

improvement, senior officers and the Police Authority will be assisted to make further progress with the provision of custody in their force area.

Denis O'Connor  
HM Chief Inspector of Constabulary

Anne Owers  
HM Chief Inspector of Prisons

October 2009

## 2. Background and key findings

- 2.1 HM Inspectorates of Prisons and Constabulary are undertaking a programme of joint inspections of police custody suites, as part of the UK's international obligation to ensure regular independent inspection of places of detention. These inspections do not look only at the implementation of the Police and Criminal Evidence Act (PACE) codes (1984) and guidance on the safer detention and handling of persons in police custody (2006). They are also informed by *Expectations* about the appropriate treatment of detainees and conditions of detention, which have been developed by the two inspectorates to assist best custodial practice.
- 2.2 At the time of the inspection, Leicestershire Constabulary had five custody suites designated under PACE for the reception of detainees. Beaumont Leys, Keyham Lane, Loughborough and Wigston operated 24 hours a day and dealt with detainees arrested as a result of mainstream policing. Coalville was a part-time custody suite that was opened at weekends to deal with bail returners. The largest custody suite in the force area at Euston Street, Leicester, was closed for refurbishment. When it re-opened, the plan was to close Beaumont Leys. There were two non-designated suites at Melton Mowbray and Oakham. This inspection was mainly conducted in the five designated custody suites, but visits were made to all suites operating in the force area and the closed Euston Road. A survey of prisoners at HMP Leicester, who had formerly been detained at custody suites in the force area, was conducted by HM Inspectorate of Prisons researchers and a HM Inspectorate of Constabulary staff officer to obtain additional evidence (see appendix III).
- 2.3 The force cell capacity when Euston Street re-opened would be 77, but at the time of the inspection it was 55 on weekdays and 63 at weekends. In 2008-09, 27,810 detainees had been held in force custody suites, with Euston Street holding the greatest number at 10,428. The projection for 2009-10 was that this would drop to 27,000. A small number (12) of detainees had been held out of area since June 2009 at Nuneaton. Suites held a mixture of adults, juveniles and immigration detainees. The average length of time spent in police custody was eight hours 47 minutes.
- 2.4 Comments in this report refer to all suites unless specifically stated otherwise.

### Strategic overview

---

- 2.5 There was a clear and understandable line management structure from the Assistant Chief Constable (ACC) crime to detention officers working in custody suites. All staff working in custody were permanent and designated sites were managed centrally. The staffing model used was a concern in relation to the number of detention officers deployed.
- 2.6 A clear estates policy was focused on updating all custody facilities in line with the safer detention and handling of persons in police custody guidance (2006). The largest custody suite was closed, which was increasing pressure on the other sites.
- 2.7 Some positive partnership work was identified, but relationships with the UK Border Agency needed to be further improved to reduce delays in moving immigration detainees from police custody. There were good working relationships with the Police Authority, with formal and informal opportunities for feedback. This was also the case with independent custody visitors, who reported excellent relationships with the force and a willingness to act on their feedback.

- 2.8 Custody managers were dip sampling custody records and the general standard of recording was good.

## Treatment and conditions

---

- 2.9 Detainees were treated respectfully. The needs of detainees from minority groups were not generally taken into account unless individuals were assessed as particularly vulnerable. No provision had been made for detainees with disabilities, but religious and language needs were well catered for.
- 2.10 Custody sergeants carried out initial risk assessments and these were updated if circumstances changed. Custody sergeants were not given refresher risk of harm training. Not all cells were covered by cameras and most suites contained multiple ligature points. Daily checks on the condition of cells and detention rooms were not always taking place and quarterly checks were not always sufficiently thorough.
- 2.11 There was some confusion over recording use of force and use was not monitored centrally to identify trends. Captor spray (a pepper contact spray) had been used, but it was not always clear why this had been necessary.
- 2.12 The physical conditions varied, with some older sites in poor condition. Not all showers and toilets offered enough privacy and neither showers nor women's hygiene packs were routinely offered. Replacement clothing usually comprised paper suits, exercise was rarely offered and supplies of reading material were limited. Catering arrangements were adequate.

## Individual rights

---

- 2.13 Custody sergeants ensured that detention was correct and custody was not being used as a place of safety for children. Dependency issues were taken into account and detainees could have someone informed of their whereabouts.
- 2.14 Staff were adhering to PACE, but the PACE definition of a child meant those aged 17 were not routinely given access to an appropriate adult. The appropriate adult service was generally well run, but there were some gaps in access. Detainees were not interviewed when under the influence of substances and were given the required breaks during interview.
- 2.15 There were serious deficiencies in the storage and management of DNA and forensic samples.
- 2.16 Detainees were not told how to complain and there was no system to manage or monitor racist complaints.

## Healthcare

---

- 2.17 Competent healthcare professionals met detainees' physical health, mental health and substance use needs. Clinical governance arrangements were reasonable, but some of the newer systems and processes were not well embedded, resulting in a lack of clarity of roles and responsibilities. There were clinical policies and standing operating procedures, but these were not well known or monitored by the police. Staff did not have particularly good access to training and neither they nor some custody staff received adequate resuscitation and defibrillation training. Clinical staff had appraisals and there was some audit of their work, but this was not shared with the police.

- 2.18 Clinical rooms were reasonable, but there was a lack of infection control guidance. Medicines management was good. Detainees had access to a health professional while in custody and most response times were within limits, but appointments were sometimes 'booked' for a later time with the agreement of the custody staff in order to meet contractual obligations rather than patient need. Response times were not robustly monitored by the police. Nurses could provide detainees with medication for drug or alcohol withdrawal as well as other minor conditions.
- 2.19 The arrangements for detainees with drug or alcohol problems were excellent. Workers were visible and had good links with the community teams as well as having staff in the courts and the local prison.
- 2.20 There was no mental health diversion team as such, but health professionals could refer detainees to a mental health crisis team. The team had an agreement with the primary care trust that it would see any referral within 24 hours, but responsiveness was not monitored by the police. A Section 136 suite at one of the local hospitals was used about once a day, but staffing issues often meant delays in getting appropriate staff to take over the care of the detainee from the police.



### 3. Strategy

#### Expected outcomes:

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

- 3.1 An assistant chief constable had portfolio responsibility for custody services. The constabulary had recently invested sizeable amounts of money in an ongoing programme to upgrade parts of its custody estate. The Police Authority lead for custody took an active interest in custodial matters and played a proactive and supportive role. A superintendent based within the criminal justice department had oversight of custody provision within Leicestershire Constabulary and was responsible for the strategic development of custody. The management of custody policies and procedures rested with the superintendent, supported by one inspector, responsible for operational delivery while the inspector led on delivering safer detention provisions.
- 3.2 An assistant chief constable (ACC) was the senior portfolio holder for custody issues within Leicestershire Constabulary. There was ample evidence that strategic priority was given to custody and there was clear strategic direction in relation to the development of custody within the context of administration of criminal justice. An extensive refurbishment programme formed part of an ongoing estates strategy, which was strongly supported by the Police Authority. Wigston custody suite had recently re-opened and the largest custody suite, Euston Street, was closed for refurbishment. There were plans to modernise Loughborough custody suite by the end of 2009 and Beaumont Leys in financial year 2010.
- 3.3 Five designated custody suites operated under the control of the central criminal justice department: Beaumont Leys, which had 14 cells and four interview rooms; Keyham Lane, which had 13 cells, four detention rooms and five interview rooms; Loughborough, which had 12 cells and three interview rooms; Wigston, which had 12 cells and three interview rooms; and Coalville, which had six cells and two detention rooms and was open only at weekends for bail returners. Euston Street, the largest suite with 36 cells and nine interview rooms, was closed for refurbishment. Each suite was managed by an inspector who was the custody site manager. Between 7am and 11pm from Sunday to Thursday and from 7am to 3am on Friday and Saturday, they also managed all Police and Criminal Evidence (PACE) issues and reviews of detention, ensuring that detainees were dealt with appropriately. The inspectors were line managed by the chief inspector operations.
- 3.4 The force also had two non-designated police stations with cells available at Melton Mowbray (three cells) and Oakham (four cells). The latter site we were subsequently told had been decommissioned after the inspection. Responsibility for these had been devolved to the basic command unit (BCU) commanders of the areas where they were sited and therefore fell outside the control of the criminal justice department.
- 3.5 The custody suite managers had line management responsibilities for the custody sergeants, senior detention officers (SDOs) and detention officers (DOs). The police sergeants in the custody suites were posted into custody roles from patrol teams, their postings in custody varying in duration. Overall, there were 36 custody sergeants within the criminal justice department supported by 10 SDOs and 33 DOs, although there were five vacant DO posts. We had serious concerns about the current staffing model and the vacancies being carried. In some custody suites, particularly Keyham Lane, staffing levels were one custody sergeant and one DO or SDO per team, in this case covering 13 cells and four detention rooms. The duties

of the DO included fingerprinting, photographing, DNA testing, drug testing (if applicable) and obtaining 'Treadmark' footwear impressions from every person coming into custody, all of which detracted from their main custody duties of detainee welfare and safety. Staff reported feeling under pressure at busy times when custody numbers were high, a problem that was exacerbated by the fact that the largest suite at Euston Street was closed.

