



# Report on an unannounced inspection visit to police custody suites in Lincolnshire

10–13 January 2011

by

HM Inspectorate of Prisons and

HM Inspectorate of Constabulary

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# 1. Introduction

This report is part of a programme of inspections of police custody carried out jointly by our two inspectorates. These inspections form a key part of the joint work programme of the criminal justice inspectorates and contribute to the United Kingdom's response to its international obligation to ensure regular and independent inspection of all places of detention<sup>1</sup>. The inspections look at force-wide strategies, detainee treatment and conditions, respect for their individual rights and health care provision.

Lincolnshire police has five designated custody suites working 24 hours a day – providing a total capacity of 67 cells. During this unannounced inspection, all suites were visited. The inspection was informed by a survey at HMP Lincoln of prisoners who had previously been held in Lincolnshire police cells.

There was some confusion about strategic arrangements for custody, which were also subject to an ongoing, wider review and restructuring of the force. This had led to weaknesses in management oversight and, while staffing levels appeared adequate, consistent performance was also inhibited by the widespread use of constables to cover civilian detention officers and the tendency for custody sergeants to only stay in post for short periods. There was also no specific estates strategy. However, relations with the Police Authority were described as positive and there was a well-supported independent custody visitor scheme.

Interactions witnessed between staff and detainees were professional. However, too little attention was paid to the specific needs of different groups of detainees, for example women, children or those with disabilities. Some booking-in areas lacked privacy and the quality of risk assessments was variable, with too little evidence of adequate staff awareness of the importance of rousing intoxicated detainees. Custody suites were clean but there were numerous ligature points and health and safety monitoring was inconsistent.

A positive approach was taken to balancing the priorities of progressing cases and ensuring detainees' rights under the Police and Criminal Evidence Act. However, the out-of-hours 'appropriate adult' scheme was limited and it was not easy for detainees to make a complaint while in custody. The management of forensic samples was generally sound.

The provision of health care services was satisfactory, with good clinical governance and medicines management. Substance misuse services were good but mental health provision was extremely poor. Despite the best efforts of the force, partnership working with the relevant NHS mental health trust was weak and in too many cases police stations were used as places of safety under the Mental Health Act, rather than detainees being taken to more appropriate community provision.

Overall, this is a disappointing inspection. It came at a time when the force was undergoing significant change, which perhaps helped explain why we identified continued failings that had been previously identified by other external bodies. More strategic emphasis on custody was required, with particular attention to improving risk assessment and mental health services. The report sets out a number of recommendations that we hope will assist the Chief Constable and the Police Authority to improve the quality of custody provision. We expect

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

them to consider these in the wider context of force priorities and resourcing, and to provide us with an action plan in due course.

Sir Denis O'Connor  
HM Chief Inspector of Constabulary

Nick Hardwick  
HM Chief Inspector of Prisons

March 2011

## 2. Background and key findings

- 2.1 HM Inspectorates of Prisons and Constabulary have a programme of joint inspections of police custody suites, as part of the UK's international obligation to ensure regular independent inspection of places of detention. These inspections look beyond the implementation of the Police and Criminal Evidence Act 1984 (PACE) codes of practice and *Safer Detention and Handling of Persons in Police Custody* 2006 (SDHP) guide, and focus on outcomes for detainees. They are also informed by a set of *Expectations for Police Custody*<sup>2</sup> about the appropriate treatment of detainees and conditions of detention, which have been developed by the two inspectorates to assist best custodial practice.
- 2.2 At the time of this unannounced inspection, Lincolnshire police had five custody suites designated under PACE for the reception of detainees, operating 24 hours a day. These dealt with detainees arrested as a result of mainstream policing; we visited them all during the inspection. The force had a cell capacity of 67 in the designated suites, and also had several standby designated suites which jointly had a capacity of 20 cells. In the period from 23 March 2010 to the inspection, 16,017 detainees had been held. In the same period, 121 detainees had been held for immigration matters.
- 2.3 The designated suites and cell capacity of each was as follows:

Area	Custody suite	Number of cells
West division	Lincoln	22
East division	Skegness	15
	Boston	10
South division	Grantham	14
	Spalding	6
Standby custody suites		20

- 2.4 HM Inspectorate of Prisons researchers and inspectors carried out a survey of prisoners at HMP Lincoln who had formerly been detained at custody suites in the force area, to obtain additional evidence (see Appendix II).<sup>3</sup>

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<sup>2</sup> <http://www.justice.gov.uk/inspectorates/hmi-prisons/expectations.htm>

<sup>3</sup> **Inspection methodology:** There are five key sources of evidence for inspection: observation; detainee surveys; discussions with detainees; discussions with staff and relevant third parties; and documentation. During inspections, we use a mixed-method approach to data gathering, applying both qualitative and quantitative methodologies. All findings and judgements are triangulated, which increases the validity of the data gathered. Survey results show the collective response (in percentages) from detainees in the establishment being inspected compared with the collective response (in percentages) from respondents in all establishments of that type (the comparator figure). Where references to comparisons between these two sets of figures are made in the report, these relate to *statistically significant* differences only. Statistical significance is a way of estimating the likelihood that a difference between two samples indicates a real

- 2.5 Comments in this report refer to all suites, unless specifically stated otherwise.

## Strategic overview

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- 2.6 There was leadership by a chief officer but some confusion about strategic arrangements for the provision of custodial services. The force devolved day-to-day management for custody to divisions but was looking to centralise it within the Criminal Justice and Partnership (CJ&P) department. This was part of a wider review and restructuring of the force. Current structures made it difficult to drive through change, and the force had not acted on previous critical external reviews of custody.
- 2.7 The force did not have an estates strategy for future developments and use of the custody estate but this was included in the ongoing review. Relationships with the Lincolnshire Police Authority (LPA) were described as positive. There was a well-supported independent custody visitors (ICV) scheme operating.
- 2.8 Staffing levels were mostly adequate, although there was widespread use of police constables to cover for civilian custodians (detention officers) and most custody sergeants worked in custody for short periods. There was a custody manager based in each of the three operational divisions but they were not full time in roles and they did not line manage custody sergeants. There were quarterly strategic and divisional custody users groups. Staff training arrangements were satisfactory and refresher training was offered. 'Learning the lessons' information was gathered and circulated. Quality assurance arrangements were inadequate.
- 2.9 Partnership work was well developed, although there were ongoing problems with strategic mental health partners.
- 2.10 There was a system for gathering use of force data but this was not reported on effectively and the force did not use the available data adequately to monitor patterns and trends.

## Treatment and conditions

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- 2.11 The staff culture was good and the interactions we witnessed were professional and appropriate. The approach to the diverse range of detainees held was adequate, although there was insufficient focus on meeting the specific needs of juvenile and female detainees. There was no strategy for managing detainees with disabilities and few adjustments had been made in custody suites. Interpreting services were used when needed. There was a lack of privacy at some booking-in desks.
- 2.12 The approach to the initial risk assessments was mixed. In most cases, they were thorough but staff appeared not always to take a proportionate approach to managing risk and some were not clear about the importance of rousing detainees who were unfit due to drink or drugs. Risk assessments were not regularly revisited as circumstances changed. Custody records did not always provide detailed information about why decisions had been made.

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difference between the populations from which the samples are taken, rather than being due to chance. If a result is very unlikely to have arisen by chance, we say it is 'statistically significant'. The significance level is set at 0.05, which means that there is only a 5% chance that the difference in results is due to chance. (Adapted from the *Dictionary of Forensic Psychology*: HM Inspectorate of Prisons.)



- 2.13 All the suites we visited were clean and there was little graffiti but we found ligature points in a number of cells. Health and safety monitoring took place but it was inconsistent.
- 2.14 The use of cell call bells was routinely explained to detainees and staff carried anti-ligature knives. Fire safety and evacuation arrangements were understood by staff but records of drills were unavailable.
- 2.15 Showers were usually provided only on request. Not all the custody suites had adequate supplies of replacement clothing, and paper suits were sometimes used instead.
- 2.16 Meals and drinks were generally offered when requested or at set mealtimes but the quality of microwave meals was poor. Exercise was sometimes offered but detainees were not routinely informed that it was available. Some reading materials were available. Few, if any, visits were facilitated.

