



Inspecting policing
in the public interest

Report on an inspection visit to police custody suites in North Wales

20–24 September 2010

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 and which form a key part of the joint work programme of the criminal justice inspectorates. These inspections also contribute to the United Kingdom's response to its international obligation to ensure regular and independent inspection of all places of detention.¹ The inspections look at strategy, treatment and conditions, individual rights and health care.

At the time of the inspection, North Wales Police had six custody suites designated under the Police and Criminal Evidence Act (PACE) for the reception of detainees: Wrexham, Mold, St Asaph, Caernarfon, Holyhead and Dolgellau. These all operated 24 hours a day.

North Wales Police had a good strategic grip on custody. The force had recently conducted its own comprehensive review of its use of custody and this had already led to improvements. It is pleasing that its own self-assessment and conclusions were a good match with what we identified independently. The custody review had examined the issue of management and staffing levels and we agree this was an area that needs to be addressed; as currently organised, staffing levels in some custody suites at some times are inadequate.

The force had invested in the estate which was generally in good condition with the exception of Wrexham. The Wrexham custody suite was a concerning contrast to the good provision we found elsewhere and needed urgent attention. Conditions in Wrexham were very poor – the custody suite was dark and dirty; there was limited in-cell sanitation; call bells were taped over (as they were at two other locations); and there were inadequate arrangements to ensure detainees had access to the toilets when required.

Physical conditions were generally good elsewhere, and everywhere, including Wrexham, we saw positive and appropriate interactions between staff and detainees. Detainees' rights under PACE were observed and there was good work with more vulnerable detainees, such as children, those with mental health problems and drug users. There were excellent nursing provision and good clinical care but delays in response times for forensic medical examiners and some evidence of inappropriate processes for managing of medications.

At times inspectors found the approach of custody staff was too risk-averse. In particular, detainees who were judged to be at risk of self-harm had their own clothing removed and replaced with 'smocks' too readily. This sometimes required the use of force and the 'smocks', which were provided without underwear, could be humiliating. This approach to managing risk was disproportionate in too many cases. In contrast, some staff were unclear about how to rouse detainees where this was deemed necessary.

The force's relationships with other service providers – particularly the local health board and some contracted health care providers – needed to be strengthened. The force was obliged to act as a 'place of safety' for those with mental health problems on too many occasions and for too long. In a similar way we were concerned to observe one incident where a custody suite had been used as 'a place of safety' for a 14-year-old juvenile – although we did not understand this to be a regular occurrence.

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

Overall, North Wales Police provided good custody facilities. The financial climate means it will be a challenge to maintain these standards but the strategic approach the force has taken means it is well placed to meet this challenge. Conditions in Wrexham were the exception – and required urgent attention.

Sir Denis O'Connor
HM Chief Inspector of Constabulary

Nick Hardwick
HM Chief Inspector of Prisons

November 2010

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*² 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, North Wales police had six custody suites designated under PACE for the reception of detainees: Wrexham, Mold, St Asaph, Caernarfon, Holyhead and Dolgellau. The custody suites operated 24 hours a day and dealt with detainees arrested as a result of mainstream policing and all were visited during the inspection. A survey of prisoners at HMP Altcourse who had formerly been detained at custody suites in the force area was conducted by an HM Inspectorate of Prisons researcher and HM Inspectorate of Constabulary inspector to obtain additional evidence (see appendix III).
- 2.3 The force cell capacity was 92: Wrexham had 24 cells, Mold nine, St Asaph 32, Caernarfon 10, Holyhead 10 and Dolgellau seven. In the 12 months to 20 September 2010, these cells had been used for 26,091 detainees. St Asaph, Wrexham and Caernarfon were the busiest of the suites during this time. In the same period, 61 detainees had been held for immigration matters.
- 2.4 Comments in this report refer to all suites, unless specifically stated otherwise.

Strategic overview

- 2.5 An assistant chief constable (ACC) had strategic management responsibility for custody, supported by the head of the Administration and Justice Department (AJD) and an inspector. Responsibility for the day-to-day running of custody was devolved to the three divisional commanders. Custody sergeants were permanent and managed by a custody inspector in each division. Custody detention officers (CDOs) were managed by custody sergeants. Staff were well trained and refresher training had recently been introduced. Staffing ratios at some custody suites at certain times of the day, or resulting from absences, were inadequate. The custody managers had a range of duties, which made it difficult for them to dedicate sufficient time to custody, and management arrangements were fragmented.
- 2.6 A regular custody managers meeting and a quarterly strategic meeting took place. The chief officer group had links with strategic partners but those with health care providers were challenging. A comprehensive review of custody in the force had been completed and a number of recommendations made. There was a good relationship with the police authority (PA) and an active and challenging independent custody visitors (ICV) scheme.
- 2.7 The force had invested in the estate and was engaged in an ongoing refurbishment programme of the custody suites, which, with the exception of Wrexham, were in a good state

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

of repair. There were difficulties associated with managing the use of some cells at Wrexham and Holyhead, related to the onsite magistrates' courts.

- 2.8 There were programmes of dip sampling of custody records and health and safety 'walk-throughs' took place but these were poor and there were enhanced plans to improve them. Uses of force were documented but there was limited monitoring of these or any emerging trends.

Treatment and conditions

- 2.9 The interactions between staff and detainees were professional and appropriate. The approach to juveniles was reasonable but staff had little awareness of specific issues around strip-searching or using smocks (see below). There were few differences in the way that females were dealt with. Interpreting services were used appropriately and the faith needs of detainees were generally well met. Access for detainees with disabilities was difficult in the older custody suites and there were few specific adaptations. There was a lack of privacy at the booking-in desks at Wrexham and St Asaph but not elsewhere. Toilets in cells covered by closed-circuit television (CCTV) in some suites were not obscured.
- 2.10 The quality of initial risk assessments conducted was good. The recently introduced written care plan was showing positive results. We found evidence of an excessively risk-averse approach being adopted, including examples of clothes being taken, sometimes forcibly, and routine use of smocks if there was a history of self-harm or when detainees were drunk. This undermined the generally respectful approach adopted. Some staff we spoke to did not understand the importance of rousing detainees. CCTV coverage at most of the suites was limited and we found some audible cell bell panels had been muted.
- 2.11 The age and condition of the suites was variable but most were clean and contained little graffiti. Wrexham was the exception to this, offering a poor and dirty environment. Despite the obvious investment in upgrading the suites, we found ligature points in a number of cells across the custody estate.
- 2.12 Some elements of care were over-reliant on detainee request. A mattress and pillow were provided routinely but not always cleaned between uses. Few showers were facilitated. Hygiene packs for female detainees were provided but only on request. Tracksuits were available but underwear was limited. Exercise was sometimes provided, particularly for detainees held for longer periods.
- 2.13 Most staff we met were aware of the fire evacuation arrangements, although this was not the case with some relief sergeants. Detainees at most suites were offered food routinely but we interviewed some who had gone for several hours without this happening. The meals provided were of poor quality. Drinks were offered regularly. Limited reading material was available.

Individual rights

- 2.14 We found a positive approach to balancing the priorities of progressing cases with the rights of detainees. Detainees were offered a copy of PACE and comprehensive leaflets in a range of languages. PACE was generally well adhered to and staff encouraged detainees to avail themselves of legal assistance. Not all staff were aware of the process for getting an immigration solicitor. There had been some unacceptable delays in UK Border Agency (UKBA) dealings with immigration detainees. Staff made calls notifying someone that the detainee had been arrested but few calls were offered to detainees.

- 2.15 Staff did not routinely ask if new detainees had primary care responsibilities for a dependant. They were required to ask a series of in-depth questions to ensure that detainees were released safely. We found an example of a juvenile held under section 46 of the Children Act 1989 who had been locked in a cell (see paragraph 5.4).
- 2.16 Appropriate adult provision for juveniles was generally good but the service was limited at night and less well developed for vulnerable adults. Staff adhered to the PACE definition of a child, which meant that 17-year-olds were not provided routinely with an appropriate adult. Arrangements for managing DNA and forensics were good, with only minor issues evident.
- 2.17 Detainees were not told how to make a complaint but most staff said that they would notify the duty inspector if a detainee wished to do so. One inspector told us that they would not take any complaints until the detainee had left custody, which was contrary to force policy.