- 3.6 All custody sergeants and detention staff had received specific custody training before their deployment into the custody suites. The training had originally been a two-week custody course, but in the past 10 months had been extended to four weeks to cover all aspects of custody duties, including roles and responsibilities, legislation, first aid, food hygiene, managing risk/harm, drugs testing, use of the Police National Computer (PNC) and the NSPIS custody system. DOs new to the force also received a two-week training course that included an introduction to the police service, training in the use of force IT systems, pocket books and taking DNA samples.
- 3.7 During interview, custody sergeants indicated that they did not receive any refresher training, despite the fact that several had been in post for a number of years. The force had recognised this and intended to introduce a one-day custody refresher course starting in the latter part of 2009. Refresher first aid training was also planned for all custody staff from autumn 2009 (see chapter on treatment and conditions).
- 3.8 Custody staff worked a nine-hour dayshift, late shift and nightshift. This allowed a rostered handover period to be factored into the shift pattern for all shifts apart from the nightshift to dayshift handover, when the force relied on the goodwill of custody staff to arrive early to complete a handover.
- 3.9 The constabulary's relationship with the Crown Prosecution Service (CPS) was described by managers as very positive. Due to financial constraints, however, the CPS was moving from providing face-to-face advice in police stations to a telephone-based advice service staffed locally during the day. Outside normal working hours, this service would continue to be provided by CPS Direct.
- 3.10 We were told that working relationships with the Police Authority were very effective, with feedback provided both formally and informally. They had no concerns over the service provided and were very positive about their relationships with the force, which they found to be very approachable and responsive.
- 3.11 An attempt had been made at chief inspector level to tighten existing protocols with the UK Border Agency, but delays in facilitating the removal of immigrant detainees from the country continued (see chapter on individual rights) and staff said they no longer had any faith that the situation would improve. The situation had led to cells becoming blocked, which impacted on operational capacity.
- 3.12 Strategic custody group meetings took place every two months and were supported by monthly custody manager meetings. Management was aware of the complaints process, but we could not identify a feedback loop from the Department for Professional Standards (DPS) to custody managers in respect of the number or type of complaints made by detainees.
- 3.13 There was a Police Authority lead for the independent custody visitors (ICV) scheme, which was viewed as an important independent oversight mechanism. ICVs visited the four main designated custody suites at Euston Street, Keyham Lane, Wigston and Loughborough at least once a week. Feedback forms submitted after every visit were routed through the Police Authority lead, who passed on any issues raised to the chief inspectors within the criminal

justice department. Their experience was that issues raised were addressed promptly and efficiently and timely feedback was always provided both formally and informally. Issues identified were recorded centrally, as were the actions taken to address them, and these were further discussed formally at a quarterly meeting involving members of the ICV and the criminal justice department chief inspectors.

- 3.14 DNA and forensic samples were inadequately stored in fridges and freezers. Old blood, urine, DNA and forensic samples were found at six sites and it was unclear whether they should have been sent for analysis or stored elsewhere if still required, or disposed of properly if not (see chapter on individual rights).
- 3.15 Quality assurance checks of custody records were carried out by custody managers, who were required to dip sample 20 random records a month, the details of which they supplied to the central criminal justice department.
- 3.16 There was some confusion about how the use of force was being recorded and monitored (see chapter on treatment and conditions).

## Recommendations

---

### To Leicestershire Constabulary

---

- 3.17 The current staffing model in custody suites should be reviewed to ensure it allows for the care and welfare of detainees to be met.
- 3.18 Custody refresher training should be provided to all staff who work within the custody environment as a matter of course, including topics such as safer custody and child protection.
- 3.19 Shift patterns should be reviewed to ensure handovers are factored into all shifts.



## 4. Treatment and conditions

### Expected outcomes:

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

- 4.1 Staff treated detainees politely and professionally, but there was limited recognition of the needs of women and juveniles and no provision for detainees with disabilities. Interpreters were used when necessary. Risk assessments were carried out, but some suites contained multiple ligature points. Use of force was not monitored centrally. The physical conditions varied, with Beaumont Leys and Coalville in poor condition and Loughborough adequate only for detainees spending a short time in custody. Not all detainees could use the toilet in private and women were not automatically given hygiene packs. Other basic provisions, such as outdoor exercise and showers, were not routinely offered. A good range of meals was available.

### Respect

---

- 4.2 Most detainees had relatively short journeys to the custody suite in police vehicles, usually cars, although vans were used if a detainee was violent. Immigration detainees were transported to the custody suite by private contractors. Their vehicles were in satisfactory condition, but there was some graffiti and the fridge was dirty, although it contained only water in sealed bottles.
- 4.3 Staff tended to adopt a standard approach towards all detainees and followed the questions on the national strategy for police information systems (NSPIS). They had only a limited awareness of the particular needs of detainees from different minority groups and made no formal distinction in how they were treated. There were no policies relating to the different needs of various detainee groups. Women and juveniles were treated differently only if assessed as particularly vulnerable, although staff said a female member of staff would always be available in the custody suite when a female juvenile was being held. Custody sergeants said they would benefit from additional training in areas such as child protection, the use of restraints, strip searching and self-harm. None of the cells had been adapted for use by detainees with disabilities, but we were told the refurbished Euston Street suite would have doors wide enough for wheelchairs as well as an adapted toilet and a hearing loop.
- 4.4 Staff were generally considerate towards detainees and treated them politely and professionally. We observed good interactions between staff and detainees, with staff organising transport home for released detainees and collecting prescriptions from the pharmacy on their behalf. A professional telephone interpreting service was available at all suites and frequently used, and there was a pool of interpreters to call on for help with face-to-face interviews. Religious needs were recognised and items such as prayer mats and religious texts were generally available. A cordless telephone that could only be used for outgoing calls allowed detainees to make calls in private from their cells to legal representatives and to make appropriate domestic calls.
- 4.5 The booking in desk at Wigston was extremely high and afforded little privacy. In all the main suites, more than one detainee could be booked in at the same time at neighbouring desks, which afforded little privacy and could impede disclosure.

- 4.6 Apart from the provision of appropriate adults (see chapter on individual rights), children and young people were subject to the same treatment and conditions as everyone else. If no appropriate adult was available during the booking in process, staff initially advised juveniles of their rights and entitlements and then did so again when an appropriate adult was present. Staff also said they relied on officers bringing detainees to the station to advise them of any potential Schedule One offenders (convicted of an offence listed in schedule one of the Children and Young Person Act 1933 against a child or young person under the age of 18 years) due to arrive so that they could be separated in the holding chute.

## Safety

---

- 4.7 When detainees arrived, the custody sergeant completed the standard risk assessment on NSPIS, checked the Police National Computer for any relevant 'markers' and noted the detainee's general presentation, demeanour and body language. They said they would ensure the detainee was seen quickly by a doctor if they had any concerns about vulnerability or health. Decisions on the level of supervision for each detainee were made before placing them in a cell and initial risk assessments were amended to reflect any change in circumstances and risk level. Staff completed risk of harm training as part of their initial custody training, but sergeants felt they would benefit from refresher training. Anti-ligature knives were carried by detention officers and available to other staff at all suites.
- 4.8 None of the cells at Beaumont Leys were covered by closed-circuit television (CCTV), but all cells at Loughborough, Keyham Lane and Wigston had CCTV and some also had life signs monitoring. Some CCTV screens were located in offices behind the front desks so were not easily monitored. Staff were aware of the trigger factors relating to self-harm and made appropriate observations as instructed by the custody sergeant, rousing detainees when necessary. However, there were multiple ligature points in most custody suites, which presented some significant safety issues.
- 4.9 The force had introduced a daily health and safety walk-through by either a detention officer or senior detention officer to check the condition of the cells and detention rooms and highlight any issues requiring attention, immediate or otherwise. Staff said these did not always take place due to competing demands on the time, and the lack of capacity. The custody manager, support services cleaning manager and a force health and safety representative carried out a quarterly health and safety walk-through, although occupied cells were not always cleared so some were not checked on consecutive visits. Some cells identified through this process as high risk due to possible ligature points were not taken out of service.
- 4.10 Custody staff demonstrated the skills and competencies to deal with detainees at risk of harm to others. Staff escorting violent/dangerous detainees into the custody suite advised custody sergeants beforehand and custody sergeants said the holding chute and booking-in area would be cleared of non-police personnel. Detainees who were also in a drunken state were taken straight to the cell and booked in afterwards. There was no cell sharing in the custody suites.

