Report on an inspection visit to police custody suites in North Yorkshire Police

15 – 19 February 2010

by

HM Inspectorate of Prisons and

HM Inspectorate of Constabulary

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

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Contents

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. They also contribute to the United Kingdom's response to its international obligation to ensure regular and independent inspection of all places o detention.[1] The inspections look at force-wide strategies, treatment and conditions, individual rights and healthcare.

North Yorkshire Police has four primary designated custody suites working 24 hours a day – at York, Harrogate, Scarborough and Northallerton – and two further part-time suites at Skipton and Selby. During this inspection, all six suites were visited with the main concentration on the full-time suites. The inspection was further informed by a survey of prisoners at HMP Hull, who had previously been held in North Yorkshire police cells.

A clear management structure was in place under the strategic lead of an assistant chief constable, with the four main suites centrally managed and the part-time suites under local control. There had been considerable investment in upgrading the estate. Overall the staffing model was good, although we had some concerns with levels of cover at Scarborough. Training and refresher courses were available, although they were not mandatory and there was no monitoring of which staff had attended.

There were monthly quality assurance checks on custody records, the results of which were made available at least locally, but these checks were not standardised and the learning points were not disseminated more widely in a way that allowed further reference. Similarly, while use of force was recorded on the intranet, the resultant analysis was used primarily by training staff and not to inform custody policy or practice directly.

Custody staff were respectful and caring in their dealings with detainees, and diversity awareness was included in initial training, although this was not specific to child welfare or protection. Women were generally treated the same as male detainees.

All detainees were risk assessed on arrival and the electronic systems highlighted those with any known history of self-harm or suicide-related behaviour. However, we found examples where assessments had not reflected areas of risk that were flagged by the local or national intelligence systems.

Accommodation was generally clean, well decorated and free from graffiti. There were some ligature points and we noted that staff did not generally carry ligature knives. Health and safety walk-through checks varied from suite to suite, and there was no audit trail to confirm what had been checked or that the checks had taken place. Custody staff were not involved in these checks or informed of their completion.

The provisions of the Police and Criminal Evidence Act were adhered to robustly, although this meant that appropriate adults were not sought for 17 year olds. Detainees with little or no English were well catered for but generally detainees were not routinely asked about any dependency obligations.

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

Early court cut-off times, in particular at Scarborough and Harrogate, were likely to lead to unnecessary detention overnight and, while provision was usually made for the most vulnerable, this needed to be addressed at strategic level.

As found in other inspections, there were problems with the storage and handling of DNA and forensic samples at most of the custody sites. Some samples dated back to 2007, while others were undated and/or not stored in date order. The force needs to review their policies and procedures urgently to address these problems.

Healthcare services had just moved to a new contractor and the force had allocated a full-time inspector to oversee transition. We identified some concerns with staffing levels but the main problems related to the management of medicines, which was generally unsatisfactory. Substance use services were variable, and mental health services underdeveloped. Apart from Scarborough, there was no contractual provision of mental health support and there were no non-police Section 136[2] suites in the county; hence all custody suites were used as a place of safety.

This inspection identified a generally positive picture of custody in North Yorkshire. However, this report sets out a number of recommendations that we believe will assist the Chief Constable and the Police Authority to improve the quality of provision. We expect them to consider these in the wider context of force priorities and resourcing, and to provide us with an action plan in due course.

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March 2010

[2] Suites designated as a place of safety under Section 136 of the Mental Health Act 1983.

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*[3] 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 Yorkshire Police had four primary custody suites designated under PACE for the reception of detainees across the county. These were located at York, Harrogate, Scarborough and Northallerton. Designated custody facilities were also available and used in two part-time secondary suites at Skipton and Selby. The four primary suites operated 24 hours a day and dealt with detainees arrested as a result of mainstream policing. This inspection was largely conducted in these custody suites, but visits were made to the other custody facilities in the force area. A survey of prisoners at HMP Hull, who had formerly been detained at custody suites in the force area, was conducted by HM Inspectorate of Prisons researchers to obtain additional evidence (see appendix III).

2.3 The force cell capacity was 79. York was the biggest suite with 24 cells, Scarborough had 17, Harrogate 14, Northallerton and Selby both had nine and Skipton six. In the 12 months to the end of January 2010, these cells had been used for 22,533 detainees.

2.4 Comments in this report refer to all suites unless specifically stated otherwise.

Strategy

2.5 Management of the four primary custody suites was centralised and the two secondary suites were managed locally by a chief inspector. There had recently been considerable investment in upgrading the custody estate. This was ongoing and there were plans for a new build at Harrogate.

2.6 An assistant chief constable (ACC) had strategic management responsibility, supported by a chief superintendent and the head of administration of' justice (AoJ). Custody sergeants were permanent and managed by inspectors with oversight of the four full-time suites. Detention officers (DOs) were managed by custody sergeants. Staff were well trained, but take up of refresher training was mixed. We had concerns over staffing levels in some custody suites. There were advanced plans to change the staffing mix and key duties of sergeants and DOs.

2.7 Good strategic links had been developed. There was a range of meetings where custody could be discussed, although there was no forum at which to meet formally with local external partners. Dip sampling of custody records took place, but arrangements varied between suites. The Police Authority (PA) indicated good relations with the force and there was a challenging independent custody visitors (ICV) scheme in operation. Relationships with external partner organisations were mostly strong, although further progress needed to be made with regard to mental health.

[3] http://www.justice.gov.uk/inspectorates/hmi-prisons/expectations.htm

2.8 There was some monitoring of use of force, but management information on patterns and trends was not fed back to custody managers.

Treatment and conditions

2.9 Relations between staff and detainees were relaxed and respectful and first or preferred names were mostly used. Staff said they tended to treat all detainees the same way. We observed some differences in how juveniles were dealt with, although there were few specific formal policies. Women were treated similarly to men, other than where they were located, and hygiene products were provided only on request. There were limited arrangements in place to meet the needs of detainees with disabilities.

2.10 Booking in desks did not offer much privacy, but glass-fronted consultation rooms were well used. Risk assessments were carried out on arrival in custody, but the quality was mixed. They were reviewed and revised as circumstances changed. Staff did not carry anti-ligature knives, but were aware of the importance of rousing detainees. The use of cell call bells was explained, but some were routinely muted. Staff attended basic approved restraint techniques training every six months. They emphasised the use of de-escalation techniques with difficult detainees, with restraints used as a last resort.