Health care

- 2.18 Health care was provided by a mixture of doctors and nurses who were employed by the force. Clinical governance structures were adequate but there were fragmented management arrangements for health care professionals. Clinical rooms were variable in quality but all were reasonably clean and tidy.
- 2.19 Medicines management was reasonable, with no discrepancies; stock levels were low and adequate arrangements for destruction were in place. Nurses routinely secondary dispensed medications and CDOs administered medications from nurses' patient group directions (PGDs). There was also evidence of a nurse administering a controlled drug. The force made efforts to collect medications from detainees' home addresses. Resuscitation equipment was good, staff were trained in its use and the equipment was checked regularly.
- 2.20 We observed some excellent care provided to detainees by nurses but forensic medical examiners (FMEs) rarely attended. It was not always clear from custody records when health care professionals were called or when they saw detainees. The quality of some clinical records was excellent.
- 2.21 Substance misuse support was offered by a single provider and all suites had daily visits from drug workers. The services provided were in development but already good. Some detainees who would have benefited from substance misuse support were not being referred by police staff.
- 2.22 Services for detainees with mental health problems were mixed, with particular problems in referring to the mental health trust in the west of the force area. Too many detainees were being taken to police custody under section 136 of the Mental Health Act.³

Main recommendations

- 2.23 The use of self-harm prevention smocks should be reviewed and procedures clarified to ensure that they are used only when risk factors indicate that they are necessary.
- 2.24 When appropriate, detainees should be roused to elicit a response.

³ 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.

- 2.25 Checks should be put in place to ensure that alarm bells are not disabled other than in exceptional circumstances and detainees in cells without in-cell sanitation have access to toilet facilities when required.
- 2.26 The environment at the Wrexham custody suite should be improved and deep cleaned.
- 2.27 All detainees should be able to see a health care professional appropriate for their needs, including the administration of controlled drugs, within a reasonable time.

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 Good progress had been made in custodial provision over the previous 12 months. There was clear and unambiguous chief officer leadership and there had been considerable investment to develop the custody facilities. An assistant chief constable (ACC) was the lead officer for the custody portfolio and there was active engagement by the Police Authority (PA) with regard to forward planning and development of the custody estate. The force was also exploring potential collaborative custodial arrangements with a neighbouring force.
- 3.2 The force had recently carried out a comprehensive and thorough review of custody and was well informed about its future planning options. The National Policing Improvement Agency (NPIA) had also carried out an assessment of custody provision by its capability review team.
- 3.3 The PA was supportive of the force and we were told that there was a good relationship between them. The PA was aware of recent recommendations arising from the Independent Police Complaints Commission (IPCC) in relation to deaths in police custody. The force operated a devolved model of custody, whereby custody suites and staff were managed by three divisions, eastern, central and western.
- 3.4 While the day-to-day management of custody was devolved, the head of Administration of Criminal Justice Department (AJD) had lead responsibility for developing custody policy. She was supported by a full-time police inspector.
- 3.5 The western division was responsible for the custody suites at Holyhead, Dolgellau and Caernarfon; the central division for the custody suite at St Asaph and the eastern division for the custody suites at Wrexham and Mold. Each division had an inspector who was a custody manager (CM) and they were responsible for their divisional custody suites, staff and operational effectiveness.
- 3.6 A number of staff, at different levels and locations, expressed concerns about the ratio of staff to detainees. We were told that the high number of detainees held sometimes made it difficult to manage risk effectively and to meet the welfare needs of detainees. Issues included custody sergeants in some of the western suites having to manage detainees without the support of a CDO at key times of the day, and the sergeant at Holyhead not having a CDO for the majority of the time. The force had inspected detainee throughput and cell capacity as part of the comprehensive review of custody, and at the time of the inspection was looking into improving the match between resources and demand.
- 3.7 All three CMs spent up to 80% of their time on operational and non-custody duties, so did not have the capacity consistently to review and dip-sample custody records to an appropriate standard. This was especially the case between 2am and 7am, when there was only one operational inspector on duty for North Wales, who also had to carry out custody reviews under PACE. We were told that this was being actively reviewed.
- 3.8 All custody sergeants were permanently posted into custody and had undergone an approved custody course. Relief cover for these sergeants was provided by sergeants from the patrol sections, who had also received custody training. Custody detention officers (CDOs) were

used in some custody suites but not all of them had received approved custody training before being deployed in custody suites. If CDOs were absent or were in need of support because of high demands being placed on them, they were supported or augmented by untrained police constables taken from patrol sections. These officers were limited in the duties they could safely undertake.

- 3.9 The Local Criminal Justice Board was chaired by the chief constable, and three superintendents worked in partnership roles. Relationships with the Crown Prosecution Service (CPS) were positive but insufficient support was offered by the local health authority and mental health trusts, particularly in respect of section 136 detainees.
- 3.10 The PA had a strong independent custody visitors (ICV) scheme. It was well supported by the PA and the force, which held quarterly meetings with panel members, and there were good arrangements for dealing with the concerns raised by panel members. The head of the AJD or the AJD inspector always attended the quarterly meetings.
- 3.11 Police officers and staff recorded the use of force in their custody records, and police officers in their evidential pocket notebooks, but use of force forms had not been completed for every recorded instance in the custody records we examined. They also submitted a use of force report but the data were not analysed.

Recommendations

- 3.12 The force should review the current management arrangements for custody and staffing levels to ensure the care and welfare of detainees.
- 3.13 The force should collate the use of force data and monitor the use of force locally and at force-wide level, for example by ethnicity, location and officer involved.

Good practice

- 3.14 *The force had conducted a thorough review of custody arrangements which had enabled them to make a number of positive changes and identify further areas for improvement.*

4. Treatment and conditions

Expected outcomes:

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

Respect

- 4.1 Detainees were transported in both police and G4S cellular vehicles. Those we inspected were clean and in good condition. Specially adapted police estate cars were often used when transporting detainees long distances between custody suites, as they were generally more comfortable.
- 4.2 The booking-in processes we observed at custody suites were respectful and professional. The language used was appropriate to the detainee and first or preferred names were mostly used. Detainees we spoke to mainly described their interaction with staff as good and felt that they had been well treated.
- 4.3 The booking-in desks at the central and eastern custody suites (St Asaph, Mold and Wrexham) did not allow sufficient privacy during interviews, which often required them to disclose quite personal information. Detainees experienced long waits at the central and eastern custody suites during busy periods, either in small holding rooms or in police vehicles at Mold.
- 4.4 With some notable exceptions, awareness and checking of detainees' diverse needs were not evident at the custody suites. Female detainees were not routinely offered the opportunity to speak to a female member of staff and most staff assumed that they would ask for anything they needed. Staff had not been given any awareness training on child welfare. Some had a good understanding of the distinct needs of juveniles but others said that they were treated the same as adult detainees, other than using an appropriate adult. Juvenile detention rooms were located close to the custody desk in the western custody suites but not in the central and eastern custody suites, and in Wrexham the detention cells were those furthest from the booking-in desk. At Caernarfon, appropriately, we saw a juvenile waiting in a holding room at the front of the custody suite with his mother, rather than in a cell. Age-appropriate language was used with him and staff were patient and responsive to requests by both mother and son.
- 4.5 Only Mold had an area suitable for booking in detainees with disabilities. There were no other adapted facilities for such detainees at any of the suites. There were no portable hearing loops and not all staff were aware of how to access signing services. Staff said that each detainee's needs were assessed individually and that they would allow detainees to keep mobility aids if a risk assessment showed it to be appropriate. A range of materials was available to enable detainees to attend to their religious and faith needs, except at Dolgellau and Caernarfon, where only copies of the Bible were available. Staff said that they would allow Muslim detainees to use washing facilities before praying where there were none in the cells. At Holyhead, written guidance was provided to staff about specific religious and dietary issues for Muslim detainees.
- 4.6 At Wrexham and Holyhead, where there were shared cells with the on-site court, we saw interruptions from court staff and visitors wishing to access the cells used to accommodate those going to court (looked after by G4S), as the separate entrance to these cells was no

longer accessible. This was difficult for custody staff to manage alongside their main focus on the care and welfare of police detainees.