## Use of force

---

- 4.11 Managers at all levels believed the use of force was recorded both in custody records and through the submission of a separate form to Learning and Development for monitoring purposes. However, front-line staff said the use of force was recorded only in custody records and officer pocket books following the withdrawal of the use of force form in recent years. This did not enable managers to monitor trends or identify use against certain groups.

- 4.12 Staff said force was used only as a last resort and only in extreme circumstances. However, there were examples where captor spray had been used and it was not always obvious from CCTV footage why this had been necessary. Custody sergeants said detainees were occasionally handcuffed and escorting officers were asked to provide an explanation of the reason for this. All staff involved in using force had been trained in the approved techniques and received annual refresher training. Detainees subject to use of force were seen by a health professional only if they requested it themselves or had any visible injuries. Control and restraint equipment was in good order.

## Physical conditions

---

- 4.13 Conditions in the suites varied widely. Cells at Wigston and Keyham Lane were generally clean with little graffiti, while those at Beaumont Leys and Coalville were in poor condition and contained graffiti, some of it racist. Cells at Loughborough were in need of deep cleaning and were so cramped that some staff said they felt vulnerable when working there on their own. In our survey, only 5% of respondents, against a comparator<sup>2</sup> of 19%, said the ventilation and air quality in cells was good. The equipment and fittings were generally in good condition, apart from the multiple ligature points (see section on safety). Booking in desks at all suites were high and the small booking in areas afforded little privacy, although detainees could make calls in private using a cordless telephone (see section on respect).
- 4.14 The showers at Beaumont Leys were dirty, there were no separate showers for men and women and, as at Keyham Lane, had low saloon doors that made them particularly unsuitable for use by female detainees. The shower at Loughborough was located with a toilet, which was unhygienic, and the shower at Wigston was out of order and staff said this had mainly been the case since the suite opened. The general arrangements for showering across all suites and the lack of privacy were of particular concern for female detainees.
- 4.15 All custody suites enforced a no smoking policy, but smokers were not offered nicotine replacement therapy.
- 4.16 Fire drills took place at least annually and staff demonstrated that they could safely evacuate custody suites in an emergency. Sufficient handcuffs were available to ensure cells could be evacuated safely.
- 4.17 Detainees were told how and when to use the call bells. Bells were responded to promptly.

## Personal comfort and hygiene

---

- 4.18 Cells were cleaned daily and tidied between uses. Mattresses and clean blankets were provided, but pillows were not and mattresses were not hygienically cleaned after use. Most suites contained adequate supplies of clean blankets, clothing, footwear, underwear and hygiene packs.
- 4.19 Most cells contained toilet and washing facilities, but detainees at Beaumont Leys could not use the toilet in private as there was no screening. In all the other suites, CCTV monitoring screens were pixilated to allow detainees to use the toilet in private. The only exception to this was at Loughborough, where one of the monitors allowed an unrestricted view. Toilet paper was routinely issued, but hygiene packs were not automatically offered to female detainees.

---

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

- 4.20 Showers were only provided on request if a staff member of the appropriate sex was available. In our survey, no detainee said they had been given the opportunity to shower.
- 4.21 Detainees whose clothing was seized were usually offered paper suits, while track suits were provided only for court appearances. Underwear was available only on request and was not routinely offered.

## Catering

---

- 4.22 Meals were served at three set times during the day, although allowances were made for detainees who needed to attend court early or arrived late. A range of microwave meals was available at all suites and halal, vegan and vegetarian diets were catered for. Some suites also provided cereal, beans on toast and instant noodles. Drinks were offered regularly.

## Activities

---

- 4.23 Detainees were offered outdoor exercise only in exceptional circumstances, such as when they had already been held for three or four days. In our survey, only 2% of respondents said this had been offered. The limited supply of reading material consisted of old magazines brought in by staff. Visits were not usually facilitated. There was a secure visits room for families at Keyham Lane, but staff said this was rarely used due to lack of staff to supervise and the short time most detainees spent in custody.

## Recommendations

---

- 4.24 Cells adapted for use by detainees with disabilities should be provided.
- 4.25 There should be formal policies setting out how staff should deal with juveniles and women held in custody.
- 4.26 Closed-circuit television screens should be located in areas that enable easy monitoring.
- 4.27 All cells should be fit for purpose and free of ligature points.
- 4.28 Health and safety walk-throughs should take place daily.
- 4.29 Use of force should be monitored centrally to identify any issues or trends.
- 4.30 The reasons for the deployment of incapacitant sprays in custody should be recorded in custody records and centrally. Managers should quality assure such usage and satisfy themselves as to appropriateness, proportionality and any health and safety issues.
- 4.31 The physical conditions of suites at Beaumont Leys and Coalville should be clean and in a good state of repair.
- 4.32 Booking in desks should not be too high and should afford privacy to detainees.
- 4.33 On an individual assessed basis, nicotine replacement should be available to smokers.

- 4.34 Mattresses should be cleaned between uses and kept clean.
- 4.35 Pillows should be provided routinely to all detainees.
- 4.36 Views of toilets in cells covered by closed-circuit television should be obscured.
- 4.37 All female detainees should be offered a hygiene pack.
- 4.38 Detainees held overnight and those who are dirty should be offered a shower and shower areas should afford sufficient privacy, particularly for female detainees.
- 4.39 Detainees should be offered access to an outdoor exercise area.
- 4.40 Detainees held over 24 hours, and young people, should be allowed visits.
- 4.41 Detainees should be offered suitable reading material at all sites.



## 5. Individual rights

### Expected outcomes:

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

- 5.1 Detainees could have someone told of their whereabouts and any dependency issues were addressed, although not formally identified. Detainees were given access to legal representation, but appropriate adults were not available to juveniles 24 hours a day. There was no formal provision of support on discharge for vulnerable detainees. DNA and forensic samples were not well managed and not always properly stored. Detainees were not told how to make a complaint and there was no system to manage or monitor racist complaints.

### Rights relating to detention

---

- 5.2 Custody sergeants checked the grounds for arrest and detention with the arresting officer and cited examples where they had refused to accept detainees because these were not established or clear. They also pursued officers to ensure that cases were dealt with as quickly as possible to minimise how long detainees spent in custody. The UK Border Agency (UKBA) sometimes needed to lodge immigrant detainees with the force while arrangements were facilitated for their removal from the country. Custody staff expressed concern at the delays in this, which regularly saw individuals held in custody for up to four or five days at a time.
- 5.3 There was no evidence that the suite was used as a formal place of safety for children and young people under section 46 of the Children Act (1989).
- 5.4 Where appropriate, someone known to the detainee was routinely informed that they had been arrested and detained. There were no specific questions on NSPIS to prompt custody staff to ask detainees about any dependency issues, but staff did so on their own initiative and the generally relaxed and open relationships between staff and detainees meant detainees were quick to raise any concerns. Staff used their common sense to resolve problems.
- 5.5 A professional telephone interpreting service was used extensively for detainees who could not speak English and a public service interpreting organisation was contracted to provide face-to-face interviews. Very little information was displayed in languages other than English. Only Loughborough had a hearing loop for detainees with a hearing impairment, although another would be available in the refurbished Euston Street suite.
- 5.6 There was limited formal pre-release risk management planning to ensure the safe discharge of vulnerable detainees, but staff were sensitive to their needs. In one example, a custody sergeant instructed a police officer to transport a detainee with a serious alcohol problem back to his home.

### Rights relating to PACE

---

- 5.7 All detainees were given the opportunity to consult in private with a legal representative and there was a duty solicitor scheme. Individuals considered vulnerable were not interviewed without a responsible adult present. Juveniles were also not interviewed without an appropriate adult, but custody staff adhered to the PACE definition of a child so detainees aged 17 years

were not provided with an appropriate adult unless they were otherwise vulnerable. The youth offending team provided juveniles with appropriate adults on week days, while The Appropriate Adult Scheme (TAAS) provided this service throughout the week for vulnerable adults and from 5pm to midnight on weekdays and 8pm to midnight at weekends for juveniles. TAAS was not available to juveniles between midnight and 8am, which created the possibility of delays.

- 5.8 Detainees were informed on admission to custody about their right to see the PACE code of practice and all custody suites had an up-to-date copy.
- 5.9 Custody records and our observations indicated that detainees were not interviewed while under the influence of alcohol or drugs or medically unfit, were not denied any services during interviews and were given the required breaks between interviews.
- 5.10 DNA samples, taken for a range of offences including violent crimes and burglary, were found in freezers and in some cases in an overnight property store fridge. Some dated back over a year and had not been submitted to the national database or processed. Several forensic samples connected with sexual offences dating back to 2007 were also found, along with a swab with blood on it that was being kept in an unsealed bag.
- 5.11 The cut-off time for morning court was 8.30am and for afternoon court was 2pm. There was no video link facility.
- 5.12 Legal representatives were regularly provided with the first two sheets of a detainee's custody record. Full copies of custody records were provided to detainees and their legal advisers on request after release.