## Individual rights

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- 2.17 We found a positive approach to balancing the priorities of progressing cases with the rights of individuals. Detainees were offered a copy of PACE and comprehensive leaflets in a range of languages. PACE was generally adhered to.
- 2.18 Legal assistance was offered and freely available. Staff made calls to notify someone of the detainee's arrest.
- 2.19 We found no examples of children who had been held in custody under section 46 of the Children Act 1989 but getting access to a PACE place of safety bed for juveniles was a problem.
- 2.20 Detainees were not routinely asked if they had any dependency obligations. Pre-release risk assessments resulted in some appropriate actions being taken but the quality of these was mixed.
- 2.21 Staff mainly called on family members or family friends to act as appropriate adults (AAs) for juvenile and vulnerable adult detainees. When this was not possible or appropriate, social services provided an AA both for juveniles and vulnerable adults. The service was poor out of hours and we found examples of detainees who had not been provided with an AA when this should have happened.
- 2.22 The management of DNA was generally good. The cut-off times for courts were mainly too early, resulting in longer stays in custody than would otherwise be necessary. Detainees were not routinely told how to make a complaint, and the arrangements for taking complaints were confused.

## Health care

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- 2.23 Primary health services were provided by G4S and were generally good. Clinical governance arrangements were well developed and medicines management robust, although there was some secondary dispensing. The force made efforts to collect medications from detainees' home addresses. Resuscitation equipment was available to custody staff, who were trained in its use.

- 2.24 We observed some good care provided to detainees by health services professionals, and waiting times were reasonable. Clinical rooms were variable in quality.
- 2.25 Substance misuse services were delivered by Addaction and were also good. Despite efforts made by the force, mental health services were extremely poor and too many detainees were held under section 136 of the Mental Health Act 1983.<sup>4</sup>

## Main recommendations

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- 2.26 Staff deployed in custody suites should have knowledge and skills required to work in custody.
- 2.27 Risk assessment procedures should be revised to ensure greater consistency, regular reviews and better management oversight.
- 2.28 Lincolnshire police should address the safety issues around ligature points and, where resources do not allow them to be dealt with immediately, the risks should be managed.
- 2.29 Appropriate arrangements should be in place to divert people with mental health problems from police custody suites, including those being assessed under section 136 of the Mental Health Act.

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<sup>4</sup> Section 136 enables a police officer to remove someone from a public place and take them to a place of safety – for example, a police station. It also states clearly that the purpose of being taken to the place of safety is to enable the person to be examined by a doctor and interviewed by an approved social worker, and for the making of any necessary arrangements for treatment or care.

## 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 The strategic leadership of custody provision in the force was in a period of flux. The force was going through a reorganisation, led by the Deputy Chief Constable (DCC), under a policing change programme which included custody provision. The aim was for this to be finalised by April 2011.
- 3.2 The reorganisation was likely to reduce the force from three geographical divisions to one whole-force structure. As part of this reorganisation, the force was considering a move away from its current model, whereby custody provision had been devolved to the three divisions, with some corporate oversight from headquarters (HQ), and towards a centralised custody model under the command of the CJ&P department. It was anticipated that this would allow for greater consistency and permanent staffing, thereby reducing risk, as well as delivering a better service.
- 3.3 An assistant chief constable (ACC) was the portfolio holder for custody provision. He maintained an overview of custody through a superintendent within the CJ&P department. Day-to-day responsibility and management of custody provision lay with the policing divisions. There was a chief inspector at HQ who was responsible for producing custody policy and protocols.
- 3.4 While there was evidence of chief officer awareness of the challenges facing the force, from a custodial perspective there were significant weaknesses in management oversight and staffing arrangements. The command structure from the ACC through CJ&P and the central team worked well but the force had limited scope to ensure that the policy and procedures were implemented consistently at divisional level.
- 3.5 There were custody managers in each division but each carried additional responsibilities and therefore could provide only limited time to the role of custody manager and did not work with all of the custody teams owing to their different and dedicated shift patterns. Some inspectors worked from locations which were not custody locations and visits to custody suites were therefore not as frequent as they should have been. Performance development reviews (PDRs) for staff were completed by their own shift inspectors, rather than custody managers, so there was a gap between their performance and development needs.
- 3.6 This had led, in part, to a lack of intrusive supervision of custody staff on some shifts. It also meant that custody managers were unable to comply with the force's own 'Custody Audit and Inspection Guidance'. Dip-sampling of custody records took place inconsistently and there was no central overview from HQ. No dip-sampling was cross-referenced with closed-circuit television (CCTV) footage, to quality assure the accuracy of custody records, and this left the force exposed to risk.
- 3.7 Some custody sergeants were permanently posted into custody for 12 months, while others were rotated through custody from operational uniform shifts. Some of the rotational duties were ad hoc and some sergeants operating in custody suites had not had any custody training for many years. It was evident from speaking to and observing some staff that their knowledge and computer skills were out of date and that they had suffered from a deterioration in skills

during their deployment outside of custody. A lack of a corporate approach to the way in which each of the three divisions deployed their staff compounded these issues further, although we found all custody staff to be polite, professional and respectful.

- 3.8 Most staff had attended nationally accredited custody training before being deployed in custody suites, although police constable gaolers had been deployed into custody from divisional uniform duties without being trained. These officers were relatively inexperienced and therefore unfamiliar with their duties. This was a high-risk approach and placed detainees, staff and the force at unnecessary risk from adverse incidents. However, the force had recently introduced measures to ensure that only trained staff were deployed into custody and there was a rolling refresher training regime which was controlled from HQ.
- 3.9 Some of these issues had been identified previously; for example, the National Policing Improvement Agency (NPIA) Custody Peer Reviews of 2007 and 2009 had highlighted issues relevant to the management of custody and staffing but there had been some inertia in dealing with them. The force lacked a strategic plan for the custody estate, although a custody suite had recently been built at Grantham and the custody suite at Lincoln had been refurbished. The custody suite at Spalding was due to be closed in mid-January 2011 for refurbishment and the force was considering a rationalisation of the existing custody provision which could result in the closure of suites.
- 3.10 The LPA was described to us as having 'a very strong working relationship' with the force, in terms of criminal justice and custody generally, with the LPA lead officer for custody also being the chairman of the Professional Standards Committee. The LPA had been urging the force 'for a number of years' to produce an estates strategy, which had been only partly addressed by the appointment of an asset manager, who had recently carried out a review of the estate. The LPA ran an ICV scheme, which had three panels, mirroring the divisional structure. They were well supported by the LPA, which prepared quarterly reports on ICV visits to custody suites. ICVs had recently been provided with accredited training. ICV feedback was captured well, with consistent updating on matters raised.
- 3.11 The deputy chief constable sat on the Local Criminal Justice Board (LCJB), which included representatives from the Crown Prosecution Service (CPS), defence solicitors, the Prison Service and the Youth Offending Service. The superintendent for CJ&P was the chair for the strategic custody user group, which met quarterly, in parallel with divisional user group meetings. Relationships with the UK Border Agency (UKBA) were described as 'strong', although there were too many detainees being held in custody for long periods on immigration matters (see section on individual rights).
- 3.12 Monthly analysis of all 'near-death' incidents was carried out by the force's Professional Standards Department, which emailed guidance to all staff who might carry out custody duties. While the service was comprehensive, these emails were not held by the force in one central location on the intranet, where they could be readily accessed by all staff when required, but had to be filed by individual staff for their own information.
- 3.13 Mental health provision was poor and working relationships with mental health providers in the county had broken down, despite the personal intervention of the Chief Constable.

## Recommendation

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- 3.14 Custody managers should have time to carry out sufficient dip-sampling of custody records to quality assure standards of practice.