2.11 Work to upgrade the custody suites was nearly complete. These were generally very clean and free of graffiti, but some ligature points were found. Health and safety checks were not always well conducted. Smoking was not allowed in any of the suites. Fire evacuation procedures were well developed.

2.12 Washes and showers had to be requested and some toilets covered by closed-circuit television (CCTV) were not obscured. Toilet paper was usually available in cells. Mattresses were not wiped down after each use and blankets were mainly provided only on request. A range of suitable replacement clothing was available. Hot meals were provided, but the quality was poor. Hot and cold drinks were offered regularly. Exercise was provided only on request and was sometimes unsupervised. Reading material and visits were rarely offered.

Individual rights

2.13 Custody sergeants looked critically at the reasons for detention. Detainees were asked if they wanted someone informed they were in custody. Custody was not used as a place of safety for children and young people under the Children Act. Dependency obligations were not routinely explored with newly arrived detainees.

2.14 Few immigration detainees were held and relationships with the UK Border Agency (UKBA) were described as good. There were some delays in detainees being collected, but these were not typical. Interpreting services were good.

2.15 PACE was adhered to and up-to-date codes of practice were available. The duty solicitor scheme worked well. Defence solicitors were positive about relationships with staff and said staff were respectful to detainees. Appropriate adult (AA) provision was mixed, particularly out-of-hours and for vulnerable adults. Staff adhered to the PACE definition of a child, which meant

17 years were not routinely provided with an AA.[4] Arrangements for managing DNA and forensics needed to be improved.

2.16 Pre-release risk assessments were usually carried out, but sometimes lacked depth, although a good leaflet was also issued to detainees. Court cut-off times varied and some were too early. Detainees were not told how to make a complaint and any who did were usually sent to the police station front office to do so on release.

Healthcare

2.17 A new private provider, Medacs, had recently taken over the provision of healthcare and governance arrangements were being developed. A police inspector worked full time with the new provider to ensure a smooth transition. Provision included nurse and forensic medical examiner (FME) cover. Custody staff were not clear about what to expect from the new contract, including response times.

2.18 Treatment rooms were reasonable, but there was some uncertainty about who was responsible for general housekeeping of the rooms. The management of medications was a mixed picture, with poor security of medications at some suites. The contractor was introducing defibrillators to all the suites.

2.19 Detainees were routinely asked on arrival if they wanted to see a healthcare professional (HCP). The new health contractor was not consistently meeting the call-out time target, but it was early days in the contract. Custody staff were encouraged to dispense medications inappropriately. Symptomatic relief for substance users was provided and methadone scripts continued if detainees were held in custody for longer periods.

2.20 Clinical records were retained by HCPs, but arrangements for this were not satisfactory and a new clinical information system was being implemented. Care plans were being developed by HCPs and a summary entered on the custody record.

2.21 Substance use services varied depending on location. There was good continuity of care and links to community services in York and Northallerton, although this was less well developed elsewhere. Needle exchange was provided at all suites. Services for detainees with alcohol issues were less well developed, with only a signposting service offered.

2.22 Services for detainees with mental health problems were underdeveloped. There were no Mental Health Act section 136 specialist place of safety suites in the county and a significant number of these detainees were brought into custody.

Main recommendations

2.23 Risk assessments should take into account all the relevant information available to staff, who should actively engage with detainees when booking them in to custody.

2.24 The processes for carrying out health and safety, maintenance and cleanliness checks should be reviewed and formalised across the custody estate and the results reviewed

[4] 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.

by managers. Staff should be provided with appropriate training to allow them to carry out these checks.

2.25 Appropriate adults should be readily available to support juveniles aged 17 and under and vulnerable adults while in custody.

2.26 Keys to medicine cabinets should be secured and accessible only to healthcare professionals.

2.27 There should be a liaison and/or diversion scheme that enables detainees with mental health issues to be identified and diverted into appropriate mental health services.

3. Strategy

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

3.1 An ACC was the senior portfolio holder for custody issues in North Yorkshire Police. Strategic priority was given to custody and there was clear strategic direction. There had historically been an under-investment in the custodial estate, but with the strong support of the PA, which had provided additional funding, work to upgrade and refurbish the designated custody suites had started in summer 2009. This was due to be completed in March 2010 and demonstrated North Yorkshire's commitment to upgrade and professionalise its custody capability. Plans were also under way to build a new police station and custody suite at Harrogate and it was hoped this would be completed by 2012. Following a review of demand across the county, the suite's cell capacity was due to increase initially by two cells, although a further eight could be added in future if required. The force clearly had a long-term strategic plan for the continued development of its custody estate.

3.2 North Yorkshire's four primary designated custody suites operated under the control of the central Administration of Justice (AoJ) unit. Apart from Northallerton, the suites were each managed by an inspector (two for York) who was the custody manager (CM). At Northallerton, management cover was provided from York. They managed all PACE issues and reviews of detention. When they were off duty, this work fell to operational inspectors. The CMs were line managed by the AoJ head of custody units who was a chief inspector and was also responsible for the management of custody policies and working practices. The chief inspector, AoJ head of custody units was in turn line managed by the head of AoJ, who reported to the chief superintendent, specialist operations directorate (SOD). Responsibility for the two secondary designated custody suites at Selby and Skipton rested with a chief inspector in the safer neighbourhood area where they were located.

3.3 The ACC and chief superintendent, SOD, meet weekly and were supported by monthly SOD senior management team (SMT) meetings and fortnightly AoJ SMT meetings. The chief constable (CC) also held regular challenging quarterly health checks with the head of AoJ. However, there were no custody user meetings where local custody issues could be discussed and resolved.

3.4 Under the workforce modernisation programme, a custody consultation group had been set up, chaired by the chief inspector, AoJ head of custody units. This allowed staff to air their views on proposed changes, but had also led to some uncertainty as custody sergeants and DOs did not know how their roles would evolve.