## **Rights relating to treatment**

---

- 5.13 Detainees' property was routinely bagged and recorded electronically, but was then placed in unlocked lockers or cupboards. In one case, over £400 belonging to a detainee was recorded and placed in a sealed property bag, but then placed in an insecure locker in a small staff room.
- 5.14 Detainees were not routinely told how to make a complaint. Independent Police Complaints Commission complaint forms were available only at Beaumont Leys, but were not on display. Staff said custody sergeants would, where possible, deal with any detainee's complaint informally and that the duty inspector would be called in to deal with any that could not be resolved in this way. There were no formal arrangements for dealing with racist complaints and no monitoring of these to establish trends or patterns with particular groups of staff.

## **Recommendations**

---

- 5.15 **Managers should liaise with the UK Border Agency to ensure that immigration detainees are held in police custody for the shortest possible time.**
- 5.16 **More posters should be displayed in languages other than English.**
- 5.17 **Formal pre-release risk management planning should be implemented consistently and any actions taken recorded on NSPIS.**
- 5.18 **Juveniles should be able to receive the services of an appropriate adult when required.**

- 5.19 Detainees aged 17 years should be provided with an appropriate adult.
- 5.20 The issues surrounding the lack of quality control systems and processes for taking, storing and submission of DNA and forensic samples should be addressed as an urgent priority, including a referral to the forensic science regulator.
- 5.21 Detainees' property should be stored securely.
- 5.22 Information about how to make a complaint should be given to all detainees during the booking in process in a format they understand and clearly displayed in the custody suites.
- 5.23 Detainees should be able to make a formal complaint about treatment during arrest or detention while still in custody and all such complaints should be promptly and fully investigated.
- 5.24 The number and nature of complaints with a racial element should be monitored by managers and any trends identified acted on.



## 6. Healthcare

### Expected outcomes:

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

- 6.1 Detainees had access to competent healthcare professionals who met their physical health, mental health and substance use needs. Clinical governance arrangements were reasonable, but there was some lack of clarity of roles and responsibilities. There were clinical policies and standing operating procedures, but these were not well known or monitored by the police. Staff did not have particularly good access to training and neither they nor some custody staff received adequate resuscitation and defibrillation training. Clinical staff had appraisals and there was some audit of their work, but this was not shared with the police. Clinical rooms were reasonable, but there was a lack of infection control guidance. Medicines management was good. Most response times were within limits, but appointments were sometimes 'booked' for a later time with the agreement of the custody staff to meet contractual obligations rather than patient need. Nurses could provide detainees with medication for drug or alcohol withdrawal as well as other minor conditions.

### Clinical governance

---

- 6.2 Forensic medical examiner (FME) and custody nurse services were provided by Primecare under a service level agreement. The FMEs were predominantly male so requests by female detainees to see a female doctor often could not be accommodated. Most custody nurses were female. One nurse and one doctor were on call for the whole constabulary area at all times, with an additional nurse on duty for Friday and Saturday evenings. The nurses were using Beaumont Leys as their base, but this was a temporary arrangement while Euston Street was being refurbished.
- 6.3 Doctors were self-employed and worked as FMEs under consultancy agreements. Nurses were directly employed by Primecare and some had other employment. Good governance processes to ensure the appropriate recruitment, initial training and supervision of staff were monitored by Primecare. They included a structured induction programme and a probationary period with shadowing opportunities for initial shifts. Staff had yearly appraisals and some audit of their work, but said further training and professional development was not easily accessible. There was no evidence of a training needs analysis to inform the needs of healthcare professionals. No mandatory training had been provided by the constabulary. Clinical supervision was offered, but most staff said they did not take this up because it was difficult to organise within their working day. Professional registration was recorded and monitored by Primecare via a database. A recently introduced resource folder included Primecare protocols and procedures and contact details for key senior staff, but it was not available at all sites.
- 6.4 There was a protocol and a tracker system to ensure the safety and whereabouts of healthcare staff, although these were not functioning. Primecare's lone worker policy included the requirement for an annual risk assessment of individual staff.
- 6.5 The Primecare contract was monitored retrospectively by the constabulary through monthly minuted meetings at which Primecare presented data on response times. However, the only challenges to response times in the minutes we saw were for the sexual offences service rather than the custody service, which formed the bulk of the work. The force relied on custody

staff informing them of any issues with response times at the time of the problem, which did not always occur.

- 6.6 Written health information for detainees was limited and in English only. Telephone interpreting services were frequently used and accessed and monitored through custody staff. On-site interpreters were also used and we saw one FME consulting with a detainee in Punjabi.
- 6.7 There were a dedicated medical examination rooms with en suite toilets at all five designated suites. All were adequately tidy, but not all were clinically clean. The room at Coalville required cleaning, as did its en suite facilities. Environmental risk assessments were undertaken at all sites and a refurbishment programme was under way as part of the constabulary's safer detention action plan.
- 6.8 The rooms were minimally equipped and FMEs and nurses carried their own examination equipment with them from station to station. No inventory was available and there was no evidence that the type or quality of equipment was monitored.
- 6.9 Some basic dressings and bandages were stored in the medical rooms and first aid kits were available, but these were not sealed or checked regularly. Each room had a defibrillator, oxygen and masks, which were stored appropriately. Staff said custody nurses received only basic life support training and therefore were not trained to use the defibrillator. Detention officers had regular defibrillation training, but custody sergeants did not, although the equipment was not readily accessible to custody staff. There was limited evidence that resuscitation equipment was checked regularly and some confusion over who was responsible for this. A system for equipment checking by healthcare professionals had recently been implemented in response to the local safer detention action plan. The portable suction unit was primed and ready for immediate use, apart from at Coalville where the equipment was incomplete.
- 6.10 None of the sharps boxes were dated and signed. Staff said clinical waste was collected regularly by a contractor. We found non-clinical waste in these bins, including food. One bin at Keyham Lane was broken and taken out of use during the inspection. The service level agreement for clinical waste was not held at the station for viewing.
- 6.11 All medical rooms had facilities for hand washing, including foam soap dispensers, alcohol gel and paper towels, and latex gloves and couch roll, although the rolls were not attached to the couches for easy use. There were no arrangements to conduct regular infection control monitoring or audit. There was evidence of arrangements for cleaning the medical rooms, but newly introduced (August 2009) cleaning schedules that set out minimum cleaning requirements were not being recorded. No infection control policies or protocols were held in the medical room. Staff said infection control advice was available from the local acute NHS trust and that Primecare did not have a dedicated lead for infection control.
- 6.12 Detainees were seen with a chaperone only if a risk assessment deemed one to be necessary. Clinical consultations were carried out with the door closed. There were no privacy curtains around the examination couches.
- 6.13 Medicines were kept only at Beaumont Leys, in padlocked rigid boxes that were then taken by the nurses when they visited other stations. FMEs carried their own small stock of medications. All healthcare professionals carried only an agreed stock of appropriate medicines. A range of patient group directions (PGDs) were in place to facilitate supply and administration of medicines by custody nurses, including substitute medications for drug and alcohol withdrawal.

- 6.14 There were good stock control arrangements for the medicines carried by nurses and evidence of regular stock checks and secure storage in when not in use. The arrangements for FME medication were less robust and Primecare expected FMEs to make safe, secure arrangements for transportation and storage. At least one of the doctors carried his medications in an unlockable bag. Medications prescribed and dispensed by a FME were kept with the custody record for administration by custody staff, so were not secure.
- 6.15 There were no medicines management care policies, current British National Formulary or other reference resources available in the medical examination rooms and healthcare staff did not have on-site access to reference material via the internet. There was a protocol to ensure that unused medicines were disposed of through a locked post box, which was emptied on request.
- 6.16 There was good evidence of audit and monitoring systems for the appropriate completion of medical records both on site and via a centralised system.