## 4. Treatment and conditions

### Expected outcomes:

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

### Respect

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- 4.1 Most of the detainees we spoke to had been transported to the custody suite in police cars, and a few in a police van. They described vehicles as having been reasonably clean and comfortable. They had all been handcuffed while being transported but handcuffs had been removed on arrival at the custody suite. The prisoner escort records we saw had been completed properly.
- 4.2 Interactions between custody staff and detainees were good, and first names used routinely. We observed a good level of care; for example, custody staff checked detainees' understanding of what was happening to them, over and above simply reading them their rights, particularly in Grantham, where we observed some excellent interactions. Detainees were searched respectfully and any property removed and recorded accordingly.
- 4.3 There was limited evidence of staff exploring the specific needs of women, juveniles and detainees from minority groups in sufficient depth. When asked about diversity, staff said that they tried to treat everyone the same. We were told that additional female staff could be called on from the police station if needed but this was not offered routinely. There were stencils on the walls of female cells, informing occupants that hygiene packs were available on request. We observed juvenile detainees being dealt with in an age-appropriate manner but staff had not undertaken any child protection or 'safeguarding' awareness training. In Boston, which often detained a large number of non-native English speakers, there were limited illustrative notices in relevant languages. Despite their good intentions, we were not convinced that staff would always recognise the specific diversity needs of detainees.
- 4.4 Provision for detainees with disabilities was limited and there was no overarching policy about how they would be accommodated. At Lincoln, the only toilet that had been adapted for such detainees had to be accessed via the treatment room and it was being used to store equipment. In some custody suites, all cells had low bed plinths, which would have caused difficulty for detainees with disabilities. Grantham, a modern custody suite, could accommodate detainees using a wheelchair but this was not the case in Boston and Skegness. Not all of the custody suites had hearing loops or Braille information for detainees with hearing or sight disabilities. A Qur'an, prayer mat and Bible were available in the custody suites although staff at Boston were not aware of this. All cells were equipped with an arrow indicating the direction of Mecca.
- 4.5 Telephone and face-to-face interpreting services were available for all detainees whose first language was not English. In Boston, custody staff were experienced in dealing with foreign nationals but this usually resulted in longer booking-in times, which did not appear to have been considered as part of the staff resource.
- 4.6 The layout of booking-in areas offered little privacy. While custody staff tried to deal with detainees one at a time, some detainees told us that they were unhappy about disclosing private matters where they could be overheard. During the inspection, this was exacerbated at

Boston and Lincoln by the large number of staff and others present in the booking-in area. In the booking-in area in Lincoln, a white board containing information about detainees, including their names, was visible to anyone entering the custody suite. Lincoln, Boston and Skegness custody suites had a two-handset system for telephone conversations with interpreters, which provided greater privacy to non-English-speaking detainees during the booking-in process.

## Recommendations

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- 4.7 Diversity training should be improved, to enable more effective engagement with minority groups.
- 4.8 Some cells should be adapted for use by detainees with physical disabilities, and access to toilet facilities for such detainees should be improved.
- 4.9 Booking-in areas should allow for private communication between detainees and staff and confidentiality of personal information.

## Housekeeping point

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- 4.10 A Bible, Qur'an and a suitable prayer mat should be provided in all custody suites.

## Safety

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- 4.11 Staff going off duty provided a thorough briefing for colleagues starting their shift, although for some handovers this was not formally built into the shift pattern. Custody sergeants undertook initial risk assessments in a conversational manner, based on what was said by detainees and arresting officers; they noted safety markers in existing computerised records and made use of their own knowledge of the detainee, and their observations of the detainee's behaviour and mood.
- 4.12 In our analysis of 30 custody records, detainees' clothing had been removed in nine (30%) cases, which was excessive. Red overalls were provided to those at risk of self-harm, on the basis that if a ligature was made from them, it could easily be seen. This practice seemed unnecessarily stigmatising. In one case, a female detainee who had attempted to self-harm had been left naked in her cell for 12 hours. Her clothes had subsequently been returned to her so that she could be interviewed, and she had then been left for four hours in her own clothing, with no further assessment of risk. We brought this case to the attention of the force.
- 4.13 There was limited evidence that risk assessments were reviewed, other than at the shift handover. There was also inconsistency in custody staff's knowledge of the procedural 'levels of risk' on which a detainee could be placed.
- 4.14 We observed appropriate rousing being conducted but one custody sergeant we talked to did not seem to be aware of the need to elicit more than a 'yes or no' response when rousing intoxicated detainees. We found an example in a custody record where rousing had been required but, according to the entries, had not taken place consistently. Entries in custody records were generally poor. Although a few showed some knowledge of the detainees, too many were cursory.

- 4.15 Constant watches required additional officers to be drawn in from patrols, and at Lincoln we were told that this could result in reluctance on the part of custody sergeants to approve this measure. By contrast, we saw constant watches taking place at Boston.
- 4.16 All custody suites had some cells with CCTV coverage and these were used appropriately for higher-risk detainees. In all custody suites, staff carried anti-ligature knives either on their belt or attached to bunches of keys which were generally, although not constantly, on their person throughout their duty day.

## Recommendations

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- 4.17 **The removal of detainees' clothing should cease to be the standard response to any concerns about self-harm; when clothing is taken away, assessments should be reviewed regularly.**
- 4.18 **When appropriate, detainees should be roused to elicit a response.**

## Housekeeping point

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- 4.19 Staff should carry anti-ligature knives.

## Use of force

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- 4.20 The force policy was that all uses of force should be recorded on a use of force form, and also on the custody record if the incident occurred in custody. However, this did not always happen and, of the forms that had been submitted, there was only limited analysis of the data they contained. Although staff said that force was used only as a last resort, we could find no information to confirm this, although we were reassured by the positive staff culture in custody, which was clearly focused on the welfare of detainees. We were assured that staff had been trained in the approved techniques and had received annual refresher training.
- 4.21 There were no clear and agreed procedures to manage potentially violent detainees. We were told that, with the authority of the custody sergeant, handcuffs and Velcro straps could be used but protocols for their use were not known to staff or found at any of the custody suites we inspected. In our prison survey, fewer detainees from Lincolnshire than from comparable areas said that they had been victimised by custody staff.

## Recommendations

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- 4.22 **Lincolnshire police should submit a use of force form in every appropriate instance, and should monitor the use of force at each custody suite by ethnicity, age, location and officers involved, in line with Association of Chief Police Officers (ACPO) guidance.**
- 4.23 **Governance should be improved to ensure that custody staff employ consistent, approved methods when using force.**

## Physical conditions

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- 4.24 All of the custody suites were clean and there was little graffiti. The cleaning regime was robust and thorough. However, we found ligature points in most cells and there were some concerns about the presence of old ventilation grilles. The force started to address these issues during the inspection. Procedures for health and safety 'walk-throughs' of custody suites varied between suites and there was no central oversight of these processes. Deep cleaning requirements were highlighted by the on-call cleaning company and resulted in prompt action and the return of the cell to operational use within a few hours.
- 4.25 We found no records showing the regularity of fire alarm tests, although staff said that they did take place, and staff could not recall fire drills ever taking place. At Grantham, there were insufficient plastic handcuffs to evacuate all detainees from the building safely and securely if necessary. The use of cell call bells was explained to detainees.
- 4.26 There was a strict no-smoking policy throughout the custody suites and this appeared to be strictly enforced. Staff were unsure as to whether nicotine replacements were available at the suites, although this was not raised as an issue by the detainees we spoke to.

## Recommendation

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- 4.27 **Health and safety walk-through arrangements should be thorough and consistently applied at all custody suites.**

## Housekeeping points

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- 4.28 Records should be kept in custody suites of when fire bells are tested and evacuation drills should take place.
- 4.29 All suites should have sufficient handcuffs to evacuate detainees securely.

## Personal comfort and hygiene

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- 4.30 All custody suites had showers. In our survey, 92% of ex-detainees stated that they had stayed overnight in police custody but only 22% indicated that they had been offered a shower. Staff told us that a shower would generally be arranged for any detainee who requested one but that it was not routine to offer this or inform the detainee that it was available.
- 4.31 Mattresses were in a good condition and were wiped down after each use. Clean blankets were provided for most detainees on being placed in a cell and always during sleep periods.
- 4.32 Toilet paper was not routinely provided and detainees had to request it each time it was needed. Toilets in all cells monitored by CCTV were electronically obscured but detainees were not routinely told this.
- 4.33 The family and friends of detainees were allowed to bring in replacement clothing if needed. Stocks of paper clothing and foam slippers were maintained. There were some tracksuit tops and bottoms available but shortages meant that paper clothing was sometimes offered when a detainee had their clothing removed for evidential purposes. In Lincoln, we saw one female



detainee being released in a police-issue paper top and no shoes but she was taken home in a police car by two female officers. Replacement underwear was not available at all suites.