3.5 There were 32 custody sergeants in AoJ supported by 33 DOs. Custody sergeants were line managed by CMs who in turn line managed DOs. The police sergeants were posted into custody roles from patrol teams, with the expectation that they would remain in post for at least two years. All custody sergeants and DOs received specific custody training, some of which was delivered jointly where appropriate. Most were initially based at York to allow them to work alongside an experienced member of staff before working at one of the smaller suites. The five-week in-force course was based on nationally-approved training and covered all aspects of custody duties. Refresher and ongoing training was offered through a training day rostered into shift patterns every five weeks. This was also delivered jointly when appropriate, such as for training in first aid and completing prisoner escort records

(PERs). However, this training was not mandatory and there was no formal monitoring to ensure staff attended.

3.6 Staff were well trained and focused on detainees' needs, but we had concerns about some aspects of the staffing model. At Scarborough, the staffing model was one custody sergeant and two DOs, but it was not unusual for only one DO to be on duty. DO duties included fingerprinting, photographing and DNA testing every detainee coming into custody, all of which diverted them from their main duties of maintaining detainee welfare and safety. We were told the staffing model for all custody suites was under review through the workforce modernisation programme.

3.7 There were good working relationships with partners across North Yorkshire. However, custody suites were used as a place of safety under section 136 of the Mental Health Act 1983 because no other suitable premises had been identified in the North Yorkshire area (see section on healthcare). The PA was positive about its relationship with the force, which it found both approachable and responsive. There was a PA lead for the ICV scheme, which was seen as an independent oversight mechanism. There were five ICV panels, each with its own coordinator, to cover the six designated suites (the York panel also covered Selby). Feedback was discussed locally and action taken as necessary as well as being formally discussed at quarterly panel meetings. ICV chairs reported good relationships with the force.

3.8 Monthly quality assurance checks were carried out by CMs, but they used different methods for dip sampling custody records and there was no standard for how many records would be reviewed or what information would be checked. Details of checks were recorded on local spreadsheets. Findings were addressed directly with individual staff members and generic learning points were disseminated among all staff. Learning from any custody adverse incident report was posted as a 'message of the day' on computer terminals and logged on a spreadsheet. The details were also sometimes circulated to staff by email or through an organisational learning bulletin circulated by professional standards department. However, anyone wanting to find a previous learning point had to check through every individual incident on the relevant spreadsheet. Staff had access to the web link for the Independent Police Complaints Commission (IPCC) learning the lessons bulletin.

3.9 Use of force documentation was on the intranet. This was simply a tick box form with no space for a written account of events. Staff said they would always include a written account in detainees' individual custody records. The paperwork was sent to the central services directorate and analysed. A quarterly report showed the types of force used, locations and whether the outcome had been successful. Any member of staff using force frequently was also highlighted. The report was sent only to police safety trainers and was not used directly to inform policies and practice. CCTV coverage of use of force was reviewed only if a complaint was made or if the use of force was planned, such as to remove an unruly detainee from a cell.

Recommendations

3.10 There should be sufficient custody staff on duty to ensure that detainees' care and welfare needs can be met effectively.

3.11 Clear directions should be issued to formalise the quality assurance of custody records to ensure consistency and equity across the force.

3.12 The use of force monitoring form should be amended to capture all available information and to monitor the use of force centrally so that custody managers can identify patterns and monitor trends.

Housekeeping points

3.13 Custody refresher training should be mandatory for all staff working in the custody environment.

3.14 Staff should have easy access to learning points from adverse incidents through a dedicated page on the force intranet.

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 Vans with a caged off area at the back were often used to transport detainees to police custody. These were clean and well equipped, but the caged areas allowed very little room to sit upright.

4.2 Custody staff were professional and respectful in their dealings with detainees and made every effort to put them at their ease, particularly juveniles. Some staff spoke of the importance of caring for detainees in their charge, but others were more businesslike. All detainees were addressed by their first or preferred names.

4.3 Diversity awareness training was included as part of the initial custody training, but many staff felt this was the minimum requirement for dealing with the wide range of detainees in custody. Some were instinctively sensitive to gender, age and cultural differences and were aware of potentially culturally sensitive issues around searching detainees.

4.4 Staff had not received specific awareness training in child welfare or protection, although those we spoke to used common sense to identify the distinctive needs of children, explaining things clearly and using less formal language. Glass-fronted consultation rooms were widely used to allow juveniles contact with family members acting as AAs. This meant that children could meet with supportive adults out of their cells without compromising safety. However, we observed a case where a young person was strip searched without apparently considering the impact this might have on him or how this could be reduced, for example by waiting for a family member acting as an appropriate adult to arrive.

4.5 Female detainees were largely treated the same as men and were not always offered the opportunity of talking to a female member of staff. Staff assumed that female detainees would ask if they needed anything, including sanitary items, and did not consider that they might be unwilling or unable to do so. We observed one female detainee having to talk about intimate issues in a crowded area before being given sanitary protection.

4.6 Records indicated that 74 immigration detainees had been held in the six months to December 2009. They were usually dealt with by UK Border Agency (UKBA) officials within 24 hours, although staff told us that delays of up to three days, particularly at weekends, had occurred on occasion. There was recognition of detainees' religious needs. Bibles were available and Qur'ans and prayer mats suitable for Muslims were kept at all primary suites, but no religious texts or artefacts for other faiths.

4.7 No cells had been adapted to meet the needs of detainees with physical disabilities. Staff said each case was managed individually, but there were no formal arrangements or policies. Hearing loops had been installed at the primary suites to assist detainees with hearing impairment. Scarborough had an adapted toilet and a lower section of the booking in desk suitable for use with detainees who were wheelchair users.

4.8 Otherwise, booking in desks were in an open area that did not offer any privacy. This was a particular issue at York where up to three booking in points could be used at the same time. This potentially had a serious impact on detainees who already had difficulty communicating, because they had little or no English or because it made them reluctant to disclose confidential information or vulnerabilities.

Safety

4.9 All detainees were risk assessed on arrival in custody. The Niche computerised custody record system highlighted anyone held previously with a known history of self-harm or suicide-related behaviour or who was a risk to others. The risk assessment interviews we observed at the booking in stage covered the key areas, but some were rather mechanical in that the questions were merely read to detainees without any real engagement with them. Most assessments were balanced and proportionate and staff were not overly risk averse, but we found examples where they did not' reflect important areas of risk flagged by the local intelligence system or the police national computer. (See main recommendations.)