Recommendations

- 4.7 **Booking-in desks should allow effective and private communication between detainees and staff.**
- 4.8 **There should be clear policies and procedures to meet the specific needs of female and juvenile detainees and those with disabilities.**

Safety

- 4.9 Custody sergeants completed risk assessments with detainees on arrival. Those we looked at were clear and contained useful information, and a wide range of information sources had been used to compile them, including the Police National Computer, previous custody records and information from the arresting officer. The custody records at Caernarfon recorded observations from the nurse on duty (when available) and the custody sergeant told us that a health check was prioritised for those at risk of self-harm. The force had recently introduced a care plan that indicated the level of observations associated with each level of risk with which detainees could present and this was used well.
- 4.10 We were told by a number of custody sergeants that consideration would be given to placing detainees with a history of self-harm or who were drunk in a non-tear smock, to prevent them from harming themselves. In some of the records we reviewed, the use of the smock was disproportionate to the risk of harm indicated in the risk assessments. In the custody record analysis, 50% of the 15 detainees who had presented with current or previous self-harm or suicide issues had had their clothing removed and been placed in a smock, sometimes forcibly. Subsequent to the inspection, the force carried out its own analysis of this which still indicated overuse of smocks, albeit not at the levels indicated by our analysis. Most detainees that were placed in the smocks were not permitted to wear underwear and there was no replacement underwear available.
- 4.11 Cells with CCTV were routinely used for high-risk and vulnerable detainees, and an appropriate level of direct observation was applied. We did not observe the use of CCTV as a substitute for personal interactions. We saw some positive staff engagement with vulnerable detainees. Custody records demonstrated that observations took place within the prescribed intervals and were not at predictable times. They also showed that staff checked the breathing of sleeping detainees but, primarily at the western suites, usually did not rouse them. Some of the staff we spoke to about this did not understand the importance of physically rousing some detainees. The coverage and quality of some CCTV coverage was poor and we were aware that the force had advanced plans to address this.
- 4.12 There was not always a formal handover time between shifts, relying instead on the good will of staff to arrive early for their shift. Briefings we observed included sharing information about detainees, focusing on those who were vulnerable, such as children or detainees on constant observation. There were no shared cells in any of the sites. Anti-ligature tools were attached to the cell keys at all of the custody suites. Some of the cells we checked contained ligature points. When we pointed these out to the force, they were receptive and planned a review of how they could be remedied or the associated risks managed.

- 4.13 Appropriate measures were taken to minimise the risk of harm to others caused by potentially violent detainees. Arresting officers alerted custody staff when they brought in a violent detainee and other detainees were kept clear of the booking-in area. We saw a potentially violent detainee being moved from Caernarfon and he was treated in a calm way, with staff available if assistance was required.

Recommendation

- 4.14 An overlap period should be built into all shifts, to facilitate an effective handover between staff.

Housekeeping point

- 4.15 Detainees required to wear self-harm prevention smocks should be provided with underwear.

Use of force

- 4.16 New arrivals were given a rub-down search and handcuffs were removed as soon as possible. Staff were appropriately trained in use of force techniques, with refresher training taking place annually and an up-to-date record kept of those who had attended. We saw one disruptive detainee at Wrexham dealt with calmly and appropriately, without the need for force, while a juvenile detainee was also being booked in.
- 4.17 Detainee interviews and custody record analysis indicated that force did not appear to be overused but local and force-wide monitoring was limited (see section on strategy). Detainees subject to force were seen by a doctor when there were visible signs of injury, or staff or the detainee requested it.

Physical conditions

- 4.18 Conditions in the suites were variable but the considerable investment that had been made was evident in most of the custody suites operating. There was a continuing process of refurbishment and maintenance of the suites.
- 4.19 In our survey, 51%, against the 29% comparator, said that the cells were clean and 40%, compared with 56%, said that they contained graffiti.⁴ Staff adopted a zero tolerance approach

⁴ 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 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

to graffiti or damage. We found evidence that daily cell checks were not carried out to a consistent standard and, while most custody suites were clean, Wrexham was not. The custody area at this suite was dark and painted black and many of these cells had little or no natural light. We brought this to the attention of custody staff but it was not cleaned during the course of the inspection. Cells were in a poor state, with graffiti on some cell walls and blood left smeared on the walls in three cells. The cells that had integral sanitation in this suite smelt strongly of urine and the toilets were dirty. In cells without in-cell sanitation, we were told that staff were not always available to ensure detainees had access to the toilet when required so detainees had to urinate on the floor. The floor was sticky underfoot. In our survey, 40% of respondents, against a comparator of 20%, said that cell temperatures were adequate but we found the cells in Wrexham to be cold.

- 4.20 Cell bells were tested daily. Detainees we spoke to knew how to use the bells. We saw staff responding to cell bells in the western suites. At St Asaph, Wrexham and Mold, the sound panels had been muted by covering them with tape and we some observed delays in staff responding to them.
- 4.21 Smoking was not permitted at any of the custody suites, although custody staff said that they sometimes allowed detainees to smoke on the exercise yard; in our custody record analysis, one detainee, in Dolgellau, had been permitted to smoke in the exercise yard on three occasions during his time in custody. Smokers could be offered nicotine replacement if agreed by medical staff.
- 4.22 Evacuation procedures were publicised in each suite and were understood by dedicated custody staff, but not always by relief sergeants. Plastic handcuffs were available in Caernarfon and Holyhead. Smoke alarms were fitted and checked weekly and we were told in Caernarfon that an evacuation exercise had been carried out in the week before the inspection.

Personal comfort and hygiene

- 4.23 All cells contained a mattress but blankets and pillows were not routinely provided in all suites. Mattresses were not routinely cleaned between occupations but were inspected for soiling. Detainees were provided with fresh blankets in all of the suites except Dolgellau, where we were told that staff judged whether blankets could be used again for new occupants. In each custody suite there were sanitary products for female detainees but these were not routinely offered and women were not asked if they required them.
- 4.24 Most cells had integral sanitation but toilet paper had to be requested in some suites. Toilets in cells covered by CCTV at Caernarfon, Dolgellau and St Asaph were not obscured. The showers could be used in private but detainees were rarely offered one. In the custody record analysis, only five (out of 30) detainees had had a shower while in custody. Five detainees going to court, including one in Wrexham, held for over 32 hours, had not been offered a shower. A basic range of hygiene products was provided, including towels and toothbrushes.
- 4.25 All custody suites contained basic sets of replacement clothes, including sweatshirts, tracksuit bottoms and plimsolls. Each suite had an adequate stock of sizes. No change of underwear was provided, although paper underwear for females was available at Mold.

Recommendations

- 4.26 The toilet should be obscured or blanked out on closed-circuit television screens covering cells with integral sanitation.
- 4.27 All detainees held overnight, or who require one, should be offered a shower.

Housekeeping points

- 4.28 Mattresses should be wiped clean after each use and clean blankets provided.
- 4.29 All female detainees should be offered a hygiene pack on arrival.
- 4.30 All cells should contain a supply of toilet paper.
- 4.31 Replacement underwear should be available if required.

Catering

- 4.32 A good variety of microwavable meals was offered which met a range of dietary requirements and religious needs. The calorific content of the food was poor, which was particularly an issue for detainees held for longer periods of time. Custody staff in most of the suites told us that family and friends could bring in food in sealed packaging.
- 4.33 Hot drinks were given on request, and routinely when locating detainees in cells. Custody staff told us that they offered food at mealtimes but did not always check if newly arrived detainees had eaten, although they provided food if it was requested. However, some detainees reported waiting a long time for a meal. In the record analysis, 67% of detainees in our sample were offered at least one meal while in custody.

Recommendation

- 4.34 Food should be of sufficient quality and calorific value to sustain detainees for the duration of their stay.

Activities

- 4.35 All custody suites had a small exercise yard but detainees were rarely offered the opportunity to use it, even if they had been held for longer than eight hours. The exercise yards were also used to provide fresh air to relieve the effects of incapacitant spray if deployed.
- 4.36 None of the custody suites had an adequate supply of reading materials; in each custody suite there was a limited supply of newspapers, magazines and a small selection of books but nothing was available in easy-read format. We did not see any materials being routinely offered to detainees. In our survey, just 8% of respondents said that they had been offered anything to read, against the 14% comparator.

- 4.37 Visits could be facilitated in all the custody suites except Holyhead, where the room was out of use. We were told that the visiting facilities were rarely used but could be authorised for detainees staying overnight.

Recommendation

- 4.38 Detainees held for long periods should be offered outdoor exercise.

Housekeeping point

- 4.39 Appropriate reading material should be offered to detainees.