- 4.34 All cells were checked after each occupation, used blankets were removed for laundering, mattresses and pillows were wiped down and any minor cleaning deemed to be required was undertaken by custody staff.

## Recommendations

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- 4.35 All detainees held overnight, or those who require one, should be offered a shower.
- 4.36 Suitable alternative clothing should always be provided to detainees when needed.

## Housekeeping points

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- 4.37 All toilet areas covered by CCTV should be effectively obscured and detainees should be informed of this.
- 4.38 Detainees should be routinely provided with toilet paper.

## Catering

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- 4.39 Food and drink were served at regular mealtimes or on request. With the exception of toast, all food provided was in the form of microwaveable meals; these catered for basic dietary requirements but were of poor quality and not substantial for detainees held for long periods. In most custody suites these meals were listed, to give custody staff information about which ones were suitable for halal requirements, vegetarians and so on.
- 4.40 Food preparation areas were clean and staff we spoke to had received basic food hygiene training.

## Activities

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- 4.41 All custody suites had exercise yards, which staff let detainees use when requested, but detainees were not routinely informed that exercise was available. Most detainees we spoke to did not know that outside exercise was available. There were small stocks of magazines and books, although many were old and worn. Staff had made efforts to provide books in the Eastern European languages spoken by many detainees in the area. Visits were rarely, if ever, allowed.

## Housekeeping point

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- 4.42 Detainees should be routinely informed of the provision for outside exercise.



# 5. Individual rights

## Expected outcomes:

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

### Rights relating to detention

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- 5.1 Custody staff were notified and given relevant details about whether or not a detainee being brought into custody was aggressive or vulnerable. Custody sergeants ascertained the circumstances of the detainee's arrest and checked the grounds for detention. We were given anecdotal examples of occasions when sergeants had refused to accept detainees, as the grounds for detention had not been clearly established. We saw that custody sergeants, particularly at Grantham, were prepared to challenge the proportionality of arrest and detention, especially when children or juveniles were involved. Training had recently been delivered to all custody staff at Grantham, covering the basic elements of arrest in order to reinforce the importance of applying the 'necessity test' (i.e. that it be lawful and proportionate). Custody sergeants ensured that cases were dealt with as quickly as possible, to minimise the length of time that detainees spent in custody. The suites were not used as a place of safety for children under section 46 of the Children Act 1989.<sup>5</sup>
- 5.2 A total of 121 immigration detainees had been held in the custody suites between 23 March 2010 and the inspection. Data provided by the force indicated that many of these had been moved on relatively quickly by UKBA but that, of the last 100 such detainees dealt with, 22 had been held for more than 48 hours (UKBA guidance indicates this should be the case only exceptionally). We were told that the situation was less problematic at Boston, where there was an immigration office located in the same building as the custody suite. Staff working at the custody suite in Boston appeared to have good working relationships with their UKBA colleagues.
- 5.3 Detainees were asked on arrival if they wanted someone to be told of their whereabouts. We saw custody staff at Lincoln and Spalding encouraging detainees to tell someone where they were but telephone calls were made in a public area and afforded little privacy. There was a separate telephone booth at Spalding but this was used exclusively for calls to legal representatives. All detainees were given a notice of their rights and entitlements, which was available in a range of languages.
- 5.4 Detainees were not routinely asked if they had any dependency obligations. We were told that female detainees usually brought any concerns about childcare to the attention of either the arresting officers or custody suite staff. All sergeants said that they would allow detainees access to the telephone to contact family or friends to put childcare arrangements in place during the detention period.
- 5.5 Pre-release plans were completed on all detainees but these mostly lacked any substantial content. We observed two vulnerable detainees being transported home by police staff. We were informed about a number of cases where custody staff had collaborated with community-

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<sup>5</sup> Section 46(1) of the Children Act 1989 empowers a police officer, who has reasonable cause to believe that a child would otherwise be likely to suffer significant harm, to remove the child to suitable accommodation and keep him/her there.

based services, such as social workers and emergency housing staff, to assist vulnerable detainees on release. This was most developed at Skegness, where vulnerable, homeless detainees were sometimes placed with a local bed and breakfast proprietor, after funds had been secured from the local authority.

## Recommendations

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- 5.6 The force should engage with UK Border Agency to ensure that immigration detainees are held for the shortest possible time.
- 5.7 Custody staff should ensure that any dependency issues of detainees are identified and, where possible, addressed.

## Rights relating to PACE

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- 5.8 A police inspector conducted all reviews of detention, and those that we observed were generally thorough and timely. All custody suites had up-to-date copies of PACE and all detainees were offered a copy to take to their cell. All suites also held copies of the guidance on the safer detention and handling of persons in police custody. All detainees were able to consult legal representatives in private, free of charge, and there were sufficient adequately equipped interview rooms in each of the suites. A duty solicitor scheme was in operation. Custody staff described good relationships with defence solicitors, and the interactions we saw were friendly but professional. Defence solicitors were given access to information on custody records, and could apply in writing for a copy of them.
- 5.9 Family members or family friends were usually contacted to act as an AA. When this was not possible or appropriate, local social services staff provided the referral link for AA services, both for detainees under the age of 17 and vulnerable adults. Staff said that the service was generally reliable but that there was little in place after 9pm, and out-of-hours support from the emergency social services duty team (EDT) for juveniles was limited. In all but the most serious cases, custody sergeants bailed juveniles rather than holding them in custody overnight. There were no available services for vulnerable adults after 9pm, and staff told us that such services were generally less reliable than those for juveniles. We came across cases where, although information in the custody record had indicated the need for an AA, one had not been provided, with no explanation for this. The force adhered to the PACE definition of a child instead of that in the Children Act 1989, which meant that those aged 17 were not provided with an AA unless otherwise deemed vulnerable.<sup>6</sup> Police were aware of the requirements for local authorities to provide place of safety beds for juveniles but told us that these were not available in the county.
- 5.10 Detainees were not interviewed while under the influence of drugs or alcohol, and the custody records we sampled demonstrated that detainees were granted appropriate break periods and had access to food and drink during interviews. Detainees could obtain a full copy of their custody record by submitting a request in writing on release from custody but they were not told of this during their initial interview.
- 5.11 The handling and processing of DNA and forensic samples taken from detainees was good. There were clear procedures in respect of continuity of evidence and collection of samples. We

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<sup>6</sup> Although this met the current requirements of PACE, in all other UK law and international treaty obligations, 17-year-olds are treated as juveniles. The UK government has committed to bringing PACE into line as soon as a legislative slot is available.

identified only a couple of local issues regarding some old DNA samples which had not been processed sufficiently well.

- 5.12 Detainees were transported to court in a timely manner but the court cut-off times were too early, at between 12pm and 2pm, which in some cases resulted in unnecessarily long stays in custody.

## Recommendations

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- 5.13 Senior police officers should engage with the local authority to ensure that they meet their statutory obligation to provide place of safety beds for juveniles.
- 5.14 Appropriate adults should be available to support juveniles aged 17 and under and vulnerable adults in custody, including out of hours.
- 5.15 Senior police officers should engage with HM Court Service to ensure that early court cut-off times do not result in unnecessarily long stays in custody.

## Rights relating to treatment

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- 5.16 Detainees were not routinely informed how to make a complaint about their treatment. Custody records showed that if detainees were in custody long enough to have their detention reviewed by an inspector, they were routinely asked if they wanted to make any representations about their time in custody. Inspectors we spoke to said that this was intended to act as an opportunity for detainees to raise complaints. Detainees we interviewed said that this had not been made clear to them. While some custody staff told us that complaints would be taken while the detainee was in custody, other staff said that they would only be taken from detainees on their release from custody, which could be seen as a mechanism for suppressing them. The force did, however, provide posters explaining how to make a complaint, and these included contact information for the Independent Police Complaints Commission.<sup>7</sup>

## Recommendation

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- 5.17 Detainees should be told how to make a complaint and be able to do so before they leave custody.