4.10 When individuals had identified risks, the risk management plans developed were appropriate. Staff did not hesitate to obtain medical advice when necessary, but this was not always reflected in custody records. Detainees assessed as presenting a potential risk to others were kept separate from other detainees. Custody sergeants had detailed awareness of all the individuals held in their care and paid appropriate attention to high risk cases. Apart from the 7am shift change, which relied on good will for a handover to take place, staff starting times overlapped, allowing custody sergeants enough time for a comprehensive handover briefing. The frequency of detainee observations was routinely reviewed at each change of shift. Custody records also showed that levels of observation were revised, but it was not always clear when or why such changes had been made. CCTV cameras covered all communal areas and some cells. They were difficult to monitor constantly, but staff did not overly rely on them. Staff routinely roused detainees when appropriate. No cells were shared.

4.11 Self-harm and suicide were covered in initial custody training, but few staff we spoke to had received refresher training. Staff did not carry anti-ligature knives, but these were kept behind the custody booking in desk in all suites except Selby. There were some ligature points in cells and other detainee areas, despite the recent refurbishment. These were pointed out to the force and a programme to address them was instituted immediately.

Use of force

4.12 Custody staff completed use of force forms and submitted them as required. Staff said force was used only as a last resort. All those involved in using force had been trained in the approved techniques and received bi-annual refresher training. Detainees subject to use of force were not routinely seen by a health professional and staff said they would call medical staff only if there were any visible injuries. Control and restraint equipment was in good order. Where detainees were handcuffed on arrival at the custody suites, these were removed soon after reception. Mechanical restraints were limited to leg straps (Velcro fastenings), handcuffs (rigid and non-rigid) and spit hoods.

Physical conditions

4.13 Cells and communal areas were clean, well decorated and free of graffiti. Cells were brightly lit and adequately heated and ventilated. Staff enforced a zero tolerance approach to graffiti and

detainees were warned that they would be held responsible for any damage found after they had vacated a cell.

4.14 Arrangements for daily and weekly checks of the facilities to identify health and safety, maintenance and cleanliness issues varied from suite to suite. There was no audit trail to confirm what had or had not been checked and checks were not always completed. Staff said they lacked the necessary training to carry these out. There was an annual health and safety 'walk through', but CSMs said they were not involved in these and did not receive any confirmation they had been completed. (See main recommendations.)

4.15 None of the suites allowed smoking and arrangements to offer nicotine replacement therapy varied from suite to suite. Staff at Scarborough used a limited risk assessment to provide nicotine gum, but staff at other suites said this happened only at the discretion of FMEs. Staff were aware of evacuation plans in the event of a fire. These included handcuffing detainees and attaching the cuffs to a single heavy chain, which seemed risky and time-consuming in an emergency. Fire alarms were tested monthly and evacuation procedures tested at least bi-annually.

4.16 All cells had a cell bell that was checked by staff whenever a new detainee was located in a cell. Detainees were shown the bell and told how and why to use it. Staff responded to them promptly, but bells at York had been silenced by staff, who said the suite had never had an audible system. We activated the buzzer, but it was immediately silenced again by the custody sergeant.

Personal comfort and hygiene

4.17 All detainees were given a mattress, but these were not routinely wiped down after each use. Blankets were clean and given out on request and routinely for detainees staying overnight. There were no pillows, but detainees requesting one were given an extra blanket to use instead.

4.18 Suites were cleaned daily and a deep cleaning contractor was on 24-hour call to deal with any cells contaminated by body fluids. Detention staff were supposed to clean cells generally between uses, but we did not always see them doing so.

4.19 No cells had washing facilities, but there were sinks outside cells and these were kept clean. Showers were very clean, but appeared little used. Staff said detainees who arrived dirty and those held over 24 hours were offered a shower, but not routinely those held overnight. In our survey, 18% of respondents, against a comparator of 10%, said they had been offered one. Showers could be used with reasonable privacy and soap and towels were available. Toilet paper was provided in most cells we looked at. The CCTV monitors of cells at Scarborough did not have the toilet area obscured.

4.20 Detainees who had their clothes removed on arrival were given tracksuits or, depending on their risk of self-harm, non-tear suits. They were also given T-shirts and plimsolls. Underwear and child-size clothes were not available and we saw one child offered adult-size clothing.

Catering

4.21 A limited range of microwave meals was available, but the quality and calorific content were poor. Custody records did not always indicate that meals were offered. We saw staff offer

drinks regularly and on request. Staff had received food hygiene training and food preparation areas were clean.

Activities

4.22 The suites had exercise yards, but staff said exercise was only offered to those held over 24 hours and rarely to anyone else. Detainees who had been held overnight told us they had not been offered outdoor exercise. Staff said exercise was sometimes unsupervised, although all yards were covered by CCTV. Each suite had a limited selection of books and magazines, but these were not routinely offered and there was nothing specifically for younger readers or detainees with learning difficulties. There were no formal visiting arrangements, but staff said they allowed visits in exceptional circumstances.

Recommendations

4.23 Refresher training on meeting the specific needs of the diverse range of detainees found in custody, including juveniles, women and those with disabilities, should be offered.

4.24 Booking-in areas should allow sufficient privacy to facilitate effective communication between staff and detainees.

4.25 All cells should be fit for purpose and free of ligature points and custody staff should be trained to identify potential ligature points.

4.26 All staff should carry anti-ligature knives.

4.27 Views of in-cell toilets covered by closed-circuit television should be obscured.

4.28 Detainees held overnight should be offered a shower.

4.29 All female detainees should be offered a hygiene pack on arrival.

4.30 The food provided should be of a sufficient quality and calorific content to sustain detainees held for long periods.

4.31 Detainees held overnight or for longer periods should be offered outdoor exercise.

Housekeeping points

4.32 The cell bell call system at York should always be activated.

4.33 Mattresses should be wiped down after each use.

4.34 A supply of replacement underwear should be available.

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 were robust in ensuring that detention was used only when appropriate. We observed custody sergeants checking relevant background information and questioning the arresting officer to establish the grounds for detention. They gave examples of when they had refused detention. There was no evidence that suites were used as a formal place of safety for children and young people under Section 46 of the Children Act 1989.