5. Individual rights

Expected outcomes:

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

Rights relating to detention

- 5.1 Custody sergeants checked that the detention of those being held was appropriate before authorising it, and the reasons for detention were clearly recorded on the custody record. We saw custody staff discuss in detail arrangements for the detention of a young female who was intoxicated. The custody sergeant took into account the need to minimise the length of detention of this vulnerable female, while ensuring that she was not released while intoxicated and that the arresting officers were not impeded in progressing the case.
- 5.2 In the year to 20 September 2010, the force had held 61 detainees solely under immigration powers. One custody record documented a detainee being held for 30 hours. Staff reported that, while UKBA's response time had improved recently, it was still not unusual for detainees to be held for up to three days.
- 5.3 Reviews of detention were conducted in line with requirements. There were isolated cases where reviews were delayed for operational reasons, such as competing custody demands. The electronic custody record management system alerted the custody sergeant to impending custody reviews by a series of colour-coded warning flags. The warning could also be monitored by the duty inspector. Due to the geographical distances between some of the suites, some reviews were conducted over the telephone or via webcam at Wrexham and St Asaph custody suites. When reviews took place while detainees were asleep, it was not always clear from the custody records that they were informed of the review when they woke up.
- 5.4 We found one case where the Dolgellau custody suite had been used as a place of safety for a juvenile under section 46 of the Children Act 1989. The juvenile, aged 14, had been removed from a potentially dangerous environment. The social services emergency duty team (EDT) had been contacted but had been unable to offer alternative accommodation and the juvenile had been placed in a locked cell until collected by a social worker the following morning.
- 5.5 All detainees were offered a copy of their rights and entitlements, which were available in languages other than Welsh and English. Detainees, including immigration detainees, were told that they could inform someone of their whereabouts, and delays in exercising this right were authorised at inspector level. The custody records documented whom, if anyone, detainees wanted informed of their arrest. Detainees were not always allowed to speak to family members themselves.
- 5.6 Staff had access to telephone interpreting services but there were often delays in getting interpreters to attend the custody suites, as they often travelled long distances to get there. We observed one immigration detainee waiting over six hours for an interpreter to attend so that he could be interviewed. We saw two separate Polish nationals being booked in – one in Wrexham and one in Mold. In Wrexham, a police officer who spoke Polish was brought into the suite to act as an interpreter. The officer's presence and languages skills reassured the detainee.

- 5.7 Staff did not routinely ask if detainees had primary care responsibilities for dependants.
- 5.8 Pre-release risk management planning for vulnerable detainees was conducted to ensure that they were released safely. Detainees with mental health problems were given details of a telephone support line when leaving detention. There were information leaflets detailing support organisations and agencies but they were located behind the custody desk and custody staff told us that they did not distribute them routinely. Custody records showed that transportation home was the main action taken, and in our custody record analysis 13% of detainees were provided with transport home from custody.

Recommendations

- 5.9 Custody suites should not be used as a place of safety for juveniles.
- 5.10 Custody staff should ensure that detainees' dependency obligations are routinely identified and, where possible, addressed.

Rights relating to PACE

- 5.11 Detainees were routinely offered an opportunity to read a copy of the PACE code of practice. They were given a continuous period of eight hours' rest from interviewing in a 24-hour period and we saw no examples of them being interviewed while under the influence of drugs or alcohol.
- 5.12 Detainees were able to consult their legal representatives in private. All detainees were asked on arrival if they required a solicitor and their responses were recorded in custody records. Those who initially refused this offer could change their minds at any stage during their detention. Referrals made through the duty solicitor scheme were responded to promptly. We witnessed solicitors arriving within half an hour of the initial referral. The reasons for a detainee refusing to have a duty solicitor were not recorded on the custody record. Posters in different languages in Mold advised detainees of their right to a free solicitor. Immigration detainees could receive specialist telephone advice from immigration lawyers, and custody records indicated that this service was being used, but not all staff we spoke to were aware of it. Detainees using this service were not always able to use telephones confidentially. Detainees and their solicitors were able to obtain copies of their custody records easily and many solicitors routinely asked for these on arrival at the custody suite.
- 5.13 Family and friends were usually approached to act as appropriate adults (AAs) in the first instance. The Youth Offending Service coordinated the AA service for juvenile detainees, and social services provided AAs for vulnerable adults. Trained social workers and support workers were on call to attend the custody suites up to 4.30pm on weekdays. The service was more limited at weekends and during the night, when the EDT was responsible for the AA service. In our custody record analysis, of 11 detainees presenting with mental health problems, three had been provided with an AA. All three juveniles in our sample had been provided with AAs. Police adhered to the PACE definition of a child instead of that in the Children Act 1989, which meant that those aged 17 were not routinely provided with an AA unless otherwise deemed vulnerable.⁵

⁵ 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.

- 5.14 DNA and forensic matters were handled well, with only minor issues evident, and the force had taken steps to ensure that samples and exhibits were submitted or dealt with as appropriate.
- 5.15 There were no excessive delays in transporting detainees to court. The court cut-off time in Mold and St Asaph was around 1.30pm and in Caernarfon it was later, depending on negotiations with the court clerk. The magistrates' courts in Wrexham and Holyhead were adjoined to the custody suite and cut-off times were therefore reasonable. There were no court video-link facilities.

Recommendation

- 5.16 Appropriate adults should be readily available to support juveniles aged 17 and under and vulnerable adults in custody, including out of hours.

Housekeeping point

- 5.17 Custody staff should be aware that immigration detainees can access specialist telephone advice through the duty solicitor scheme.

Rights relating to treatment

- 5.18 Key staff had recently had training in dealing with complaints which emphasised these should be viewed and dealt with positively. Despite this detainees were not always told how to make a complaint. Information in relation to complaints was not recorded on the notice of rights and entitlements. Staff told us that if a detainee complained, they noted it on the custody record and notified the duty inspector. In Wrexham, custody staff said that they directed detainees who wished to complain to the front desk of the police station, where they were given a complaint form, but when we went to the front desk it was closed. Detainees who went to court and/or prison did not have the opportunity to have their complaint recorded or investigated. Despite this, it was notable that the force had facilitated a number of training sessions for custody and other police staff which focused on the practical issues of taking and recording complaints, and not acting to suppress them.⁶

Recommendation

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

⁶ 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

- 6.1 The force employed custody nurses to provide health services to detainees, along with two forensic medical examiners (FMEs). Mental health services were provided by Betsi Cadwaladr University Health Board. Substance use services were provided by ARCH Initiatives Cymru.
- 6.2 There was a clinical governance framework and discussions were ongoing to ensure that this fed into the force governance structure. A group had been assembled, with appropriate membership that included relevant force representatives and partner organisations. The terms of reference had been agreed, as had standing agenda items, such as training, medications, risk identification and management. The group met quarterly and there was a clear action log from each meeting.
- 6.3 Staff had access to interpreting services if required (see section on individual rights).
- 6.4 Nurse managers had secured a range of training opportunities for the nursing staff, such as adult protection training, first responder resuscitation training and mental health first-aid. Clinical supervision had also been arranged but not fully implemented. The FMEs organised their own continual professional development and invoiced the police force for any costs incurred.
- 6.5 Our examination of custody records showed that eight (27%) detainees had been seen by a health care professional but it was not always clear on the detention log when a health care professional had been summoned to see a detainee. The longest wait we found was three hours and 17 minutes. However, we were told that on some occasions the wait could be longer, particularly in the western division. When we looked at clinical records, we found time lapses of over five hours between the detainee being booked into custody and being seen by a nurse but there was no record of the time that the nurse had been called.
- 6.6 The state of the clinical rooms varied. While most were of a reasonable size, the rooms at Caernarfon and Mold were too small and the rooms at Wrexham and Mold were poorly located. There had been no infection control audits carried out and some of the rooms were cluttered. While all the sharps bins were secured to the wall, not all had been signed and dated at the start of use. Some clinical waste sacks contained domestic rubbish. Some of the rooms contained wooden couches and none had paper roll couch covers, using forensic couch covers instead. At St Asaph, the clinical room was also used by custody staff. All the clinical rooms, except at St Asaph and Wrexham, were left unlocked when not in use and all had a toilet attached to the room. This was sometimes used by staff and visitors, such as solicitors, and on occasions they interrupted clinical consultations.
- 6.7 Medication storage was good in the clinical rooms; the cupboards were tidy and contained minimal stock and there were no discrepancies in the recording of medications. There were concerns about medicines management. Nurses worked to patient group directions (PGDs), which were for single doses of a range of medications. However, we found that, on occasion,

they left further doses of the medication in labelled plastic bags, to be given to detainees by custody detention officers, which was not in line with the PGDs and constituted secondary dispensing. They also carried out secondary dispensing for medications prescribed by the FME and faxed to them. We were reassured by the force after the inspection that these practices had ceased.

- 6.8 There was emergency equipment in every custody suite, supplied by the ambulance service. The kit included an automated external defibrillator, oxygen and suction and was identical in each suite. Custody staff checked the equipment daily and most custody staff were trained in its use.

Recommendations

- 6.9 There should be robust infection control procedures for all the clinical rooms, which should be clean.
- 6.10 Medications should only be prescribed and administered in line with relevant professional guidance.