## Patient care

---

- 6.17 The healthcare professionals' rota provided adequate 24-hour cover, with additional staff routinely allocated at busy times. FMEs and nurses were expected to cover a large geographical area. Response times were generally within the 90 minutes specified by the Primecare contract, although there was evidence of Primecare call centre staff 'booking' an appointment for a healthcare professional to attend at a specific time, so avoiding the nurse or doctor breaching the contractual time limits.
- 6.18 Detainees could request to see a healthcare professional at any point. Custody staff requested brief details of the reason to determine the level of urgency. If a detainee was displaying obvious signs of physical and/or mental health needs, custody staff logged a call for a healthcare professional and noted it on the custody record. Most calls were passed to custody nurses unless there was a specific requirement for a doctor, such as following the use of Tasar. Detainees with an obvious physical need, such as pain or open wounds, were taken immediately to the local accident and emergency department. We observed some good clinical assessments by nursing staff, who were professional and caring, and offered reassurance to detainees and good clinical care.
- 6.19 Any detainee who brought in prescribed medication was seen and assessed by a healthcare professional. The medications were then prescribed by an FME as required. Nurses could use PGDs to administer a one-off dose of a range of medications, including dihydrocodeine for opiate withdrawal and diazepam for alcohol withdrawal, but the FME then had to visit to assess the patient and prescribe and dispense further doses if required. Detention officers could administer doses of medications dispensed by the FME. Detainees who required a methadone prescription were seen by the FME and, if necessary, arrangements were put in place for the police to collect a private prescription.
- 6.20 The recording of healthcare interventions was inconsistent. Custody nurses completed a comprehensive assessment document and entered a summary of information onto the custody record via NSPIS. Completed records were sealed in an envelope and stored in a locked filing cabinet at the nurses' base in Beaumont Leys. Completed records were collected at one to two monthly intervals and taken for secure storage by a contractor. At Beaumont Leys, a number of records were stored on an open shelf awaiting collection. There were monitoring arrangements through dip sampling to assess the quality of nurses' clinical records, both on site and via a centralised system. Evidence of audit was seen and records sampled were

completed appropriately. Detainee consent to intervention or treatment was routinely recorded and audited and we saw staff obtaining verbal consent for some procedures.

- 6.21 FMEs routinely recorded interventions in an individual book, which they retained for personal reference, and entered a summary onto the custody record via NSPIS. There were no quality monitoring arrangements or steps taken to ensure that FME records were completed appropriately and held securely or if there were processes for safe archiving.
- 6.22 Not all Primecare staff had been trained in the use of NSPIS. This meant some custody records appeared incomplete because they recorded the information that would have been on NSPIS on a form 450B, which was kept with the paper copy of the detention log/front sheet. Arrangements for storage and retrieval of these forms were unclear.
- 6.23 Steps were taken to preserve the confidentiality of health information provided by detainees wherever possible within the bounds of acceptable risk and safety. There was a good system for clinical information to be transferred with any detainee taken to hospital from the custody suite by the police. They had an envelope, pre printed with a proforma, that could be used by police escort staff and hospital clinicians to record limited information to ensure that relevant information was communicated. More detailed clinical details were put inside the envelope. The envelope was printed with clear instructions that it was to be opened only by healthcare professionals.
- 6.24 Where record retrieval was required to support writing of a court statement, Primecare requested the relevant record from the storage company, scanned it and emailed a copy to the nurse at her home. The system used was unencrypted system and potentially presented a confidentiality risk.

## Substance use

---

- 6.25 There were excellent arrangements for detainees with drug or alcohol problems. Substance use workers employed by Addaction were visible in the police stations and were available to see detainees from 6.30am until 10pm daily. They had a good rapport with custody staff and good links with the community teams, as well as having staff in the courts and the local prison. They were based at Wigston, Beaumont Leys and Loughborough and covered the other custody suites. They saw all adults who had allegedly committed a 'trigger offence' and all those who tested positive to a class A drug. In the previous month, an average of 30% of all tests had been positive, with variations across the different custody suites. They also saw anyone who requested to see them on a voluntary basis. Their remit included alcohol, as part of a nationwide pilot, and each worker had a target of 20 consultations with detainees with alcohol issues each month.
- 6.26 The substance use workers checked to see if detainees with drug issues were known to the service, carried out assessments as required and provided brief interventions or a follow up appointment with a treatment worker depending on the outcome of the initial assessment. If the detainee was in custody at night and released before the workers came on duty, custody staff had access to their diary and could book the detainee an appointment for an initial assessment. Clients who failed to attend follow up appointments, which were part of their bail conditions, were reported to the police as a 'breach' and a warrant was issued for their arrest. The team had access to clean needles and syringes to give to detainees if required.

- 6.27 Detainees with alcohol issues were assessed and, depending on the results, provided with brief interventions, the services of an alcohol outreach worker or referral to an alcohol treatment programme.
- 6.28 This generally positive picture was confirmed in our survey, where 59% of respondents, against a comparator of 40%, reported seeing a drug or alcohol worker and 52%, against a comparator of 34%, said they had received relief medication for immediate symptoms.
- 6.29 The team was not funded to take on juveniles, but would see them and signpost them to other services. The team also provided services to the courts and to the local prison so could follow clients and ensure they were linked into services, which was commendable. Staff said they had a good, informal rapport with the nurses, who referred clients to them, but they saw less of the FMEs.
- 6.30 The team also provided training to probationary police constables, as well as to sergeants on refresher training.

## Mental health

---

- 6.31 There was no mental health worker based at the stations visited, but there were good systems for FMEs to refer detainees to local NHS crisis intervention teams. Detainees who disclosed mental health problems or were in obvious mental health distress were referred by custody staff or nurses to the FME for prompt assessment. Nurses could not refer directly to the crisis team, which led to inevitable delays before a detainee was seen by the most appropriate health professional. The team saw the patient once the police had seen them and decided a course of action.
- 6.32 Two mental health teams served the local authority and PCT areas. The NHS mental health teams had their own discrete clinical governance arrangements, with systematic monitoring and audit measures and a framework for ensuring that actions were planned, taken and evaluated as appropriate continuously to improve quality outcomes. However, this was not shared with, or monitored by, the police.
- 6.33 The crisis team provided a service for adults. Services to adolescents ceased at aged 16 and staff we spoke to expressed their concerns about the care of detainees aged between 16 and 18. There was a CAMHS service on call for detainees under 16 years.
- 6.34 A dedicated Section 136 suite sited at a local hospital was staffed by Leicestershire Partnership Trust. Staffing was drawn from the Trust's in-patient facilities from 8am to 4pm and from the community crisis teams from 4pm to 8am. This presented challenges for both staff groups, and police officers told us anecdotally of delays in being relieved by healthcare staff when they took a detainee to the suite. Crisis team staff said that inadequate resourcing of the unit meant delays could occur.
- 6.35 Detainees were brought to the unit straight from the community by police officers, supported by a formal agreement for handover, unless they were deemed to be intoxicated or exceptionally violent, in which case they were taken to the local accident and emergency department or a custody suite respectively. However, the agreement seemed to be available only on the criminal justice website under the title 'Operation Cinnamon 2'. An identified link inspector liaised with the mental health trust.

- 6.36 The unit had been open for about a year and had received some 300 detainees, of whom about two-thirds were discharged home with the support of mental health workers. The remainder were admitted to hospital, either voluntarily or under the Mental Health Act. Custody staff reported only very occasional use of the custody suite as a place of safety for detainees with a higher risk of violence and aggression. Not all FMEs were Section 12 approved, but healthcare and custody staff did not report difficulties accessing an approved doctor. However, staff did say there were long delays for a FME to see any detainees in custody once they had been requested to attend the suite.

## Recommendations

---

- 6.37 The police should monitor all healthcare contracts to ensure response times and performance indicators are met.
- 6.38 FMEs and other healthcare professionals should receive ongoing training, supervision and support to maintain their professional registration and development.
- 6.39 All health services staff should be encouraged to engage in clinical supervision.
- 6.40 The clinical (medical examination) rooms should be clinically clean, appropriately equipped and fit for purpose at all times.
- 6.41 All medications on site should be stored safely and securely.
- 6.42 Safe and effective medicines management should be supported by appropriate access to reference information by healthcare staff.
- 6.43 All equipment, including resuscitation kit, should be ready for use and regularly checked and maintained and all staff (healthcare and custody staff) should understand how to access and use it effectively.
- 6.44 Female detainees should be able to see a female doctor on request.
- 6.45 Clinical record systems should be consistent in terms of accessibility, scope and quality and kept confidential at all times.
- 6.46 Arrangements for detainees with mental health problems should be reviewed and the police should have robust arrangements that are known and agreed by all parties involved, including services for juveniles.