5.2 On arrival, detainees were encouraged to let someone know they were in custody or to let staff do so on their behalf. However, detainees were not routinely asked about any dependency obligations and, even where asked, these were not recorded in custody records. Staff said they would try to contact a detainee's family or friends to deal with any dependency issues if raised by a detainee and would call social services as a last resort. Staff at Scarborough described a good relationship with community organisations to care for children in after-school clubs.

5.3 Detainees with little or no English were well catered for, with a professional telephone interpreting service used during the booking in and risk assessment processes and to explain detainees' rights. Printed information on rights was also available in a number of languages. Interpreters attended the custody suites on request. There were no notices displayed in custody in languages other than English.

5.4 We observed that staff were generally aware of vulnerable detainees and the need to prepare pre-release risk management plans for them, although this was not always evident in custody records we reviewed. The risk assessment completed at booking in was revisited pre-release and all detainees were given a leaflet about local services for drugs, alcohol and other agencies. Most pre-release work consisted of signposting to agencies and ensuring detainees could get home safely. Detainees at Scarborough with no fixed abode could be referred to the Making Safe scheme, which aimed primarily, but not exclusively, to help those involved in domestic abuse. The scheme did not operate at the other custody suites.

Rights relating to PACE

5.5 The procedural requirements of PACE were applied efficiently. Reviews were completed on time, sometimes by telephone. A healthcare professional assessed any detainee thought to be unfit to be interviewed or detained due to drugs or alcohol and interviews did not take place until the detainee was declared fit. Appropriate rest periods and comfort breaks were provided. All detainees were offered the opportunity to consult an up-to-date copy of PACE. Defence solicitors we spoke to said PACE was applied appropriately to their clients and reported good relations with custody staff. They were given copies of custody records on request and the detainee could apply in writing for a copy of the record after release.

5.6 Detainees could consult with their legal representatives, free of charge, in one of the private interview rooms. Good use was also made of the consultation rooms, which contained a telephone that detainees could use to contact their solicitors. However, we observed an investigating officer inappropriately attempting to persuade a juvenile and their parent to be interviewed initially without a solicitor present. The custody sergeant intervened to ensure the juvenile and parent were clear about their rights and a solicitor was subsequently called to attend the interview.

5.7 Juveniles were not interviewed unless accompanied by an appropriate adult (AA), although North Yorkshire police adhered to the PACE definition of a child instead of the Children Act (1989) definition, which meant those aged 17 were not provided with an appropriate adult unless otherwise deemed vulnerable.[5] (See main recommendations.)

5.8 Staff initially looked to family members to be an AA and carried out a cursory risk assessment using their local knowledge and intelligence systems. When this was not possible or appropriate, the local youth offending team (YOT) provided an AA service between 7am and 5pm and the social services emergency duty team (EDT) did the same between 5pm and 10pm. There was no service after 10pm. Staff said it was difficult to get AAs for vulnerable adult detainees, particularly after 5pm. We tried the contact number several times, but were simply placed in a queue. These difficulties meant some adult and juvenile detainees unnecessarily remained in custody overnight.

5.9 There were no video links to the courts. The court cut-off time at Scarborough was 1pm on weekdays and 10am on Saturdays, even though the court was nearby and accessed through a closed-in corridor. Cut -ff times at Harrogate were also early at around noon, but were later at York and Northallerton. Staff said courts were generally accommodating when considering a later slot for vulnerable detainees, but the relatively early cut-off times could result in some detainees having to be unnecessarily held overnight in custody.

5.10 Systems to process DNA samples were mostly effective, but we found a few forensic samples inadequately stored at all custody suites. The oldest of these dated back to April 2008. It was unclear whether they should have been sent for analysis, stored elsewhere if still required or disposed of if no longer required. We also found a number of volunteer DNA samples in custody freezers, including 55 at Northallerton, the oldest dating back to 2007 and several of these were undated. It was not clear why these had not been submitted to the national DNA database or processed accordingly. Northallerton also had two freezers in the custody suite under the control of the criminal investigation department that were packed full and frozen solid to the extent that some drawers could not be opened. Samples were not stored in date order so it was impossible to determine what shelf an individual sample might be on.

Rights relating to treatment

5.11 Custody managers said they would expect complaints to be taken while detainees were still in custody. The chief inspector for custody met regularly with the head of professional standards to discuss the outcome of any complaints made about issues in custody. Detainees were not routinely given information about how to make a complaint and nothing was on display. Custody staff said they usually told detainees to complain at the station front offices on release and we observed this happening with a detainee at Scarborough. Racist complaints procedures were the same as for other complaints.

[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.

Recommendations

5.12 Custody staff should ensure that detainee dependency obligations are routinely identified and, where possible, addressed.

5.13 The responsible assistant chief constable should work with the equivalent manager of the court service to minimise delays in holding detainees who are to be produced at court.

5.14 The force should urgently review how it takes, stores, tracks and submits all DNA and forensic samples taken from detainees, volunteers and victims. The review should identify gaps in policies, training, storage facilities and destruction audit trails. The review should have a senior officer responsible for delivery of an action plan that addresses the issues.

5.15 Custody managers should ensure that detainees who want to make a formal complaint about their arrest or treatment in custody should be able to do this while still in custody.

6. Healthcare

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

Clinical governance

6.1 Medacs, a commercial health group, had very recently been contracted to provide health services in North Yorkshire custody suites, with the contact commencing on 1 February 2010. The provision was a mixture of nurse and FME cover. Nurses were usually the first point of contact, but detainees with significant substance use or mental health concerns were seen by an FME. A police inspector worked full-time to manage the introduction of the new contract and carried out a range of intrusive monitoring.

6.2 Staffing levels were not yet satisfactory and in some areas nurses and FMEs were brought in from neighbouring counties. Recruitment was ongoing and three new nursing staff were awaiting induction. A lead nurse had been recruited and was due to start in early March 2010. A registered general nurse (RGN) based at York also covered Harrogate, Selby and Northallerton. Two other nurses, one RGN and one registered mental nurse (RMN), provided cover to Scarborough. Skipton was covered by Medacs staff from out of area.