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<sup>7</sup> IPCC statutory guidance to the police service and police authorities on the handling of complaints, 2010



## 6. Health care

### Expected outcomes:

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

### Clinical governance

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- 6.1 Health services were provided by G4S Forensic and Medical Services (UK) Ltd (G4SFMS). Substance use services were provided by Addaction across the force area, and relationships between Addaction and the force at all levels were described as excellent. Services for detainees with mental health problems were poor, with little apparent engagement from health economy partners.
- 6.2 G4SFMS had robust clinical governance arrangements that included clear lines of management and an escalation process, so that staff could obtain further advice at any time if required. There was a comprehensive induction programme for new staff. There were opportunities for staff to have clinical supervision and there was a programme for staff appraisal. Staff had access to a range of continuing professional development.
- 6.3 G4SFMS staff were thorough in their consultations with detainees and provided a good service; in our survey, 39% of detainees seen by a health professional rated the quality of care as good or very good. Staff had access to interpreting services and knew how to use them if required.
- 6.4 The clinical rooms across the force area were in a reasonable state and most were of adequate size, except the one at Boston. There had been no formal infection control audits. Some clinical waste sacks contained domestic rubbish and most of the couches were not covered by paper couch roll. Not all of the sharps bins had been signed and dated at the start of use. Many rooms were left unlocked when not in use because resuscitation equipment was stored in them.
- 6.5 Medicines were stored in locked cupboards in each room and records were accurate. Health services professionals were able to supply and administer a reasonable range of medications using patient group directions but they also left medicines for custody staff to administer at a later time, which constituted secondary dispensing. Custody staff kept a small range of medications at the suite, supplied by G4SFMS, such as asthma inhalers, mild analgesics, glyceryl trinitrate spray and nicotine replacement patches. They were able to administer any of these, following telephone advice from a G4S forensic medical examiner (FME).
- 6.6 All of the suites had an automated external defibrillator (AED) and oxygen but there was no suction equipment. In some suites, the kits were kept by the custody desk but in others it was in the medical room. There were discrepancies as to who checked the equipment and how often it was checked. For example, at Lincoln there were daily documented checks by custodians but at Grantham there were no documented checks, although custodians assured us that the equipment was checked, and at Spalding there were no obvious checks. All of the custody staff we spoke to had received resuscitation training, including in the use of oxygen and the AED.

## Recommendation

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- 6.7 The practice of secondary dispensing by health services professionals should cease.

## Housekeeping points

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- 6.8 There should be robust infection control procedures, including regular infection control audits for all clinical rooms.
- 6.9 All examination couches should be covered with paper couch roll.

## Patient care

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- 6.10 G4SFMS provided at least one health services professional (a nurse or paramedic) to the force area throughout the 24-hour period. In addition, there were one or two doctors available. We noticed a higher than normal use of FMEs; this was explained by the poor arrangements that were in place for detainees with mental health problems (see below), which made it necessary for G4SFMS staff to undertake numerous formal mental health assessments requiring a section 12-approved doctor.<sup>8</sup>
- 6.11 G4SFMS provided the force with a comprehensive range of monthly statistics relating to their Service Level Agreement, although these were not verified by the police. Response times were generally good. The police had recently paid G4SFMS a penalty, as the number of cases seen had far exceeded the estimates made at the start of the contract. In our survey of custody records, we found that seven (23%) detainees had been seen by the FME. The longest wait had been approximately two hours, with an average wait of 12 minutes. In several cases, advice had been given over the telephone by a doctor.
- 6.12 Detainees could not be guaranteed to see a doctor of the gender of their choice if needed, although a chaperone could be made available.
- 6.13 Fifty-one per cent of respondents to our survey were on medication on arrival in custody, of whom 40% were able to continue it while in custody. Custody staff attempted to retrieve medications, including methadone, from a detainee's home or pharmacy if required.
- 6.14 All clinical records were paper based and kept appropriately in a locked metal safe which was accessible only to G4SMFS staff. The records were collected regularly by G4SMFS, scanned and digitalised onto master discs, and stored at another location. There were strict policies relating to the safeguarding of medically confidential information. There was a section on the form for signed consent for clinical examination and forensic sampling when required. Of the 31 clinical records that we looked at, only 20 (65%) had evidence of consent being obtained. Clinical staff also put an entry onto NICHE, although staff commented that it was not an easy system to use and we found it difficult to find entries by clinical staff during our analysis of custody records.

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<sup>8</sup> An electronic custody record system



## Recommendation

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- 6.15 In all cases, there should be documentary evidence that consent for a clinical examination has been obtained.

## Substance use

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- 6.16 In our survey, 42% of respondents said that they had a drug or alcohol problem, of whom 19% had been offered the opportunity to see a substance use worker.
- 6.17 Addaction workers were available during the day on weekdays, visiting each suite at least once a day and also attending the local courts. If a detainee wanted to see a worker at times when they were not available, custody or G4SFMS staff completed a referral form and left it for the worker; they then contacted the client in the community or passed the information on to prison drugs workers if necessary. Addaction and the police had a comprehensive information-sharing agreement, with the aim of getting drug- and alcohol-addicted detainees into treatment programmes.
- 6.18 Addaction workers provided initial assessments and harm minimisation advice for detainees with either drug or alcohol issues. Whenever relevant, the same worker continued to see the client following release or referred the client on to other services. Addaction and other substance use services also provided a range of other interventions. Services were available for juveniles, as well as adults, and there were reasonable services for persons with alcohol issues, such as a fixed penalty notice scheme, whereby those attending an alcohol awareness course run by Addaction received a reduction in their fixed penalty.
- 6.19 While needle exchange was not possible in the custody suites, there were a number of venues across the force area where it was possible for drug users to obtain clean needles. We saw notices about this in some of the custody suites we visited.

## Mental health

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- 6.20 In our custody record analysis, nearly one in five (17%) detainees reported mental health problems, and police custody officers and G4S staff suggested that the incidence was higher. In spite of this high frequency, there was no offender mental health strategy in Lincolnshire. Health partners did not engage effectively with the force and were failing to meet their statutory responsibilities to provide places of safety for such detainees; as a consequence, up to 500 mentally ill detainees a year were still inappropriately being placed in police cells.
- 6.21 A police inspector acted as the mental health liaison officer for the force. Lincolnshire Partnership NHS Foundation Trust (the Trust) had been contracted by Lincolnshire NHS Primary Care Trust (the PCT) to provide mental health services. There was no strategic meeting at executive level and no information-sharing protocol. The inspector and a Trust senior operational manager had recently begun to meet but relationships were underdeveloped.
- 6.22 G4S staff could telephone local crisis resolution and home treatment teams (CRHTs) for advice on detainees with suspected mental health problems; this occasionally resulted in the police transporting detainees to CRHT bases, so that detainees could be assessed. Police rarely took such detainees to local accident and emergency departments, as this generally did not result in diversion from custody and was time consuming. No specialist mental health

service was offered to adult detainees in police custody. Diversion opportunities for adults were limited. Young persons with suspected mental health problems were referred to the youth offending team (YOT). YOT mental health workers came to assess the young person or offered an appointment for assessment following release from custody.

- 6.23 There was high use of section 136 of the Mental Health Act, with more than 420 (over 47 per month) being initiated in a 10-month period. The police custody suites were being used extensively, but inappropriately, as places of safety. We were told that dedicated NHS section 136 suites at Boston and Lincoln had been developed but were not accessible to detainees. The police and Trust were working on a protocol for the use of section 136. The protocol, which had been in development for over two years, stated that the agreed places of safety in Lincolnshire for patients awaiting, and undergoing, assessment were the section 136 suites at the inpatient/hospital psychiatric service.
- 6.24 Staff had various opinions on the reasons for the non-use of the NHS facilities for detainees with mental health problems; these included lack of staffing, poor availability of section 12-approved doctors, possible tolerance to the overuse of section 136 for intoxicated persons and a low conversion rate to Mental Health Act sections following assessments, suggestive of inappropriate use of section 136. All parties expressed frustration with the situation and all, with the exception of the Trust, agreed that the NHS section 136 suites should be opened as soon as possible. The Trust was in the process of making a case for increased staffing.
- 6.25 We observed the process of providing a mental health assessment for a section 136 detainee in police custody at Lincoln. The doctor was on site at the time the detainee arrived and a social services emergency duty team member arrived within two hours, following which a joint assessment occurred. Custody officers at Lincoln said that the response times for EDT members were usually good during working hours but were often longer out of hours. We observed discussions about a plan to divert the detainee from police custody.
- 6.26 Police custody officers and support staff confirmed that they received mental health awareness training as part of their continuing professional development, although this was usually limited to one or two hours per year.