## Good practice

---

- 6.47 *The arrangements for detainees with substance use issues to see a worker and the follow up service provided were excellent, custody staff were informed about the workers' role and there was good rapport between the workers and other agencies, including prisons, as well as with detainees. Support with alcohol issues was also included and needle exchange was available on release.*

## 7. Summary of recommendations

### Strategy

---

#### To Leicestershire Constabulary

---

- 7.1 The current staffing model in custody suites should be reviewed to ensure it allows for the care and welfare of detainees to be met. (3.17)
- 7.2 Custody refresher training should be provided to all staff who work within the custody environment as a matter of course, including topics such as safer custody and child protection. (3.18)
- 7.3 Shift patterns should be reviewed to ensure handovers are factored into all shifts. (3.19)

#### Treatment and conditions

---

- 7.4 Cells adapted for use by detainees with disabilities should be provided. (4.24)
- 7.5 There should be formal policies setting out how staff should deal with juveniles and women held in custody. (4.25)
- 7.6 Closed-circuit television screens should be located in areas that enable easy monitoring. (4.26)
- 7.7 All cells should be fit for purpose and free of ligature points. (4.27)
- 7.8 Health and safety walk-throughs should take place daily. (4.28)
- 7.9 Use of force should be monitored centrally to identify any issues or trends. (4.29)
- 7.10 The reasons for the deployment of incapacitant sprays in custody should be recorded in custody records and centrally. Managers should quality assure such usage and satisfy themselves as to appropriateness, proportionality and any health and safety issues. (4.30)
- 7.11 The physical conditions of suites at Beaumont Leys and Coalville should be clean and in a good state of repair. (4.31)
- 7.12 Booking in desks should not be too high and should afford privacy to detainees. (4.32)
- 7.13 On an individual assessed basis, nicotine replacement should be available to smokers. (4.33)
- 7.14 Mattresses should be cleaned between uses and kept clean. (4.34)
- 7.15 Pillows should be provided routinely to all detainees. (4.35)
- 7.16 Views of toilets in cells covered by closed-circuit television should be obscured. (4.36)
- 7.17 All female detainees should be offered a hygiene pack. (4.37)

- 7.18 Detainees held overnight and those who are dirty should be offered a shower and shower areas should afford sufficient privacy, particularly for female detainees. (4.38)
- 7.19 Detainees should be offered access to an outdoor exercise area. (4.39)
- 7.20 Detainees held over 24 hours, and young people, should be allowed visits. (4.40)
- 7.21 Detainees should be offered suitable reading material at all sites. (4.41)

## Individual rights

---

- 7.22 Managers should liaise with the UK Border Agency to ensure that immigration detainees are held in police custody for the shortest possible time. (5.15)
- 7.23 More posters should be displayed in languages other than English. (5.16)
- 7.24 Formal pre-release risk management planning should be implemented consistently and any actions taken recorded on NSPIS. (5.17)
- 7.25 Juveniles should be able to receive the services of an appropriate adult when required. (5.18)
- 7.26 Detainees aged 17 years should be provided with an appropriate adult. (5.19)
- 7.27 The issues surrounding the lack of quality control systems and processes for taking, storing and submission of DNA and forensic samples should be addressed as an urgent priority, including a referral to the forensic science regulator. (5.20)
- 7.28 Detainees' property should be stored securely. (5.21)
- 7.29 Information about how to make a complaint should be given to all detainees during the booking in process in a format they understand and clearly displayed in the custody suites. (5.22)
- 7.30 Detainees should be able to make a formal complaint about treatment during arrest or detention while still in custody and all such complaints should be promptly and fully investigated. (5.23)
- 7.31 The number and nature of complaints with a racial element should be monitored by managers and any trends identified acted on. (5.24)

## Healthcare

---

- 7.32 The police should monitor all healthcare contracts to ensure response times and performance indicators are met. (6.37)
- 7.33 FMEs and other healthcare professionals should receive ongoing training, supervision and support to maintain their professional registration and development. (6.38)
- 7.34 All health services staff should be encouraged to engage in clinical supervision. (6.39)
- 7.35 The clinical (medical examination) rooms should be clinically clean, appropriately equipped and fit for purpose at all times. (6.40)
- 7.36 All medications on site should be stored safely and securely. (6.41)

- 7.37 Safe and effective medicines management should be supported by appropriate access to reference information by healthcare staff. (6.42)
- 7.38 All equipment, including resuscitation kit, should be ready for use and regularly checked and maintained and all staff (healthcare and custody staff) should understand how to access and use it effectively. (6.43)
- 7.39 Female detainees should be able to see a female doctor on request. (6.44)
- 7.40 Clinical record systems should be consistent in terms of accessibility, scope and quality and kept confidential at all times. (6.45)
- 7.41 Arrangements for detainees with mental health problems should be reviewed and the police should have robust arrangements that are known and agreed by all parties involved, including services for juveniles. (6.46)

### Good practice

---

- 7.42 The arrangements for detainees with substance use issues to see a worker and the follow up service provided were excellent, custody staff were informed about the workers' role and there was good rapport between the workers and other agencies, including prisons, as well as with detainees. Support with alcohol issues was also included and needle exchange was available on release. (6.47)



## Appendix I : Inspection team

---

Sean Sullivan	HMIP team leader
Anita Saigal	HMIP inspector
Ian Macfadyen	HMIP inspector
Paddy Craig	HMIC inspector
Fiona Shearlaw	HMIC inspector
Paul Eveleigh	HMIC inspector
Elizabeth Tysoe	HMIP healthcare inspector
Jan Fooks-Bale	CQC healthcare inspector
Catherine Nichols	HMIP researcher
Adam Altoft	HMIP researcher

## Appendix II : Custody Record Analysis

---

### Background

---

As part of the inspection of Leicestershire police custody cells, a sample of the custody records of detainees held between 24 and 29 June 2009 were analysed. Custody records were held electronically on NSPIS. A total sample of 30 records were analysed from across the Leicestershire area:

Custody suite	Number of records analysed
Loughborough	10
Wigston	10
Keyham Lane	10
TOTAL	30

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

### Demographic information

---

- Five (17%) of the detainees were female and 25 were male.
- Three people (10%) under the age of 17 were included in the sample.
- Twenty-two (73%) detainees were white and eight were from a black and minority ethnic background.
- Thirteen (43%) detainees had been held for longer than 12 hours, including those who had arrived during the night and were not released until the morning. One (3%) had been held for more than 24 hours.

### Removal of clothing

---

- Two detainees had had clothing removed from them.
- Five detainees had had their outer clothing removed.
- One detainee had had all clothes removed and had been given 'appropriate clothing'.

### Young people

---

- Appropriate adults had been requested for all three of the young people in our sample. For all of the cases appropriate adults had attended and sat in on interviews.
- Two young people had their clothes removed; one person was provided with a tracksuit after vomiting on his own clothes; the other, aged 12, was provided with an evidence suit.

### Interpreters

---

Three (10%) detainees in our sample could not understand English and required an interpreter. Interpreters were requested and attended. Of the three, only one person was informed of their legal rights by an interpreter.

## **Foreign nationals**

---

Six of our sample were foreign nationals:

- Four of the six were not informed of their rights as a foreign national.
- Rights were given in English for the remaining two, despite one person requiring an interpreter during interview.

## **Inspector reviews**

---

Inspector reviews were held in line with requirements. A few reviews were conducted at a delayed time due to other operational commitments.

## **Services**

---

- Six (20%) detainees asked whether they could have a telephone call; five of these were granted a call.
- Thirteen (43%) detainees had not been asked if they wanted a solicitor and did not request a solicitor themselves. The other detainees had all received legal advice.
- No detainees shared a cell while in custody.
- Fifteen (50%) detainees had requested to see the FME. Two detainees were released before a FME arrived, one of which had been sprayed with Captor, a form of pepper spray. The longest wait was three hours 45 minutes, the shortest was two minutes. The average waiting time to see an FME was 71 minutes.
- Three (10%) detainees had seen a drugs worker, after the service was offered to them.
- Nineteen (63%) detainees did not have a meal during their time in custody, seven of which were in custody for more than 12 hours. Ten of those who received no food were not offered food, but nine were offered food and declined. There were some examples of detainees being released in the morning having been held overnight with no offer of breakfast recorded, or arriving just after dinnertime and again an evening meal not being recorded as even offered. One detainee was held for about 23 hours with only one meal received, there was one record of a meal having been offered and refused.
- Two (7%) detainees had received a shower.
- Two (7%) detainees had received outside exercise.
- Three (10%) detainees had been provided with reading materials.

## **Additional points of note**

---

- The records were thorough and had a good level of detail with each entry.
- There was a record of a female detainee being Captor sprayed in her cell. She had already been Captor sprayed on arrest. She left without seeing an FME.
- Three detainees had been Captor sprayed on arrest and one was threatened with Captor spray in the detention suite. All of those who had been sprayed on arrest were not seen by a FME.
- Two of the women were given sanitary towels and one had a disposal bag and tissues too.

## Appendix III : Prisoner survey methodology

---

A voluntary, confidential and anonymous survey of the prisoner population, who had been through a police station in Leicestershire, 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 11 August 2009. A list of potential respondents to have passed through Keyham Lane/Hamilton, Beaumont Leys, Loughborough, Aodby & Wigston and Euston Street police stations was created, listing all those who had arrived from Leicestershire Magistrates court within the past month.

### Selecting the sample

---

In total, 60 respondents were approached. Seven respondents reported being held in police stations outside Leicestershire and three could speak no English so it was impossible to determine the police station they had been in. Two had gone to court. On the day, the questionnaire was offered to 48 respondents; there was one refusal, one questionnaire was returned blank and there were two non-returns. All of those sampled had been in custody within the last month.