6.3 We were told that HCPs worked exclusively for Medacs while on duty, but one FME during the inspection was unable to attend Selby immediately because they were 'in surgery'. There was an induction programme for new staff and a full-time lead FME was responsible for managing training and appraisals for all FMEs. Clinical supervision for nurses was fully supported by Medacs.

6.4 The standard of cleanliness in FME rooms was generally good, but some areas, particularly at Selby, were grubby. There was no evidence of an infection control audit. Rubbish and clinical waste bins were often mixed and not routinely emptied, and equipment in some suites was broken or not fit for purpose. Although the room at York was generally clean, the examination couch was torn and the window on the door was not opaque, allowing anyone to see inside. Custody staff were unclear about who was responsible for the general maintenance of these rooms.

6.5 The management of medicines was generally unsatisfactory and some practice was potentially unsafe. All FME rooms had large twin-lock medicine cabinets. There was no over stocking of products and all medicines were in date and correctly labelled. Drug registers had been implemented, but were not all completed correctly. In some cases, dates were missing and there was no record sheet for weekly drug checking. At Scarborough, an unlocked cabinet behind the custody desk contained an envelope of six Diazepam tablets dating back to October 2009. The management of cabinet keys varied, but was generally unsatisfactory. Keys at York were left in the desk of the unlocked FME room, those at Selby were found on the custody desk and keys at Skipton were on the same key fob as the FME door. The security of FME rooms varied, with those at York and Selby unlocked at all times. (See main recommendations.)

6.6 There was no overall policy for the management and use of emergency equipment. Medacs had delivered new oxygen cylinders to its stations, but only for use by Medacs staff and there

were no airways in the bag containing the oxygen. External automated defibrillators were held in some, but not all, suites and there was no indication of who would or could use them. The equipment was not routinely or regularly checked.

Patient care

6.7 Detainees being booked in were asked if they wanted to see a health professional. Response times for nurses were generally good, but for FMEs were sometimes unsatisfactory. The contract stipulated a response time for Medacs staff of within 60 minutes, but this was not always being achieved in the case of FMEs. During the inspection, an FME and custody staff at Northallerton agreed that the FME would attend to see an intoxicated detainee six hours later to allow them time to sober up before being examined. However, the FME eventually arrived three hours and 40 minutes after the agreed time. When we pointed this out, Medacs agreed it was unacceptable, but said it was due to a breakdown in communication between Medacs and custody staff. Our analysis of custody records indicated an average waiting of 3.5 hours since the introduction of the new contract.

6.8 Patient group directions (PGDs) were in place allowing nurses to administer medicines such as pain relief and anti-inflammatories. Nurses accepted telephone orders for medicines from FMEs and said these were always recorded. Custody staff also gave medicines such as paracetamol and Salbutamol after consultation with a healthcare professional (HCP) and this was in breach of the Nursing and Midwifery Code (2008) and Medicines Management (2007), which state that the administration of drugs via a PGD may not be delegated. The Medacs book of clinical protocols condoned this practice.

6.9 New computers had been installed for the future implementation of a force-wide clinical record system, but this was not yet in place. Staff said work was ongoing to introduce it and that it would ultimately be able to upload onto the custody record. Any contact with healthcare staff was recorded by the attending HCP and a synopsis recorded on the custody record.

6.10 We were told that nurses took records home with them, which did not comply with Caldicott guidelines[6] and governance information guidance on legal and professional obligations (2007). We were also told that FMEs did the same or kept records at their surgeries, although we were aware of advanced plans for clinical records to be stored electronically. Staff we spoke to were unsure about the company policy on giving detainees information about their treatment while in custody and there was no clear Medacs policy on this.

Substance use

6.11 Only York and Northallerton had on-site based support for detainees with substance use needs. Substance misuse services at the other suites were more ad hoc and visited only when requested to do so. The service at York was run by Compass, which provided three drug workers covering the station four days a week between 11am and 4pm. There was no weekend support. Regular Methadone users were asked for their consent to contact the community drug workers and GP and, once confirmed, the FME was asked to provide a prescription for Methadone. Symptomatic relief was also available through the FME. Substance users unknown to the drug worker were offered a comprehensive assessment and onward referral. On release, substance users living in York were offered ongoing support and others were signposted to appropriate community drug support organisations in their home

[6] The Caldicott review (1997) stipulated certain principles and working practices that healthcare providers should adopt to improve the quality of, and protect the confidentiality of, service users' information.

area. Compass also served the local courts and provided drug workers there to support clients. The service at Northallerton was provided by Addiction, which provided a drug worker to the station on most days. Harm reduction advice was offered to all substance users in the county and clean needle packs were available in FME rooms.

6.12 There was no funding for alcohol support, but detainees were signposted to community alcohol support groups when required.

Mental health

6.13 Mental health provision was very basic, with no regular mental health input to custody. We were told that there was a force protocol for the management of mentally disordered detainees, but, despite the efforts of the force, it appeared that local primary care trusts were reluctant to engage to progress work in this area.

6.14 Apart from at Scarborough, which had an RMN, Medacs was not directly contracted to provide mental health support to custody suites. Custody staff contacted the Medacs call centre to request an FME if a detainee displayed any mental health symptoms. If deemed necessary by the FME, local specialist crisis teams including psychiatrists and social workers were contacted to provide intensive support.

6.15 There was no Section 136 suite in the county and all custody suites were used as a place of safety for detainees held under Section 136 of the Mental Health Act. Between June and December 2009, 259 detainees had been held in North Yorkshire police stations under the Act. The use of police stations as places of safety had been reviewed in 2009 by the Yorkshire and Humber Improvement Partnership and the outcome was awaited. The force recognised this issue and had engaged at chief officer level with senior members of the health service to agree a protocol to allow individuals to be taken elsewhere other than a police station. (See main recommendations.)

6.16 Mental health awareness training for custody staff appeared to depend on where staff were located. We were told that such training was provided at Northallerton, but staff at other suites were unclear about what training was available to them.

Recommendations

6.17 Healthcare professionals should not instruct non-healthcare professionals to administer prescribed medicines.

6.18 There should be clear infection control procedures across all suites and the management of general and clinical waste should be managed more robustly. Cleaning schedules should be monitored.