Patient care

- 6.11 In our survey, 37% of detainees said that someone had explained their entitlement to see a health care professional while in custody. Forty-one per cent had been seen by a nurse, against the 14% comparator, but only 17% had been seen by a doctor, against the 50% comparator. This equated to a total of 44% being seen by a health care professional, against a comparator of 53%.
- 6.12 One nurse was allocated to work in the western division, based at Caernarfon, and another was based at St Asaph. The Caernarfon-based nurse was expected also to cover Dolgellau and Holyhead, while the nurse at St Asaph also covered Wrexham and Mold. During the inspection, the roster showed that there were gaps of three or four hours without dedicated nurse cover at some suites. On two nights during the inspection, owing to sickness, one nurse covered all three divisional areas, which was impracticable and clinically unsafe. Nurses told us that there was a system of cross-cover between divisions but the large distances involved made it difficult to respond quickly, other than by telephone. There was one FME on call for the whole force area, including for the sexual assault referral centre, during working hours; there were occasions when the FME also worked as a GP in the community.
- 6.13 When custody staff needed a health care professional, they contacted the relevant nurse, who then responded. However, if the nurse was too far away to be able to respond within a reasonable time to meet the detainee's needs, custody staff took the detainee to the local hospital or minor injury unit. A transfer of care form was completed to ensure appropriate communication between custody staff and health care staff. Even when there was no nurse on duty during a particular shift, custody staff did not contact the FME directly.
- 6.14 In our survey, 70% of detainees seen by a health professional had rated the quality of care as good or very good, against the 23% comparator for other forces and 46% in 2009. Nursing staff that we observed were courteous, caring and respectful and made efforts to obtain collateral information about a detainee (with consent) or to refer detainees to community health and social care services.

- 6.15 There were positive working relationships between nurses and custody staff and all the custody sergeants told us that the nurses were an integral part of the custody team. We saw several examples of nurses identifying detainees from the records management system (RMS), as well as accepting referrals from custody staff. Nurses led the clinical care, with telephone reference to the FME when they had clinical concerns or queries or required a prescription. We saw little evidence of face-to-face consultations by FMEs.
- 6.16 At Wrexham, the nurses told us that regular use was made of the webcam for the FME to 'see' detainees. There was no protocol to support the use of the webcam, and the images were not stored and we were concerned that the camera did not provide clinical staff with a good enough view of the patient to make a full assessment. The webcam was attached to the desk computer in the clinical room and enabled only a limited view. A log was kept of its use and showed 18 uses in the previous three months.
- 6.17 Forty-one per cent of those in our detainee custody record sample were on medication on arrival in custody, of whom 40% were allowed to continue it while in custody. There appeared to be a policy for controlled drugs not to be given to detainees because a doctor was required to administer such medications, in line with PACE. Detainees who were on a prescription of methadone in the community were administered dihydrocodeine and diazepam, even if their prescribed dose of methadone had been verified. We witnessed one case of a detainee who required a dose of a controlled drug while in custody. An FME was not able to attend the custody suite until several hours after the medication was due, so it was reluctantly but inappropriately deemed to be in the best interests of the patient for the nurse to administer the drug.
- 6.18 Health care professionals used paper records to record their contemporaneous notes about a consultation. The nurses used proforma documents, which were then stored in a locked cupboard in the clinical room at each custody suite. Intermittently, these were collected and taken to headquarters for storage. The doctors kept their own notes. We looked at a range of nurses' records and found most to be comprehensive, although some omitted to record the time that the patient was seen and not all recorded the detainees' verbal or written consent. Nurses also recorded their interventions and telephone advice from the FME on the RMS.
- 6.19 Not all clinical staff were clear about what they would do if a detainee asked them for a copy of their clinical record.

Housekeeping points

- 6.20 If video conferencing is to be used to assess detainees clinically, there should be strict governance arrangements about its use.
- 6.21 Detainees' consent should be recorded on clinical records.
- 6.22 Detainees should be able to obtain a copy of their clinical records.

Substance use

- 6.23 In our survey, 53% of respondents said that they had a drug or alcohol problem but only 28% of these said that they had seen, or been offered the chance to see, a substance use worker, against the 42% comparator. ARCH Initiatives Cymru workers were aware that detainees who needed their services were not always referred to them and made efforts to ensure that there were systems, known to custody staff, to improve rates of referral. In 2009/10, the drug

intervention programme (DIP) had resulted in a total of 306 contacts, of which 292 had been identified as being 'meaningful'.

- 6.24 ARCH Initiatives Cymru workers saw detainees for both drug and alcohol issues. In the previous six months, they had seen a total of 751 detainees under the alcohol arrest referral scheme.
- 6.25 Wrexham was a 'DIP intensive' area, so detainees who had committed a 'trigger offence' were automatically drug tested; refusal of a test constituted a further offence. A drugs worker, employed by ARCH Initiatives Cymru, was available in the Wrexham custody suite daily.
- 6.26 At all the other custody suites, the ARCH Initiatives Cymru workers visited for a couple of hours each day, attempting to time their visits to meet the greatest demand for their services. There were five teams across the force area; each team had a specific arrest referral worker but each member of the team had a community caseload, as well as providing services to the custody suites. These workers carried out an initial assessment of detainees and then offered them a second appointment in the community or referred them to counselling, assessment, referral, advice and throughcare (CARAT) services in prisons, if they were remanded into custody. If a detainee wanted to see a worker at times when they were not available, custody staff arranged an appointment with an ARCH Initiatives Cymru worker in the community.
- 6.27 Clean needles and syringes were not available in the custody suites.

Recommendation

- 6.28 All detainees who require the services of a drugs or alcohol worker should be referred appropriately, irrespective of the time of day.

Housekeeping point

- 6.29 Injecting drug users who are being released into the community should be offered clean needles by drugs workers.

Mental health

- 6.30 Strategic links with the Betsi Cadwaladr University Health Board were weak. There was a multidisciplinary group for section 135/136 of the Mental Health Act, 1983 that met but other mental health work was not dealt with at a strategic level.
- 6.31 Nurses told us that local community mental health teams were not always quick to respond to calls and could take two to three hours to attend custody suites, especially towards the end of the working day. This seemed to be more of a problem in the western division, and custody staff there told us that they took detainees to the local accident and emergency department when there were delays in getting an FME or the local mental health team to attend the suite. Out of hours, there was access to crisis teams.
- 6.32 The joint policy for section 136 stated that a detainee should not wait more than two hours following detention for an assessment during working hours and no more than four hours outside normal working hours. It also stated that if a detainee was taken to a police station, the custody staff had a responsibility immediately to contact an approved mental health practitioner (AMHP) and an FME, who should attend the police station at the same time as the

AMHP, so that the full assessment can take place'. However, we found that the practice was not in line with policy, and in most cases neither AMHPs nor FMEs attended the custody suites.

- 6.33 Nurses only saw detainees held under section 136 if there were medical concerns. Detainees were transferred to local mental health units as soon as practicable for assessment and/or admission but this was often delayed due to intoxication and/or illicit drug use. We observed one transfer at Wrexham where an intoxicated detainee had been held for approximately 12 hours between arriving in custody and being transferred to the mental health unit. The section 136 joint service protocol excluded those with indications of intoxication. This detainee told us that his care in custody had been respectful and appropriate and that he had had no objection to being assessed. Custody staff and nurses told us that they usually gave an early alert to the mental health units when they were holding a detainee under section 136, to expedite assessment and/or admission.
- 6.34 We saw records showing timely and appropriate use of the local Criminal Justice Liaison Service for a detainee with multiple social, mental health and learning disability needs.
- 6.35 Custody staff had not received mental health awareness training.

Recommendations

- 6.36 The care of detainees with mental health problems in police custody should be the subject of strategic discussions between chief officers and the health board to develop and implement robust protocols to ensure the health board promptly fulfil their responsibilities to provide detainees with mental health problems the medical care they require.
- 6.37 Police custody should be used as a place of safety for section 136 assessments only in extreme cases.
- 6.38 Custody staff should undergo mental health awareness training.