Completion of the questionnaire was voluntary. Interviews were carried out with any respondents with literacy difficulties. In total, one respondent was interviewed.

### Methodology

---

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

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

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

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

### Response rates

---

In total, 44 (92%) respondents completed and returned their questionnaires.

### Comparisons

---

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

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

The current survey responses were analysed against comparator figures for all prisoners surveyed in other police areas. This comparator is based on all responses from prisoner surveys carried out in 12 police areas since April 2008.

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

## **Summary**

---

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

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

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

# Police Custody Survey

## Section 1: About You

- Q2 What police station were you last held at?**  
Keyham Lane/Hamilton - 9; Euston Street – 2; Beaumont Leys – 18; Loughborough – 8;  
Aodby & Wigston - 2; Coalville - 1; Not recorded - 4
- Q3 What type of detainee were you?**
- |   |     |
|---|-----|
| Police detainee .....   | 88% |
| Prison lock-out (i.e. you were in custody in a prison before coming here) ..... | 7%  |
| Immigration detainee.....   | 0%  |
| I don't know.....   | 5%  |
- Q4 How old are you?**
- |                           |     |                        |     |
|---------------------------|-----|------------------------|-----|
| 16 years or younger ..... | 0%  | 40-49 years .....      | 23% |
| 17-21 years.....          | 9%  | 50-59 years .....      | 2%  |
| 22-29 years.....          | 55% | 60 years or older..... | 0%  |
| 30-39 years.....          | 11% |                        |     |
- Q5 Are you:**
- |                              |      |
|------------------------------|------|
| Male .....                   | 100% |
| Female.....                  | 0%   |
| Transgender/Transexual ..... | 0%   |
- Q6 What is your ethnic origin?**
- |   |     |
|---|-----|
| White - British .....                       | 68% |
| White - Irish.....                          | 2%  |
| White - Other.....                          | 2%  |
| Black or Black British - Caribbean .....    | 5%  |
| Black or Black British - African .....      | 7%  |
| Black or Black British - Other .....        | 0%  |
| Asian or Asian British - Indian .....       | 2%  |
| Asian or Asian British - Pakistani .....    | 0%  |
| Asian or Asian British - Bangladeshi.....   | 0%  |
| Asian or Asian British - Other .....        | 2%  |
| Mixed Race - White and Black Caribbean..... | 7%  |
| Mixed Race - White and Black African .....  | 0%  |
| Mixed Race - White and Asian .....          | 0%  |
| Mixed Race - Other.....                     | 5%  |
| Chinese.....                                | 0%  |
| Other ethnic group.....                     | 0%  |
- Q7 Are you a foreign national (i.e. you do not hold a British passport, or you are not eligible for one)?**
- |           |     |
|-----------|-----|
| Yes ..... | 12% |
| No.....   | 88% |
- Q8 What, if any, would you classify as your religious group?**
- |            |     |
|------------|-----|
| None ..... | 44% |
|------------|-----|

Church of England.....	24%
Catholic.....	17%
Protestant.....	0%
Other Christian denomination.....	2%
Buddhist.....	0%
Hindu.....	0%
Jewish.....	0%
Muslim.....	10%
Sikh.....	2%

<b>Q9</b>	<b>How would you describe your sexual orientation?</b>	
	<i>Straight / Heterosexual</i> .....	100%
	<i>Gay / Lesbian / Homosexual</i> .....	0%
	<i>Bisexual</i> .....	0%

<b>Q10</b>	<b>Do you consider yourself to have a disability?</b>	
	<i>Yes</i> .....	9%
	<i>No</i> .....	89%
	<i>Don't know</i> .....	2%

<b>Q11</b>	<b>Have you ever been held in police custody before?</b>	
	<i>Yes</i> .....	100%
	<i>No</i> .....	0%

## **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.

<b>Q12</b>	<b>How long were you held at the police station?</b>	
	<i>1 hour or less</i> .....	2%
	<i>More than 1 hour, but less than 6 hours</i> .....	5%
	<i>More than 6 hours, but less than 12 hours</i> .....	2%
	<i>More than 12 hours, but less than 24 hours</i> .....	30%
	<i>More than 24 hours, but less than 48 hours (2 days)</i> .....	33%
	<i>More than 48 hours (2 days), but less than 72 hours (3 days)</i> .....	19%
	<i>72 hours (3 days) or more</i> .....	9%

<b>Q13</b>	<b>Were you given information about your arrest and your entitlements when you arrived there?</b>	
	<i>Yes</i> .....	84%
	<i>No</i> .....	16%
	<i>Don't know/Can't remember</i> .....	0%

<b>Q14</b>	<b>Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')?</b>	
	<i>Yes</i> .....	64%
	<i>No</i> .....	32%
	<i>I don't know what this is/I don't remember</i> .....	5%

<b>Q15</b>	<b>If your clothes were taken away, were you offered different clothing to wear?</b>	
	<i>My clothes were not taken</i> .....	59%

	I was offered a tracksuit to wear .....	10%		
	I was offered an evidence suit to wear .....	26%		
	I was offered a blanket .....	5%		
Q16	Could you use a toilet when you needed to?			
	Yes .....	82%		
	No.....	18%		
	Don't Know .....	0%		
Q17	If you have used the toilet there, were these things provided?			
	Yes	No		
	Toilet paper	45% 55%		
Q18	Did you share a cell at the police station?			
	Yes .....	0%		
	No.....	100%		
Q19	How would you rate the condition of your cell:			
	Good	Neither	Bad	
	Cleanliness	16%	28%	56%
	Ventilation / Air Quality	5%	26%	68%
	Temperature	11%	29%	61%
	Lighting	32%	29%	39%
Q20	Was there any graffiti in your cell when you arrived?			
	Yes .....	57%		
	No.....	43%		
Q21	Did staff explain to you the correct use of the cell bell?			
	Yes .....	14%		
	No.....	86%		
Q22	Were you held overnight?			
	Yes .....	90%		
	No.....	10%		
Q23	If you were held overnight, which items of clean bedding were you given?			
	Not held overnight .....	10%		
	Pillow.....	0%		
	Blanket.....	69%		
	Nothing .....	21%		
Q24	Were you offered a shower at the police station?			
	Yes .....	0%		
	No.....	100%		
Q25	Were you offered any period of outside exercise whilst there?			
	Yes .....	2%		
	No.....	98%		

- Q26 Were you offered anything to:**
- |        | Yes | No  |
|--------|-----|-----|
| Eat?   | 77% | 23% |
| Drink? | 93% | 7%  |
- Q27 Was the food/drink you received suitable for your dietary requirements?**
- I did not have any food or drink* ..... 13%
- Yes ..... 38%
- No ..... 50%
- Q28 If you smoke, were you offered anything to help you cope with the smoking ban there?**
- I do not smoke* ..... 12%
- I was allowed to smoke* ..... 7%
- I was not offered anything to cope with not smoking* ..... 81%
- I was offered nicotine gum* ..... 0%
- I was offered nicotine patches* ..... 0%
- I was offered nicotine lozenges* ..... 0%
- Q29 Were you offered anything to read?**
- Yes ..... 14%
- No ..... 86%
- Q30 Was someone informed of your arrest?**
- Yes ..... 37%
- No ..... 40%
- I don't know* ..... 7%
- I didn't want to inform anyone* ..... 16%
- Q31 Were you offered a free telephone call?**
- Yes ..... 47%
- No ..... 53%
- Q32 If you were denied a free phone call, was a reason for this offered?**
- My phone call was not denied* ..... 51%
- Yes ..... 0%
- No ..... 49%
- Q33 Did you have any concerns about the following, whilst you were in police custody:**
- |   | Yes | No  |
|---|-----|-----|
| Who was taking care of your children        | 7%  | 93% |
| Contacting your partner, relative or friend | 45% | 55% |
| Contacting your employer                    | 10% | 90% |
| Where you were going once released          | 38% | 62% |
- Q34 Were you interviewed by police officials about your case?**
- Yes ..... 79%
- No ..... 21% If No, go to Q35

- Q35 Were any of the following people present when you were interviewed?**
- |                   | Yes | No  | Not needed |
|-------------------|-----|-----|------------|
| Solicitor         | 79% | 18% | 3%         |
| Appropriate Adult | 8%  | 33% | 58%        |
| Interpreter       | 8%  | 29% | 63%        |
- Q36 How long did you have to wait for your solicitor?**
- I did not requested a solicitor* ..... 21%
- 2 hours or less ..... 13%
- Over 2 hours but less than 4 hours..... 8%
- 4 hours or more ..... 59%
- Q37 Were you officially charged?**
- Yes ..... 86%
- No..... 10%
- Don't Know ..... 5%
- Q38 How long were you in police custody after being charged?**
- I have not been charged yet* ..... 10%
- 1 hour or less ..... 8%
- More than 1 hour, but less than 6 hours ..... 10%
- More than 6 hours, but less than 12 hours ..... 26%
- 12 hours or more..... 46%