## Recommendation

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- 6.27 There should be an offender mental health strategy and information-sharing protocol in Lincolnshire, and regular strategic meetings between police officers and Lincolnshire Partnership NHS Trust.

## 7. Summary of recommendations

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<b>Main recommendations</b>	<b>To Lincolnshire Police</b>
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- 7.1 Staff deployed in custody suites should have knowledge and skills required to work in custody. (2.26)
- 7.2 Risk assessment procedures should be revised to ensure greater consistency, regular reviews and better management oversight. (2.27)
- 7.3 Lincolnshire police should address the safety issues around ligature points and, where resources do not allow them to be dealt with immediately, the risks should be managed. (2.28)
- 7.4 Appropriate arrangements should be in place to divert people with mental health problems from police custody suites, including those being assessed under section 136 of the Mental Health Act. (2.29)

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<b>Recommendation</b>	<b>To the UK Border Agency</b>
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- 7.5 The force should engage with UK Border Agency to ensure that immigration detainees are held for the shortest possible time. (5.6)

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<b>Recommendations</b>	<b>To Lincolnshire Police</b>
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### **Strategy**

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- 7.6 Custody managers should have time to carry out sufficient dip-sampling of custody records to quality assure standards of practice. (3.14)

### **Treatment and conditions**

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- 7.7 Diversity training should be improved, to enable more effective engagement with minority groups. (4.7)
- 7.8 Some cells should be adapted for use by detainees with physical disabilities, and access to toilet facilities for such detainees should be improved. (4.8)
- 7.9 Booking-in areas should allow for private communication between detainees and staff and confidentiality of personal information. (4.9)
- 7.10 The removal of detainees' clothing should cease to be the standard response to any concerns about self-harm; when clothing is taken away, assessments should be reviewed regularly. (4.17)
- 7.11 When appropriate, detainees should be roused to elicit a response. (4.18)

- 7.12 Lincolnshire police should submit a use of force form in every appropriate instance, and should monitor the use of force at each custody suite by ethnicity, age, location and officers involved, in line with Association of Chief Police Officers (ACPO) guidance. (4.22)
- 7.13 Governance should be improved to ensure that custody staff employ consistent, approved methods when using force. (4.23)
- 7.14 Health and safety walk-through arrangements should be thorough and consistently applied at all custody suites. (4.27)
- 7.15 All detainees held overnight, or those who require one, should be offered a shower. (4.35)
- 7.16 Suitable alternative clothing should always be provided to detainees when needed. (4.36)

### **Individual rights**

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- 7.17 Custody staff should ensure that any dependency issues of detainees are identified and, where possible, addressed. (5.7)
- 7.18 Senior police officers should engage with the local authority to ensure that they meet their statutory obligation to provide place of safety beds for juveniles. (5.13)
- 7.19 Appropriate adults should be available to support juveniles aged 17 and under and vulnerable adults in custody, including out of hours. (5.14)
- 7.20 Senior police officers should engage with HM Court Service to ensure that early court cut-off times do not result in unnecessarily long stays in custody. (5.15)
- 7.21 Detainees should be told how to make a complaint and be able to do so before they leave custody. (5.17)

### **Health care**

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- 7.22 The practice of secondary dispensing by health services professionals should cease. (6.7)
- 7.23 In all cases, there should be documentary evidence that consent for a clinical examination has been obtained. (6.15)
- 7.24 There should be an offender mental health strategy and information-sharing protocol in Lincolnshire, and regular strategic meetings between police officers and Lincolnshire Partnership NHS Trust. (6.27)

### **Housekeeping points**

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#### **Treatment and conditions**

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- 7.25 A Bible, Qur'an and a suitable prayer mat should be provided in all custody suites. (4.10)
- 7.26 Staff should carry anti-ligature knives. (4.19)

- 7.27 Records should be kept in custody suites of when fire bells are tested and evacuation drills should take place. (4.28)
- 7.28 All suites should have sufficient handcuffs to evacuate detainees securely. (4.29)
- 7.29 All toilet areas covered by CCTV should be effectively obscured and detainees should be informed of this. (4.37)
- 7.30 Detainees should be routinely provided with toilet paper. (4.38)
- 7.31 Detainees should be routinely informed of the provision for outside exercise. (4.42)

### **Health care**

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- 7.32 There should be robust infection control procedures, including regular infection control audits for all clinical rooms. (6.8)
- 7.33 All examination couches should be covered with paper couch roll. (6.9)

## Appendix I: Inspection team

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Sean Sullivan	HMIP team leader
Fiona Shearlaw	HMIC inspector
Peter Dunn	HMIP inspector
Ian MacFadyen	HMIP inspector
Gordon Riach	HMIP inspector
Paddy Craig	HMIC inspector
Mark Ewan	HMIC inspector
Gary Boughen	HMIP inspector
Elizabeth Tysoe	HMIP health care inspector
Paul Tarbuck	HMIP health care inspector
Catherine Nichol	HMIP researcher

# Appendix II: Summary of detainee questionnaires and interviews

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## Detainee survey methodology

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

### Choosing the sample size

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The survey was conducted on 5 January 2011. A list of potential respondents to have passed through Lincolnshire police stations was created, listing all those who had arrived from Skegness, Grantham, Lincoln, Elloes (Spalding) or Boston magistrates' court within the previous two months.

### Selecting the sample

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In total, 102 respondents were approached. Fifty-one respondents reported either being held in police stations outside of Lincolnshire, or had been released, and two could speak no English and so it was impossible to determine the police station they had been in. On the day, the questionnaire was offered to 49 respondents; there was one refusal and one questionnaire was not returned. All of those sampled had been in custody within the previous two months.

Completion of the questionnaire was voluntary. Interviews were offered to any respondents with literacy difficulties. No interviews were carried out.

### Methodology

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

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

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

### Response rates

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In total, 47 (96%) respondents completed and returned their questionnaires.

## Comparisons

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

Some questions have been filtered according to the response to a previous question. Filtered questions are clearly indented and preceded by an explanation as to which respondents are included in the filtered questions. Otherwise, percentages provided refer to the entire sample. All missing responses were 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 35 police areas since April 2008.

In the comparator document, statistical significance is used to indicate whether there is a real difference between the figures – that is, 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

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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 are excluded). The actual numbers will match up, as the data are cleaned to be consistent.

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



# Police custody survey

## Section 1: About you

<b>Q2</b>	<b>What police station were you last held at?</b> Boston – 8; Skegness – 5; Spalding – 4; Lincoln – 21; Grantham – 8; Unknown - 1
<b>Q3</b>	<b>How old are you?</b> 16 years or younger..... 0 (0%)      40-49 years..... 5 (11%) 17-21 years ..... 7 (15%)      50-59 years..... 1 (2%) 22-29 years ..... 17 (36%)      60 years or older ..... 2 (4%) 30-39 years ..... 15 (32%)
<b>Q4</b>	<b>Are you:</b> Male..... 47 (100%) Female ..... 0 (0%) Transgender/transsexual ..... 0 (0%)
<b>Q5</b>	<b>What is your ethnic origin?</b> White - British..... 39 (83%) White - Irish ..... 0 (0%) White - other ..... 6 (13%) Black or black British - Caribbean ..... 1 (2%) Black or black British - African ..... 0 (0%) Black or black British - other ..... 0 (0%) Asian or Asian British - Indian ..... 0 (0%) Asian or Asian British - Pakistani ..... 0 (0%) Asian or Asian British - Bangladeshi ..... 0 (0%) Asian or Asian British - other ..... 0 (0%) Mixed heritage - white and black Caribbean ..... 1 (2%) Mixed heritage - white and black African ..... 0 (0%) Mixed heritage- white and Asian ..... 0 (0%) Mixed heritage - other ..... 0 (0%) Chinese ..... 0 (0%) Other ethnic group ..... 0 (0%) Please specify: ..... 1 (100%)
<b>Q6</b>	<b>Are you a foreign national (i.e. you do not hold a British passport, or you are not eligible for one)?</b> Yes ..... 3 (7%) No ..... 39 (93%)
<b>Q7</b>	<b>What, if any, would you classify as your religious group?</b> None..... 15 (34%) Church of England ..... 15 (34%) Catholic ..... 6 (14%) Protestant..... 0 (0%) Other Christian denomination ..... 6 (14%) Buddhist..... 2 (5%) Hindu ..... 0 (0%) Jewish ..... 0 (0%)