7. Summary of recommendations

Main recommendations

- 7.1 The use of self-harm prevention smocks should be reviewed and procedures clarified to ensure that they are used only when risk factors indicate that they are necessary. (2.23)
- 7.2 When appropriate, detainees should be roused to elicit a response. (2.24)
- 7.3 Checks should be put in place to ensure that alarm bells are not disabled other than in exceptional circumstances and detainees in cells without in-cell sanitation have access to toilet facilities when required. (2.25)
- 7.4 The environment at the Wrexham custody suite should be improved and deep cleaned. (2.26)
- 7.5 All detainees should be able to see a health care professional appropriate for their needs, including the administration of controlled drugs, within a reasonable time. (2.27)

Recommendations

Strategy

- 7.6 The force should review the current management arrangements for custody and staffing levels to ensure the care and welfare of detainees. (3.12)
- 7.7 The force should collate the use of force data and monitor the use of force locally and at force-wide level, for example by ethnicity, location and officer involved. (3.13)

Treatment and conditions

- 7.8 Booking-in desks should allow effective and private communication between detainees and staff. (4.7)
- 7.9 There should be clear policies and procedures to meet the specific needs of female and juvenile detainees and those with disabilities. (4.8)
- 7.10 An overlap period should be built into all shifts, to facilitate an effective handover between staff. (4.14)
- 7.11 The toilet should be obscured or blanked out on closed-circuit television screens covering cells with integral sanitation. (4.26)
- 7.12 All detainees held overnight, or who require one, should be offered a shower. (4.27)
- 7.13 Food should be of sufficient quality and calorific value to sustain detainees for the duration of their stay. (4.34)
- 7.14 Detainees held for long periods should be offered outdoor exercise. (4.38)

Individual rights

- 7.15 Custody suites should not be used as a place of safety for juveniles. (5.9)
- 7.16 Custody staff should ensure that detainees' dependency obligations are routinely identified and, where possible, addressed. (5.10)
- 7.17 Appropriate adults should be readily available to support juveniles aged 17 and under and vulnerable adults in custody, including out of hours. (5.16)
- 7.18 Detainees should be told how to make a complaint and should be facilitated to do so before they leave custody. (5.19)

Health care

- 7.19 There should be robust infection control procedures for all the clinical rooms, which should be clean. (6.9)
- 7.20 Medications should only be prescribed and administered in line with relevant professional guidance. (6.10)
- 7.21 All detainees who require the services of a drugs or alcohol worker should be referred appropriately, irrespective of the time of day. (6.28)
- 7.22 The care of detainees with mental health problems in police custody should be the subject of strategic discussions between chief officers and the health board to develop and implement robust protocols to ensure the health board promptly fulfil their responsibilities to provide detainees with mental health problems the medical care they require. (6.36)
- 7.23 Police custody should be used as a place of safety for section 136 assessments only in extreme cases. (6.37)
- 7.24 Custody staff should undergo mental health awareness training. (6.38)

Housekeeping points

Treatment and conditions

- 7.25 Detainees required to wear self-harm prevention smocks should be provided with underwear. (4.15)
- 7.26 Mattresses should be wiped clean after each use and clean blankets provided. (4.28)
- 7.27 All female detainees should be offered a hygiene pack on arrival. (4.29)
- 7.28 All cells should contain a supply of toilet paper. (4.30)
- 7.29 Replacement underwear should be available if required. (4.31)
- 7.30 Appropriate reading material should be offered to detainees. (4.39)

Individual rights

- 7.31 Custody staff should be aware that immigration detainees can access specialist telephone advice through the duty solicitor scheme. (5.17)

Health care

- 7.32 If video conferencing is to be used to assess detainees clinically, there should be strict governance arrangements about its use. (6.20)
- 7.33 Detainees' consent should be recorded on clinical records. (6.21)
- 7.34 Detainees should be able to obtain a copy of their clinical records. (6.22)
- 7.35 Injecting drug users who are being released into the community should be offered clean needles by drugs workers. (6.29)

Good practice

Strategy

- 7.36 The force had conducted a thorough review of custody arrangements which had enabled them to make a number of positive changes and identify further areas for improvement. (3.14)

Appendix I: Inspection team

Sean Sullivan	HMIP team leader
Andrew Rooke	HMIP inspector
Colin Carroll	HMIP inspector
Karen Dillon	HMIP inspector
Vinnett Percy	HMIP inspector
Paddy Craig	HMIC inspector
Fiona Shearlaw	HMIP inspector
Elizabeth Tysoe	HMIP health care inspector
Nicola Rabjohns	HMIP health care inspector
Adam Altoft	HMIP researcher

Appendix II: Custody record analysis

Background

As part of the inspection of North Wales police custody, a sample of the custody records of detainees held at St Asaph, Wrexham, Caernarfon, Dolgellau, Holyhead and Mold police custody suites were analysed between 6 September and 12 September. Custody records were held electronically on Niche RMS. A total sample of 30 records was analysed:

Custody suite	Number of records analysed
St Asaph	9
Wrexham	6
Caernarfon	6
Dolgellau	3
Holyhead	3
Mold	3
TOTAL	30

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

Demographic information

- Two (7%) of the detainees were female and 28 were male.
- Three (10%) people under the age of 17 were included in the sample.
- There were 29 (97%) detainees in our sample with a white British/other white background and one with a black and minority ethnic background.
- Two (7%) detainees had been held for more than 24 hours. Eighteen (60%) had been in custody overnight, including those who had arrived during the night and not been released until the morning (between midnight and 3am). Seven (23%) detainees had been held for less than six hours.
- There were no foreign nationals in our sample.

Risk assessments

Initial risk assessment statements were largely clear and contained helpful information.

- Fourteen detainees (47%) were brought into custody intoxicated. Four of these detainees were seen by a doctor or nurse, according to the notes in their detainee logs. Detainees who were intoxicated but did not see a health care professional were routinely placed on 30-minute observations as a precaution. One detainee was referred to local substance support services, ARCH Initiative Cymru.
- Fifteen (50%) detainees had current or previous self-harm or suicide issues. Seven of these detainees had their clothing removed and were placed in a 'smock' to prevent them

from harming themselves. There was information listed on the Police National Computer (PNC) about one detainee, noting a previous suicide attempt; however, this information was not reflected in their risk assessment.

- Eleven (37%) detainees in our sample had reported mental health problems. Of these, three required an appropriate adult to attend custody, and all three received this.
- Eleven (37%) detainees in our sample reported being on medication on arrival in custody. Six of these were seen by a health care professional. Of the other detainees, three were held for approximately two hours or less.
- Six (20%) detainees in our sample came into custody with an injury; two were seen by a health care professional. Three detainees reported only slight injuries and did not require the attention of a health care professional.
- In 10 (33%) risk assessments, it was noted to be a detainee's first time in custody.

Removal of clothing

Twelve (40%) of the detainees in the sample had clothing removed. All of these were given a replacement immediately; for 11 detainees this was either a tracksuit or a 'smock' and the other received a blanket.

Young people

There were three (10%) young people in our sample aged under 17 years.

- All three seemingly had an appropriate adult present both during the interview and when they received their rights. However, for two detainees, although the presence of the appropriate adult in custody was acknowledged both before and after the interview, their appropriate adult was not listed on the custody log as an attendee at the interview. For two of the three young people, their appropriate adult was a family member.
- One of the three young people was held in custody for nearly 22 hours. Due to concerns that they may have been concealing a prohibited item, the detainee was strip-searched. There were four members of staff present during the search and it took place before the arrival of an appropriate adult, as it was considered to be of an 'urgent nature'. The detainee's clothing was removed and an alternative provided; the detainee had not declared any history of self-harm.

Women

There were no questions on Niche RMS that asked gender-specific questions

Interpreters

No detainees required the use of an interpreter.

Inspector reviews

Inspector reviews were held in line with requirements. In isolated cases, reviews were delayed for operational reasons, such as competing custody demands. When reviews took place while the detainee was asleep, the detainee was routinely informed of the review when they woke up.

Services

- All detainees were routinely offered the opportunity to have someone informed of their arrest, notwithstanding operational reasons. In addition, three (10%) detainees had made a telephone call during their time in custody. Two (7%) detainees requested to make a call but their requests were refused for reasons relating to their case.
- All detainees were routinely offered legal advice but only 16 (53%) detainees accepted.
- Eight (27%) detainees were seen by a health care professional:
 - ❖ It was not always clear on the detention log when a health care professional was contacted and asked to see a detainee.
 - ❖ The longest wait found was approximately three hours and 17 minutes.
- Twenty (67%) detainees in our sample were offered at least one meal while in custody. Ten (33%) detainees were not offered a meal while in custody. One of the 10 was in custody for just over 10 hours; the other nine detainees were held for less than seven hours.
- Five (17%) detainees in the custody sample had been given outside exercise.
- Five (17%) detainees had a shower while in custody. However, five detainees went to court and were not offered a shower, including one detainee who was held for over 32 hours.
- Three (10%) detainees had been provided with reading materials.
- One detainee was permitted to smoke in the exercise yard on three occasions during their time in custody.
- No evidence of cell sharing was found.

Additional points of note

- Care plans and pre-release risk assessments had recently been introduced as formal documentation on the force's Niche RMS. There was evidence that these were being used consistently; where appropriate, care plans were detailed and used information gleaned from both the risk assessment carried out with the detainee and PNC checks.
- One detainee was given – and signed for – his rights on arrival at the station, despite being intoxicated.
- For one detainee there was a six-hour gap between detention log entries.
- Four detainees were provided with transport home from custody.