### **Section 3: Safety**

- Q40 Did you feel safe there?**
- Yes ..... 56%
- No..... 44%
- Q41 Had another detainee or a member of staff victimised (insulted or assaulted) you there?**
- Yes ..... 50%
- No..... 50%
- Q42 If you have felt victimised, what did the incident involve? (Please tick all that apply)**
- I have not been victimised* ..... 40% *Because of your crime* ..... 17%
- Insulting remarks (about you, your family or friends)* ..... 23% *Because of your sexuality* ..... 0%
- Physical abuse (being hit, kicked or assaulted)* ..... 12% *Because you have a disability*..... 0%
- Sexual abuse* ..... 2% *Because of your religion/religious beliefs* . 0%
- Your race or ethnic origin* ..... 0% *Because you are from a different part of the country than others*..... 0%
- Drugs*..... 6%
- Please describe:*
- Q43 Were you handcuffed or restrained whilst in the police custody suite?**
- Yes ..... 45%
- No..... 55%

**Q44 Were you injured whilst in police custody, in a way that you feel was not your fault?**  
 Yes ..... 26%  
 No..... 74%

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

## **Section 4: Healthcare**

**Q47 When you were in police custody were you on any medication?**  
 Yes ..... 45%  
 No..... 55%

**Q48 Were you able to continue taking your medication whilst there?**  
**Not taking medication** ..... 58%  
 Yes ..... 21%  
 No..... 21%

**Q49 Did someone explain your entitlements to see a healthcare professional, if you needed to?**  
 Yes ..... 41%  
 No..... 49%  
 Don't know..... 10%

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

	Yes	No
Doctor	46%	54%
Nurse	39%	61%
Paramedic	4%	96%
Psychiatrist	8%	92%

**Q51 Were you able to see a healthcare professional of your own gender?**  
 Yes ..... 27%  
 No..... 54%  
 Don't know..... 19%

**Q52 Did you have any drug or alcohol problems?**  
 Yes ..... 53%  
 No..... 48%

**Q53 Did you see, or were offered the chance to see a drug or alcohol support worker?**  
**I didn't have any drug/alcohol problems** ..... 50%  
 Yes ..... 29%  
 No..... 21%

**Q54 Were you offered relief or medication for your immediate symptoms?**  
**I didn't have any drug/alcohol problems** ..... 50%  
 Yes ..... 26%  
 No..... 24%

- Q55 Please rate the quality of your healthcare whilst in police custody:**
- |                       | I was not<br>seen by<br>health -<br>care | Very Good | Good | Neither | Bad | Very Bad |
|-----------------------|--|-----------|------|---------|-----|----------|
| Quality of Healthcare | 46%                                      | 0%        | 21%  | 8%      | 15% | 10%      |
- Q56 Did you have any specific physical healthcare needs?**
- No..... 60%
- Yes ..... 40%
- Please specify: Broken hand, fractured knee
- Q57 Did you have any specific mental healthcare needs?**
- No..... 73%
- Yes ..... 27%
- Please specify: Depression, Paranoia, Personality disorder



## Prisoner Survey Responses for Leicestershire Police 2009

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

### Key to tables

	Any percent highlighted in green is significantly better		
	Any percent highlighted in blue is significantly worse		
	Any percent highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
		Leicestershire Police	Police custody comparator
<b>Number of completed questionnaires returned</b>		44	418
<b>SECTION 1: General Information</b>			
2	Are you a Police detainee?	87%	86%
3	Are you under 21 years of age?	10%	10%
4	Are you Transgender/Transsexual?	0%	1%
5	Are you from a minority ethnic group? (including all those who did not tick White British, White Irish or White other categories)	28%	42%
6	Are you a foreign national?	13%	17%
7	Are you Muslim?	11%	14%
8	Are you homosexual/gay or bisexual?	0%	2%
9	Do you consider yourself to have a disability?	10%	17%
10	Have you been in police custody before?	100%	89%
<b>SECTION 2: Your experience of this custody suite</b>			
For the most recent journey you have made either to or from court or between prisons:			
11	Were you held at the police station for over 24hours?	61%	64%
12	Were you given information about your arrest and entitlements when you arrived?	84%	72%
13	Were you told about PACE?	64%	54%
14	If your clothes were taken away, were you given a tracksuit to wear?	26%	42%
15	Could you use a toilet when you needed to?	82%	88%
16	If you did use the toilet, was toilet paper provided?	46%	55%
17	Did you share a cell at the station?	0%	4%
18	Would you rate the condition of your cell, as 'good' for:		
18a	Cleanliness?	16%	26%
18b	Ventilation/air quality?	5%	19%
18c	Temperature?	11%	13%
18d	Lighting?	32%	43%
19	Was there any graffiti in your cell when you arrived?	58%	61%
20	Did staff explain the correct use of the cell bell?	14%	22%
21	Were you held overnight?	90%	90%
22	If you were held overnight, were you given clean items of bedding?	21%	34%
23	Were you offered a shower?	0%	7%

**Key to tables**

	Any percent highlighted in green is significantly better	Leicestershire Police	Police custody comparator
	Any percent highlighted in blue is significantly worse		
	Any percent highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
24	Were you offered a period of outside exercise?	2%	6%

## Key to tables

	Any percent highlighted in green is significantly better	Leicestershire Police	Police custody comparator
	Any percent highlighted in blue is significantly worse		
	Any percent highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
25a	Were you offered anything to eat?	78%	78%
25b	Were you offered anything to drink?	94%	81%
26	Was the food/drink you received suitable for your dietary requirements?	43%	39%
27	For those who smoke: were you offered <del>nothing</del> to help you cope with the ban there?	81%	76%
28	Were you offered anything to read?	14%	11%
29	Was someone informed of your arrest?	37%	43%
30	Were you offered a free telephone call?	47%	52%
31	If you were denied a free call, was a reason given?	0%	19%
32	Did you have any concerns about:		
32a	Who was taking care of your children?	6%	19%
32b	Contacting your partner, relative or friend?	44%	54%
32c	Contacting your employer?	9%	24%
32d	Where you were going once released?	39%	36%
34	If you were interviewed were the following people present:		
34a	Solicitor	80%	76%
34b	Appropriate adult	7%	6%
34c	Interpreter	7%	9%
35	Did you wait over 4 hours for your solicitor?	74%	64%
37	Were you held 12 hours or more in custody after being charged?	53%	65%
<b>SECTION 3: Safety</b>			
39	Did you feel unsafe?	45%	42%
40	Has another detainee or a member of staff victimised you?	50%	45%
41	If you have felt victimised, what did the incident involve?		
41a	Insulting remarks (about you, your family or friends)	29%	27%
41b	Physical abuse (being hit, kicked or assaulted)	15%	16%
41c	Sexual abuse	2%	2%
41d	Your race or ethnic origin	0%	7%
41e	Drugs	6%	17%
41f	Because of your crime	21%	21%
41g	Because of your sexuality	0%	1%
41h	Because you have a disability	0%	3%
41i	Because of your religion/religious beliefs	0%	4%
41j	Because you are from a different part of the country than others	0%	5%
42	Were you handcuffed or restrained whilst in the police custody suite?	46%	49%

**Key to tables**

	Any percent highlighted in green is significantly better	Leicestershire Police	Police custody comparator
	Any percent highlighted in blue is significantly worse		
	Any percent highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
43	Were you injured whilst in police custody, in a way that you feel is not your fault?	27%	28%

#### Key to tables

	Any percent highlighted in green is significantly better	Leicestershire Police	Police custody comparator
	Any percent highlighted in blue is significantly worse		
	Any percent highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
44	Were you told how to make a complaint about your treatment?	21%	12%
<b>SECTION 4: Healthcare</b>			
46	Were you on any medication?	46%	43%
47	For those who were on medication: were you able to continue taking your medication?	50%	39%
48	Did someone explain your entitlement to see a healthcare professional, if you needed to?	41%	36%
49	Were you seen by the following healthcare professionals during your time in police custody:		
49a	Doctor	45%	51%
49b	Nurse	39%	15%
49c	Paramedic	4%	2%
49d	Psychiatrist	7%	3%
50	Were you able to see a healthcare professional of your own gender?	26%	28%
51	Did you have any drug or alcohol problems?	52%	57%
For those who had drug or alcohol problems:			
52	Did you see, or were offered the chance to see a drug or alcohol support worker?	59%	40%
53	Were you offered relief medication for your immediate symptoms?	52%	34%
54	For those who had been seen by healthcare, would you rate the quality as good/very good?	38%	31%
55	Do you have any specific physical healthcare needs?	40%	35%
56	Do you have any specific mental healthcare needs?	28%	24%