Muslim.....	0 (0%)
Sikh .....	0 (0%)
Any other religion, please specify	1 (100%)

**Q8 How would you describe your sexual orientation?**

Straight/heterosexual.....	45 (98%)
Gay/lesbian/homosexual .....	1 (2%)
Bisexual.....	0 (0%)
Other (please specify):	2 (100%)

**Q9 Do you consider yourself to have a disability?**

Yes.....	11 (24%)
No .....	35 (76%)

**Q10 Have you ever been held in police custody before?**

Yes.....	40 (87%)
No .....	6 (13%)

## Section 2: Your experience of this custody suite

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

**Q11 How long were you held at the police station?**

Less than 24 hours.....	11 (23%)
More than 24 hours, but less than 48 hours (2 days) .....	20 (43%)
More than 48 hours (2 days), but less than 72 hours (3 days).....	11 (23%)
72 hours (3 days) or more .....	5 (11%)

**Q12 Were you given information about your arrest and your entitlements when you arrived there?**

Yes.....	39 (83%)
No .....	5 (11%)
Don't know/can't remember.....	3 (6%)

**Q13 Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')?**

Yes.....	29 (63%)
No .....	17 (37%)
I don't know what this is/I don't remember .....	0 (0%)

**Q14 If your clothes were taken away, were you offered different clothing to wear?**

<b>My clothes were not taken</b> .....	28 (64%)
I was offered a tracksuit to wear.....	7 (16%)
I was offered an evidence/paper suit to wear .....	3 (7%)
I was offered a blanket.....	5 (11%)
Nothing.....	1 (2%)

**Q15 Could you use a toilet when you needed to?**

Yes.....	42 (89%)
No .....	4 (9%)
Don't know .....	1 (2%)

<b>Q16</b>	<b>If you have used the toilet there, was toilet paper provided?</b>						
	Yes .....			21	(46%)		
	No .....			25	(54%)		
<b>Q17</b>	<b>Did you share a cell at the police station?</b>						
	Yes .....			3	(7%)		
	No .....			42	(93%)		
<b>Q18</b>	<b>How would you rate the condition of your cell:</b>						
		<i>Good</i>	<i>Neither</i>	<i>Bad</i>			
	Cleanliness	19 (40%)	14 (30%)	14 (30%)			
	Ventilation/air quality	14 (33%)	9 (21%)	20 (47%)			
	Temperature	14 (32%)	8 (18%)	22 (50%)			
	Lighting	17 (39%)	11 (25%)	16 (36%)			
<b>Q19</b>	<b>Was there any graffiti in your cell when you arrived?</b>						
	Yes .....			17	(37%)		
	No .....			29	(63%)		
<b>Q20</b>	<b>Did staff explain to you the correct use of the cell bell?</b>						
	Yes .....			14	(30%)		
	No .....			32	(70%)		
<b>Q21</b>	<b>Were you held overnight?</b>						
	Yes .....			43	(91%)		
	No .....			4	(9%)		
<b>Q22</b>	<b>If you were held overnight, which items of clean bedding were you given?</b>						
	<b>Not held overnight</b> .....			4	(8%)		
	<i>Pillow</i> .....			5	(10%)		
	<i>Blanket</i> .....			33	(63%)		
	<i>Nothing</i> .....			10	(19%)		
<b>Q23</b>	<b>Were you offered a shower at the police station?</b>						
	Yes .....			10	(21%)		
	No .....			37	(79%)		
<b>Q24</b>	<b>Were you offered any period of outside exercise while there?</b>						
	Yes .....			4	(9%)		
	No .....			43	(91%)		
<b>Q25</b>	<b>Were you offered anything to:</b>						
		<i>Yes</i>	<i>No</i>				
	Eat?	40 (85%)	7 (15%)				
	Drink?	45 (98%)	1 (2%)				
<b>Q26</b>	<b>What was the food/drink like in the police custody suite?</b>						
		<i>Very good</i>	<i>Good</i>	<i>Neither</i>	<i>Bad</i>	<i>Very bad</i>	<i>N/A</i>
		0 (0%)	4 (9%)	5 (11%)	19 (40%)	15 (32%)	4 (9%)
<b>Q27</b>	<b>Was the food/drink you received suitable for your dietary requirements?</b>						
	<i>I did not have any food or drink</i> .....				4 (10%)		

Yes ..... 19 (46%)  
 No ..... 18 (44%)

**Q28 If you smoke, were you offered anything to help you cope with the smoking ban there?**  
*I do not smoke* ..... 7 (15%)  
*I was allowed to smoke* ..... 0 (0%)  
*I was not offered anything to cope with not smoking* ..... 36 (78%)  
*I was offered nicotine gum* ..... 2 (4%)  
*I was offered nicotine patches* ..... 0 (0%)  
*I was offered nicotine lozenges* ..... 1 (2%)

**Q29 Were you offered anything to read?**  
 Yes ..... 11 (23%)  
 No ..... 36 (77%)

**Q30 Was someone informed of your arrest?**  
 Yes ..... 19 (40%)  
 No ..... 13 (28%)  
*I don't know* ..... 4 (9%)  
*I didn't want to inform anyone* ..... 11 (23%)

**Q31 Were you offered a free telephone call?**  
 Yes ..... 19 (40%)  
 No ..... 28 (60%)

**Q32 If you were denied a free phone call, was a reason for this offered?**  
*My telephone call was not denied* ..... 24 (57%)  
 Yes ..... 3 (7%)  
 No ..... 15 (36%)

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

	Yes	No
Who was taking care of your children	2 (6%)	32 (94%)
Contacting your partner, relative or friend	18 (44%)	23 (56%)
Contacting your employer	6 (18%)	28 (82%)
Where you were going once released	14 (35%)	26 (65%)

**Q34 Were you interviewed by police officials about your case?**  
 Yes ..... 42 (91%)  
 No ..... 4 (9%) If No, go to Q36

**Q35 Were any of the following people present when you were interviewed?**

	Yes	No	Not needed
Solicitor	29 (69%)	9 (21%)	4 (10%)
Appropriate Adult	2 (7%)	12 (43%)	14 (50%)
Interpreter	3 (11%)	10 (36%)	15 (54%)

**Q36 How long did you have to wait for your solicitor?**  
*I did not requested a solicitor* ..... 16 (35%)  
*2 hours or less* ..... 8 (17%)  
*Over 2 hours but less than 4 hours* ..... 5 (11%)  
*4 hours or more* ..... 17 (37%)