Appendix III: Summary of detainee questionnaires and interviews

Detainee survey methodology

A voluntary, confidential and anonymous survey of the prisoner population, who had been through a police station in North Wales, 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 13 September 2010. A list of potential respondents was created, which included all those who had arrived from the magistrates' courts of Holyhead, Llangefni, Caernarfon, Colwyn Bay, Denbigh, Dolgellau, Flint, Llandudno and Mold who had been charged at North Wales police stations in the previous two months.

Selecting the sample

In total, 56 respondents were approached. Five reported being held in police stations outside of North Wales. On the day, the questionnaire was offered to 51 respondents; there was one refusal and three questionnaires were returned blank. All of those sampled had been in custody within the previous two months.

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

Methodology

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

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

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

Response rates

In total, 47 (92%) respondents completed and returned their questionnaires.

Comparisons

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

Some questions have been filtered according to the response to a previous question. Filtered questions are clearly indented and preceded by an explanation as to which respondents are included in the filtered questions. Otherwise, percentages provided refer to the entire sample. All missing responses 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 32 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

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.

Survey results

Police custody survey

Section 1: About you

Q2	What police station were you last held at?			
	St Asaph – 25; Mold – 9; Caernarfon – 7; Wrexham – 4; Dolgellau – 1; Holyhead - 1			
Q3	How old are you?			
	16 years or younger.....	0 (0%)	40-49 years.....	11 (23%)
	17-21 years	7 (15%)	50-59 years.....	2 (4%)
	22-29 years	18 (38%)	60 years or older	0 (0%)
	30-39 years	9 (19%)		
Q4	Are you:			
	Male.....		46 (98%)	
	Female		0 (0%)	
	Transgender/transsexual		1 (2%)	
Q5	What is your ethnic origin?			
	White - British.....		43 (91%)	
	White - Irish		0 (0%)	
	White - other		2 (4%)	
	Black or black British - Caribbean.....		1 (2%)	
	Black or black British - African		1 (2%)	
	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		0 (0%)	
	Mixed heritage - white and black African		0 (0%)	
	Mixed heritage- white and Asian		0 (0%)	
	Mixed heritage - Other		0 (0%)	
	Chinese		0 (0%)	
	Other ethnic group		0 (0%)	
Q6	Are you a foreign national (i.e. you do not hold a British passport, or you are not eligible for one)?			
	Yes		3 (8%)	
	No		35 (92%)	
Q7	What, if any, would you classify as your religious group?			
	None.....		17 (39%)	
	Church of England		13 (30%)	
	Catholic		10 (23%)	
	Protestant.....		1 (2%)	
	Other Christian denomination		3 (7%)	
	Buddhist.....		0 (0%)	

Hindu	0 (0%)
Jewish	0 (0%)
Muslim.....	0 (0%)
Sikh	0 (0%)

Q8	How would you describe your sexual orientation?	
	<i>Straight/heterosexual</i>	45 (98%)
	<i>Gay/lesbian/homosexual</i>	0 (0%)
	<i>Bisexual</i>	1 (2%)
Q9	Do you consider yourself to have a disability?	
	<i>Yes</i>	6 (13%)
	<i>No</i>	40 (87%)
Q10	Have you ever been held in police custody before?	
	<i>Yes</i>	44 (96%)
	<i>No</i>	2 (4%)

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?	
	<i>Less than 24 hours</i>	17 (36%)
	<i>More than 24 hours, but less than 48 hours (2 days)</i>	21 (45%)
	<i>More than 48 hours (2 days), but less than 72 hours (3 days)</i>	7 (15%)
	<i>72 hours (3 days) or more</i>	2 (4%)
Q12	Were you given information about your arrest and your entitlements when you arrived there?	
	<i>Yes</i>	38 (81%)
	<i>No</i>	8 (17%)
	<i>Don't know/can't remember</i>	1 (2%)
Q13	Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')?	
	<i>Yes</i>	20 (43%)
	<i>No</i>	22 (47%)
	<i>I don't know what this is/I don't remember</i>	5 (11%)
Q14	If your clothes were taken away, were you offered different clothing to wear?	
	<i>My clothes were not taken</i>	19 (42%)
	<i>I was offered a tracksuit to wear</i>	10 (22%)
	<i>I was offered an evidence/ paper suit to wear</i>	3 (7%)
	<i>I was offered a blanket</i>	9 (20%)
	<i>Nothing</i>	4 (9%)
Q15	Could you use a toilet when you needed to?	
	<i>Yes</i>	44 (94%)
	<i>No</i>	3 (6%)
	<i>Don't know</i>	0 (0%)

Q16	If you have used the toilet there, was toilet paper provided?			
	Yes	26	(58%)	
	No	19	(42%)	
Q17	Did you share a cell at the police station?			
	Yes	0	(0%)	
	No	47	(100%)	
Q18	How would you rate the condition of your cell:			
		<i>Good</i>	<i>Neither</i>	<i>Bad</i>
	Cleanliness	24 (51%)	7 (15%)	16 (34%)
	Ventilation/air quality	19 (40%)	10 (21%)	18 (38%)
	Temperature	13 (28%)	8 (17%)	25 (54%)
	Lighting	25 (53%)	13 (28%)	9 (19%)
Q19	Was there any graffiti in your cell when you arrived?			
	Yes	19	(40%)	
	No	28	(60%)	
Q20	Did staff explain to you the correct use of the cell bell?			
	Yes	12	(26%)	
	No	35	(74%)	
Q21	Were you held overnight?			
	Yes	45	(96%)	
	No	2	(4%)	
Q22	If you were held overnight, which items of clean bedding were you given?			
	Not held overnight	2	(3%)	
	<i>Pillow</i>	14	(23%)	
	<i>Blanket</i>	38	(62%)	
	<i>Nothing</i>	7	(11%)	
Q23	Were you offered a shower at the police station?			
	Yes	3	(6%)	
	No	44	(94%)	
Q24	Were you offered any period of outside exercise while there?			
	Yes	7	(15%)	
	No	40	(85%)	
Q25	Were you offered anything to:			
		<i>Yes</i>	<i>No</i>	
	Eat?	35 (76%)	11 (24%)	
	Drink?	40 (87%)	6 (13%)	
Q27	Was the food/drink you received suitable for your dietary requirements?			
	I did not have any food or drink	12	(26%)	
	Yes	16	(34%)	
	No	19	(40%)	

Q28	If you smoke, were you offered anything to help you cope with the smoking ban there?		
	<i>I do not smoke</i>	3 (7%)	
	<i>I was allowed to smoke</i>	4 (9%)	
	<i>I was not offered anything to cope with not smoking</i>	39 (85%)	
	<i>I was offered nicotine gum</i>	0 (0%)	
	<i>I was offered nicotine patches</i>	0 (0%)	
	<i>I was offered nicotine lozenges</i>	0 (0%)	
Q29	Were you offered anything to read?		
	Yes	4 (9%)	
	No	43 (91%)	
Q30	Was someone informed of your arrest?		
	Yes	20 (43%)	
	No	14 (30%)	
	<i>I don't know</i>	3 (6%)	
	<i>I didn't want to inform anyone</i>	10 (21%)	
Q31	Were you offered a free telephone call?		
	Yes	22 (48%)	
	No	24 (52%)	
Q32	If you were denied a free phone call, was a reason for this offered?		
	<i>My telephone call was not denied</i>	24 (60%)	
	Yes	2 (5%)	
	No	14 (35%)	
Q33	Did you have any concerns about the following, while you were in police custody?		
		Yes	No
	Who was taking care of your children	5 (15%)	28 (85%)
	Contacting your partner, relative or friend	18 (44%)	23 (56%)
	Contacting your employer	5 (15%)	28 (85%)
	Where you were going once released	9 (24%)	28 (76%)
Q34	Were you interviewed by police officials about your case?		
	Yes	37 (84%)	
	No	7 (16%)	If No, go to Q36
Q35	Were any of the following people present when you were interviewed?		
		Yes	No Not needed
	Solicitor	26 (68%)	8 (21%) 4 (11%)
	Appropriate adult	1 (4%)	10 (40%) 14 (56%)
	Interpreter	0 (0%)	9 (39%) 14 (61%)
Q36	How long did you have to wait for your solicitor?		
	<i>I did not requested a solicitor</i>	13 (31%)	
	<i>2 hours or less</i>	5 (12%)	
	<i>Over 2 hours but less than 4 hours</i>	2 (5%)	
	<i>4 hours or more</i>	22 (52%)	