## Section 3: Safety

- Q38 Did you feel safe there?**  
 Yes ..... 33 (73%)  
 No ..... 12 (27%)
- Q39 Had another detainee or a member of staff victimised (insulted or assaulted) you there?**  
 Yes ..... 17 (38%)  
 No ..... 28 (62%)
- Q40 If you have felt victimised, what did the incident involve? (Please tick all that apply to you.)**
- |   |  |
|---|--|
| <i>I have not been victimised</i> ..... 28 (62%)                          | <i>Because of your crime</i> ..... 9 (20%)   |
| <i>Insulting remarks (about you, your family or friends)</i> ..... 3 (7%) | <i>Because of your sexuality</i> ..... 0 (0%)  |
| <i>Physical abuse (being hit, kicked or assaulted)</i> ..... 2 (4%)       | <i>Because you have a disability</i> ..... 1 (2%)                                    |
| <i>Sexual abuse</i> ..... 1 (2%)  | <i>Because of your religion/religious beliefs</i> ..... 0 (0%)                       |
| <i>Your race or ethnic origin</i> ..... 0 (0%)                            | <i>Because you are from a different part of the country than others</i> ..... 2 (4%) |
| <i>Drugs</i> ..... 5 (11%)  |  |
- Q41 Were your handcuffs removed on arrival at the police station?**  
 Yes ..... 29 (64%)  
 No ..... 9 (20%)  
*I wasn't handcuffed* ..... 7 (16%)
- Q42 Were you restrained while in the police custody suite?**  
 Yes ..... 6 (13%)  
 No ..... 40 (87%)
- Q43 Were you injured while in police custody, in a way that you feel was not your fault?**  
 Yes ..... 6 (13%)  
 No ..... 40 (87%)
- Q44 Were you told how to make a complaint about your treatment if you needed to?**  
 Yes ..... 7 (16%)  
 No ..... 38 (84%)

## Section 4: Health care

- Q46 Did you need to take any prescribed medication when you were in police custody?**  
 Yes ..... 24 (51%)  
 No ..... 23 (49%)
- Q47 Were you able to continue taking your prescribed medication while there?**
- |   |  |
|---|--|
| <i>Not taking medication</i> ..... 23 (50%) |  |
| Yes ..... 9 (20%)                           |  |
| No ..... 14 (30%)                           |  |
- Q48 Did someone explain your entitlements to see a health care professional if you needed to?**  
 Yes ..... 20 (43%)  
 No ..... 24 (51%)

Don't know ..... 3 (6%)

**Q49 Were you seen by the following health care professionals during your time there?**

	Yes	No
Doctor	23 (52%)	21 (48%)
Nurse	3 (9%)	32 (91%)
Paramedic	4 (11%)	32 (89%)
Psychiatrist	0 (0%)	34 (100%)

**Q50 Were you able to see a health care professional of your own gender?**

Yes .....	14 (34%)
No .....	16 (39%)
Don't know .....	11 (27%)

**Q51 Did you have any drug or alcohol problems?**

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

**Q52 Did you see, or were offered the chance to see a drug or alcohol support worker?**

<i>I didn't have any drug/alcohol problems</i> .....	27 (57%)
Yes .....	4 (9%)
No .....	16 (34%)

**Q53 Were you offered relief or medication for your immediate symptoms?**

<i>I didn't have any drug/alcohol problems</i> .....	27 (57%)
Yes .....	5 (11%)
No .....	15 (32%)

**Q54 Please rate the quality of your health care while in police custody:**

I was not seen by health care	Very good	Good	Neither	Bad	Very bad
18 (38%)	2 (4%)	9 (19%)	8 (17%)	4 (9%)	6 (13%)

**Q55 Did you have any specific physical health care needs?**

No .....	34 (74%)
Yes .....	12 (26%)
Please specify:	28 (100%)

**Q56 Did you have any specific mental health care needs?**

No .....	31 (67%)
Yes .....	15 (33%)
Please specify:	22 (100%)

**Thank you for your time.**



## Prisoner survey responses for Lincolnshire Police 2011

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

### Key to tables

	Any percentage highlighted in green is significantly better	Lincolnshire Police 2011	Police custody comparator
	Any percentage highlighted in blue is significantly worse		
	Any percentage highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
<b>Number of completed questionnaires returned</b>		47	1246
<b>SECTION 1: General information</b>			
3	Are you under 21 years of age?	14%	9%
4	Are you transgender/transsexual?	0%	1%
5	Are you from a minority ethnic group (including all those who did not tick white British, white Irish or white other categories)?	4%	33%
6	Are you a foreign national?	7%	15%
7	Are you Muslim?	0%	12%
8	Are you homosexual/gay or bisexual?	2%	2%
9	Do you consider yourself to have a disability?	25%	20%
10	Have you been in police custody before?	88%	90%
<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 24 hours?	76%	66%
12	Were you given information about your arrest and entitlements when you arrived?	84%	74%
13	Were you told about PACE?	63%	52%
14	If your clothes were taken away, were you given a tracksuit to wear?	41%	44%
15	Could you use a toilet when you needed to?	90%	90%
16	If you did use the toilet, was toilet paper provided?	45%	51%
17	Did you share a cell at the station?	6%	3%
18	Would you rate the condition of your cell, as 'good' for:		
18a	Cleanliness?	40%	30%
18b	Ventilation/air quality?	33%	21%
18c	Temperature?	32%	14%
18d	Lighting?	38%	44%
19	Was there any graffiti in your cell when you arrived?	37%	55%
20	Did staff explain the correct use of the cell bell?	31%	22%
21	Were you held overnight?	92%	92%
22	If you were held overnight, were you given <b>no</b> clean items of bedding?	22%	30%
23	Were you offered a shower?	22%	9%
24	Were you offered a period of outside exercise?	8%	7%
25a	Were you offered anything to eat?	86%	80%
25b	Were you offered anything to drink?	98%	83%
For those who had food:			
26a	Was the quality of the food and drink you received 'good'/'very good'?	9%	6%
26b	Was the food/drink you received suitable for your dietary requirements?	51%	45%
27	For those who smoke: were you offered <b>nothing</b> to help you cope with the ban there?	93%	93%
28	Were you offered anything to read?	24%	14%
29	Was someone informed of your arrest?	40%	44%
30	Were you offered a free telephone call?	40%	51%

**Key to tables**

	Any percentage highlighted in green is significantly better	Lincolnshire Police 2011	Police custody comparator
	Any percentage highlighted in blue is significantly worse		
	Any percentage highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
31	If you were denied a free call, was a reason given?	16%	15%
32	Did you have any concerns about:		
32a	Who was taking care of your children?	6%	15%
32b	Contacting your partner, relative or friend?	44%	53%
32c	Contacting your employer?	17%	20%
32d	Where you were going once released?	35%	31%
34	If you were interviewed were the following people present:		
34a	Solicitor	69%	73%
34b	Appropriate adult	7%	8%
34c	Interpreter	10%	7%
35	Did you wait over four hours for your solicitor?	56%	66%
<b>SECTION 3: Safety</b>			
39	Did you feel unsafe?	27%	41%
40	Has another detainee or a member of staff victimised you?	38%	41%
41	If you have felt victimised, what did the incident involve?		
41a	Insulting remarks (about you, your family or friends)	6%	20%
41b	Physical abuse (being hit, kicked or assaulted)	4%	14%
41c	Sexual abuse	2%	2%
41d	Your race or ethnic origin	0%	6%
41e	Drugs	11%	15%
41f	Because of your crime	21%	17%
41g	Because of your sexuality	0%	1%
41h	Because you have a disability	2%	3%
41i	Because of your religion/religious beliefs	0%	3%
41j	Because you are from a different part of the country than others	4%	4%
42a	Were your handcuffs removed on arrival at the police station?	76%	81%
42b	Were you restrained whilst in the police custody suite?	13%	16%
43	Were you injured whilst in police custody, in a way that you feel is not your fault?	13%	25%
44	Were you told how to make a complaint about your treatment?	15%	13%
<b>SECTION 4: Health care</b>			
46	Did you need to take any prescribed medication when you were in police custody?	51%	57%
47	For those who were on medication: were you able to continue taking your medication?	40%	36%
48	Did someone explain your entitlement to see a health care professional if you needed to?	42%	35%
49	Were you seen by the following health care professionals during your time in police custody:		
49a	Doctor	52%	48%
49b	Nurse	8%	18%
	Percentage seen by either a doctor or a nurse	53%	54%
49c	Paramedic	11%	4%
49d	Psychiatrist	0%	3%
50	Were you able to see a health care professional of your own gender?	34%	28%
51	Did you have any drug or alcohol problems?	42%	54%
	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?	19%	42%
53	Were you offered relief medication for your immediate symptoms?	24%	32%
54	For those who had been seen by health care, would you rate the quality as good/very good?	39%	28%
55	Do you have any specific physical health care needs?	27%	33%
56	Do you have any specific mental health care needs?	33%	24%