Section 3: Safety

- Q38 Did you feel safe there?**
 Yes 30 (65%)
 No 16 (35%)
- Q39 Had another detainee or a member of staff victimised (insulted or assaulted) you there?**
 Yes 17 (36%)
 No 30 (64%)
- Q40 If you have felt victimised, what did the incident involve? (Please tick all that apply to you.)**
I have not been victimised 30 (52%) *Because of your crime* 8 (14%)
Insulting remarks (about you, your family or friends) 3 (5%) *Because of your sexuality* 0 (0%)
Physical abuse (being hit, kicked or assaulted) 8 (14%) *Because you have a disability* 1 (2%)
Sexual abuse 1 (2%) *Because of your religion/religious beliefs* 0 (0%)
Your race or ethnic origin 0 (0%) *Because you are from a different part of the country than others* 1 (2%)
Drugs 6 (10%)
- Q41 Were your handcuffs removed on arrival at the police station?**
 Yes 33 (70%)
 No 10 (21%)
I wasn't handcuffed 4 (9%)
- Q42 Were you restrained while in the police custody suite?**
 Yes 5 (11%)
 No 41 (89%)
- Q43 Were you injured while in police custody, in a way that you feel was not your fault?**
 Yes 10 (21%)
 No 37 (79%)
- Q44 Were you told how to make a complaint about your treatment here if you needed to?**
 Yes 6 (13%)
 No 40 (87%)

Section 4: Health care

- Q46 Did you need to take any prescribed medication when you were in police custody?**
 Yes 19 (41%)
 No 27 (59%)
- Q47 Were you able to continue taking your prescribed medication while there?**
Not taking medication 27 (59%)
 Yes 8 (17%)
 No 11 (24%)
- Q48 Did someone explain your entitlements to see a health care professional if you needed to?**
 Yes 17 (37%)
 No 25 (54%)
 Don't know 4 (9%)

Q49	Were you seen by the following health care professionals during your time there?					
		Yes			No	
	Doctor	7 (18%)			32 (82%)	
	Nurse	18 (42%)			25 (58%)	
	Paramedic	0 (0%)			34 (100%)	
	Psychiatrist	1 (3%)			34 (97%)	
Q50	Were you able to see a health care professional of your own gender?					
	Yes					9 (21%)
	No					21 (49%)
	Don't know					13 (30%)
Q51	Did you have any drug or alcohol problems?					
	Yes					24 (53%)
	No					21 (47%)
Q52	Did you see, or were offered the chance to see a drug or alcohol support worker?					
	I didn't have any drug/alcohol problems.....					21 (47%)
	Yes					7 (16%)
	No					17 (38%)
Q53	Were you offered relief or medication for your immediate symptoms?					
	I didn't have any drug/alcohol problems.....					21 (47%)
	Yes					9 (20%)
	No					15 (33%)
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
	25 (57%)	6 (14%)	7 (16%)	1 (2%)	2 (5%)	3 (7%)
Q55	Did you have any specific <u>physical</u> health care needs?					
	No					32 (70%)
	Yes					14 (30%)
Q56	Did you have any specific <u>mental</u> health care needs?					
	No					29 (62%)
	Yes					18 (38%)

Thank you for your time.



Prisoner survey responses for North Wales police 2010

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	North Wales police 2010	Police custody comparator	North Wales police 2010	North Wales police 2009
	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				
Number of completed questionnaires returned		47	1051	47	49
SECTION 1: General Information					
3	Are you under 21 years of age?	14%	8%	14%	26%
4	Are you transgender/transsexual?	2%	1%	2%	0%
5	Are you from a minority ethnic group (including all those who did not tick white British, white Irish or white other categories)?	4%	35%	4%	8%
6	Are you a foreign national?	8%	16%	8%	15%
7	Are you Muslim?	0%	12%	0%	2%
8	Are you homosexual/gay or bisexual?	2%	2%	2%	0%
9	Do you consider yourself to have a disability?	13%	20%	13%	21%
10	Have you been in police custody before?	96%	89%	96%	92%
SECTION 2: Your experience of this custody suite					
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?	64%	65%	64%	65%
12	Were you given information about your arrest and entitlements when you arrived?	80%	73%	80%	71%
13	Were you told about PACE?	42%	52%	42%	53%
14	If your clothes were taken away, were you given a tracksuit to wear?	39%	44%	39%	52%
15	Could you use a toilet when you needed to?	94%	90%	94%	92%
16	If you did use the toilet, was toilet paper provided?	58%	50%	58%	65%
17	Did you share a cell at the station?	0%	3%	0%	4%
18	Would you rate the condition of your cell, as 'good' for:				
18a	Cleanliness?	51%	29%	51%	18%
18b	Ventilation/air quality?	40%	20%	40%	21%
18c	Temperature?	29%	14%	29%	18%
18d	Lighting?	54%	44%	54%	35%
19	Was there any graffiti in your cell when you arrived?	40%	56%	40%	51%
20	Did staff explain the correct use of the cell bell?	26%	22%	26%	26%
21	Were you held overnight?	96%	92%	96%	90%
22	If you were held overnight, were you given no clean items of bedding?	14%	30%	14%	22%
23	Were you offered a shower?	6%	9%	6%	10%
24	Were you offered a period of outside exercise?	14%	6%	14%	14%
25a	Were you offered anything to eat?	76%	80%	76%	69%
25b	Were you offered anything to drink?	88%	82%	88%	83%
	For those who had food:				
26b	Was the food/drink you received suitable for your dietary requirements?	46%	45%	46%	30%
27	For those who smoke: were you offered nothing to help you cope with the ban there?	85%	77%	85%	81%
28	Were you offered anything to read?	8%	14%	8%	13%
29	Was someone informed of your arrest?	42%	43%	42%	54%
30	Were you offered a free telephone call?	48%	52%	48%	54%

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				
		North Wales police 2010	Police custody comparator	North Wales police 2010	North Wales police 2009
31	If you were denied a free call, was a reason given?	12%	15%	12%	0%
32	Did you have any concerns about:				
32a	Who was taking care of your children?	14%	16%	14%	11%
32b	Contacting your partner, relative or friend?	44%	53%	44%	40%
32c	Contacting your employer?	14%	21%	14%	5%
32d	Where you were going once released?	25%	31%	25%	30%
34	If you were interviewed were the following people present:				
34a	Solicitor	68%	74%	68%	79%
34b	Appropriate adult	4%	8%	4%	5%
34c	Interpreter	0%	8%	0%	11%
35	Did you wait over four hours for your solicitor?	77%	66%	77%	47%
SECTION 3: Safety					
39	Did you feel unsafe?	35%	41%	35%	25%
40	Has another detainee or a member of staff victimised you?	36%	41%	36%	31%
41	If you have felt victimised, what did the incident involve?				
41a	Insulting remarks (about you, your family or friends)	6%	21%	6%	17%
41b	Physical abuse (being hit, kicked or assaulted)	16%	14%	16%	15%
41c	Sexual abuse	2%	2%	2%	0%
41d	Your race or ethnic origin	0%	6%	0%	0%
41e	Drugs	12%	15%	12%	6%
41f	Because of your crime	16%	17%	16%	17%
41g	Because of your sexuality	0%	1%	0%	0%
41h	Because you have a disability	2%	3%	2%	4%
41i	Because of your religion/religious beliefs	0%	3%	0%	0%
41j	Because you are from a different part of the country than others	2%	5%	2%	2%
42a	Were your handcuffs removed on arrival at the police station?	76%		76%	
42b	Were you restrained whilst in the police custody suite?	10%		10%	
43	Were you injured whilst in police custody, in a way that you feel is not your fault?	22%	26%	22%	29%
44	Were you told how to make a complaint about your treatment?	13%	13%	13%	8%
SECTION 4: Health care					
46	Did you need to take any prescribed medication when you were in police custody?	41%		41%	
47	For those who were on medication: were you able to continue taking your medication?	40%		40%	
48	Did someone explain your entitlement to see a health care professional if you needed to?	37%	35%	37%	31%
49	Were you seen by the following health care professionals during your time in police custody?				
49a	Doctor	17%	50%	17%	18%
49b	Nurse	41%	14%	41%	37%
	Percentage seen by either a doctor or a nurse	44%	53%	44%	44%
49c	Paramedic	0%	4%	0%	3%
49d	Psychiatrist	3%	3%	3%	0%
50	Were you able to see a health care professional of your own gender?	22%	28%	22%	23%
51	Did you have any drug or alcohol problems?	53%	53%	53%	39%
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?	28%	42%	28%	17%
53	Were you offered relief medication for your immediate symptoms?	39%	32%	39%	33%
54	For those who had been seen by health care, would you rate the quality as good/very good?	70%	23%	70%	46%
55	Do you have any specific physical health care needs?	31%	33%	31%	36%
56	Do you have any specific mental health care needs?	38%	24%	38%	22%