6.19 Resuscitation equipment should be in place and ready for use at every custody suite and staff should be trained in its use and receive annual training updates. Responsibility for the management of, and determining the need for, equipment should be clarified.

6.20 Weekly checks of drugs held in the forensic medical examiner room should be carried out and recorded appropriately.

6.21 All clinical records should be stored in accordance with Caldicott guidelines the Data Protection Act and other relative legislation.

6.22 Access to substance use services should be consistent across the county.

Housekeeping points

6.23 Torn or broken equipment in the forensic medical examiner rooms should be repaired or replaced as necessary.

6.24 Medicines left by former detainees should be returned to local pharmacies for disposal.

6.25 Detainees should be given a copy of their clinical record on request.

6.26 Forensic medical examiner rooms should be secured when not in use and keys held securely.

Good practice

6.27 *The investment in a full-time police inspector to manage the introduction of the new healthcare contract was an excellent initiative that demonstrated the force's commitment to ensuring the contract delivered what was needed.*

7. Summary of recommendations

Main recommendations

7.1 Risk assessments should take into account all the relevant information available to staff, who should actively engage with detainees when booking them in to custody. (2.23)

7.2 The processes for carrying out health and safety, maintenance and cleanliness checks should be reviewed and formalised across the custody estate and the results reviewed by managers. Staff should be provided with appropriate training to allow them to carry out these checks. (2.24)

7.3 Appropriate adults should be readily available to support juveniles aged 17 and under and vulnerable adults while in custody. (2.25)

7.4 Keys to medicine cabinets should be secured and accessible only to healthcare professionals. (2.26)

7.5 There should be a liaison and/or diversion scheme that enables detainees with mental health issues to be identified and diverted into appropriate mental health services. (2.27)

Recommendations

Strategy

7.6 There should be sufficient custody staff on duty to ensure that detainees' care and welfare needs can be met effectively. (3.10)

7.7 Clear directions should be issued to formalise the quality assurance of custody records to ensure consistency and equity across the force. (3.11)

7.8 The use of force monitoring form should be amended to capture all available information and to monitor the use of force centrally so that custody managers can identify patterns and monitor trends. (3.12)

Treatment and conditions

7.9 Refresher training on meeting the specific needs of the diverse range of detainees found in custody, including juveniles, women and those with disabilities, should be offered. (4.23)

7.10 Booking-in areas should allow sufficient privacy to facilitate effective communication between staff and detainees. (4.24)

7.11 All cells should be fit for purpose and free of ligature points and custody staff should be trained to identify potential ligature points. (4.25)

7.12 All staff should carry anti-ligature knives. (4.26)

7.13 Views of in-cell toilets covered by closed-circuit television should be obscured. (4.27)

7.14 Detainees held overnight should be offered a shower. (4.28)

7.15 All female detainees should be offered a hygiene pack on arrival. (4.29)

7.16 The food provided should be of a sufficient quality and calorific content to sustain detainees held for long periods. (4.30)

7.17 Detainees held overnight or for longer periods should be offered outdoor exercise. (4.31)

Individual rights

7.18 Custody staff should ensure that detainee dependency obligations are routinely identified and, where possible, addressed. (5.12)

7.19 The responsible assistant chief constable should work with the equivalent manager of the court service to minimise delays in holding detainees who are to be produced at court. (5.13)

7.20 The force should urgently review how it takes, stores, tracks and submits all DNA and forensic samples taken from detainees, volunteers and victims. The review should identify gaps in policies, training, storage facilities and destruction audit trails. The review should have a senior officer responsible for delivery of an action plan that addresses the issues. (5.14)

7.21 Custody managers should ensure that detainees who want to make a formal complaint about their arrest or treatment in custody should be able to do this while still in custody. (5.15)

Healthcare

7.22 Healthcare professionals should not instruct non-healthcare professionals to administer prescribed medicines. (6.17)

7.23 There should be clear infection control procedures across all suites and the management of general and clinical waste should be managed more robustly. Cleaning schedules should be monitored. (6.18)

7.24 Resuscitation equipment should be in place and ready for use at every custody suite and staff should be trained in its use and receive annual training updates. Responsibility for the management of, and determining the need for, equipment should be clarified. (6.19)

7.25 Weekly checks of drugs held in the forensic medical examiner room should be carried out and recorded appropriately. (6.20)

7.26 All clinical records should be stored in accordance with Caldicott guidelines the Data Protection Act and other relative legislation. (6.21)

7.27 Access to substance use services should be consistent across the county. (6.22)

Housekeeping points

Strategy

7.28 Custody refresher training should be mandatory for all staff working in the custody environment. (3.13)

7.29 Staff should have easy access to learning points from adverse incidents through a dedicated page on the force intranet. (3.14)

Treatment and conditions

7.30 The cell bell call system at York should always be activated. (4.32)

7.31 Mattresses should be wiped down after each use. (4.33)

7.32 A supply of replacement underwear should be available. (4.34)

Healthcare

7.33 Torn or broken equipment in the forensic medical examiner rooms should be repaired or replaced as necessary. (6.23)

7.34 Medicines left by former detainees should be returned to local pharmacies for disposal. (6.24)

7.35 Detainees should be given a copy of their clinical record on request. (6.25)

7.36 Forensic medical examiner rooms should be secured when not in use and keys held securely. (6.26)

Good practice

Healthcare

7.37 The investment in a full-time police inspector to manage the introduction of the new healthcare contract was an excellent initiative that demonstrated the force's commitment to ensuring the contract delivered what was needed. (6.27)

Appendix I: Inspection team

Sean Sullivan	HMIP team leader
Ian Thomson	HMIP inspector
Karen Dillon	HMIP inspector
Angela Johnson	HMIP inspector
Ian Macfadyen	HMIP inspector
Fiona Shearlaw	HMIC inspector
Paddy Craig	HMIC inspector
Gary Boughan	HMIC inspector
Bridget McEvilly	HMIP healthcare inspector
Steve Quinn	Care Quality Commission inspector
Catherine Nichol	HMIP researcher

Appendix II: Custody record analysis

Background

As part of the inspection of North Yorkshire police custody cells, a sample of the custody records of detainees held between 15 and 19 February 2010 was analysed. Custody records were held electronically on NICHE. A total sample of 30 records was analysed from across North Yorkshire:

Custody suite	Number of records analysed
York	12
Scarborough	6
Harrogate	6
Northallerton	6
Total	30

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

Demographic information

- Eight (27%) of the detainees were female and 22 (73%) were male.
- Four people (13%) under the age of 17 were included in the sample.
- There was one (3%) Chinese detainee and 29 (97%) white British detainees in the sample.
- Eleven (37%) detainees had been held overnight, including those who had arrived during the night and were not released until the morning. No one had been held for more than 24 hours. Seventeen (57%) detainees had been held for less than six hours.
- Risk assessments showed that nine (30%) detainees had previously self-harmed or had indications of suicidal ideation.
- Ten (33%) detainees had disclosed mental health problems, including two detainees who came into custody under section 136 of the Mental Health Act, but sectioning was later deemed unnecessary.
- One (3%) detainees disclosed learning difficulties and another two problems with reading and writing.
- There was no mention of whether it was a detainee's first time in custody

Removal of clothing

Three detainees had some clothing removed from them:

- One person, who came into custody under section 136 was dressed in a 'safe suit'.
- Of the other two, one was 15 years old and there was no indication of when or what replacement clothing they were given or what they were left wearing.

Young people

- The only person sampled who had been subject to PAVA spray was a young person aged 16. He did not see a healthcare professional.

- Only two of the four young people in the sample were interviewed and both had appropriate adults present during their interviews.
- The other two young people, both in York, had varying experiences
    - One young person, aged 15, had his mother present at all times and was in custody for less than two hours.
    - One young person, aged 14, had no appropriate adult, no legal advice given as his solicitor stated she would be at court the next day

Interpreters

One (3%) detainee in the sample could not understand English. When being booked in, he was too intoxicated to speak to an interpreter using a professional interpreting service. When sober, he had a full risk assessment and rights entitlement conducted using the service. He was not interviewed.

Inspector reviews

Inspector reviews were held in line with requirements, at the times expected, apart from two that happened early due to operational issues.

Services

- All detainees were asked if they would like somebody informed of their detention. A further four (13%) detainees made telephone calls themselves.
    - One detainee was allowed multiple calls to family and friends to sort out pet care issues.
- All detainees had been asked if they wanted a solicitor. Twelve (40%) detainees had spoken to/seen either their solicitor or a duty solicitor.
- No detainees shared a cell while in custody.
- Six (33%) detainees required the attention of a healthcare professional (HCP). The longest wait was over 10 hours where the HCP was called early in the morning for a detainee brought in for a section 136 assessment. The doctor told staff he would see the detainee in six hours once the effects of alcohol had worn off but did not arrive for a further 3 hours 40 minutes. One detainee was seen by a nurse who was on site. Of those who had to call Medacs, the average wait was just over 3.5 hours and only one waited less than an hour.
- Ten (33%) detainees had arrived in custody intoxicated. No detainee in our sample met with either a drugs or alcohol worker during their time in custody.
- Six (20%) detainees had eaten at least one meal in custody. Ten (33%) detainees did not eat a meal, but had been offered food and refused. Fourteen (47%) detainees had not received a meal, nor were they recorded as having refused one.
- Two (7%) detainees in Scarborough were given exercise; one was given exercise twice.
- No detainees were offered a shower, despite three detainees (10%) going to court after being held overnight (29 - 90% - detainees returned home after police custody). One detainee in York station was offered a ‘wash in accordance with PACE’ before court.
- Five (17%) detainees had been provided with reading materials; three of these were held in Scarborough on different days.

Additional points of note

- Both detainees brought into custody under section 136 were interviewed without an appropriate adult after a doctor's assessment to say they were not sectionable.
- Pre-release risk assessments were completed, but were sparse and failed to acknowledge risks identified in the rest of the custody record. For example, one detainee who had previous issues relating to self-harm and who disclosed that she was a victim of domestic violence. However, the pre-release risk assessment stated 'No risks relating to release'. There were examples of officers taking detainees home and noting how and where the detainees were going on release.
- Leaflets were also routinely handed out to detainees on release.
- Some initial risk assessment statements appeared contradictory. One noted the detainee was calm, compliant, lucid, fit and well, but he was brought in under section 136 and under the influence of alcohol.
- It was notable that some records had risks flagged in the warnings/flags section of NICHE that were not being noted in risk assessments.
- There were some incidents were the view of self-harm was limited. One example was of a young man who repeatedly and openly punched walls and made a threat to harm himself, but the warnings/flags section of NICHE was not updated to indicate a risk of self-harm.
- There were some pieces of information missing from records where better record-keeping would have facilitated understanding, such as a reduction in the timings of checks, or how and why family members were present to take detainees home.
- One detainee repeatedly requested to see the inspector to ask about the legality of his detention. He was in custody initially as a section 136. He never spoke to the inspector about his detention.

Appendix III: Summary of detainee questionnaires and interviews

Prisoner survey methodology

A voluntary, confidential and anonymous survey of the prisoner population, who had been through a police station in the North Yorkshire, 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 25 January 2010. A list of potential respondents to have passed through Scarborough, Harrogate, York or Selby police stations was created, listing all those who had arrived from Scarborough, Selby, York, Harrogate and Whitby Magistrates court within the past month.

Selecting the sample

In total, 65 respondents were approached. Eleven respondents reported either being held in police stations outside North Yorkshire or outside the two-month time limit. Two could speak no English, so it was impossible to determine the police station they had been in. One man could not recall his time in custody. On the day, the questionnaire was offered to 51 respondents. There were two refusals, one questionnaire returned blank and three non-returns. All of those sampled had been in custody within the last two months.

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

Methodology

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

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

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

Response rates

In total, 45 (88%) respondents completed and returned their questionnaires.

Comparisons

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

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

The current survey responses were analysed against comparator figures for all prisoners surveyed in other police areas. This comparator is based on all responses from prisoner surveys carried out in 21 police areas since April 2008.

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

Summary

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

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

Q2 What police station were you last held at?

Scarborough – 18; York – 20; Harrogate – 6; Selby – 1

Q3 What type of detainee were you?

Police detainee	42 (93%)
Prison lock-out (i.e. you were in custody in a prison before coming here)	3 (7%)
Immigration detainee	0 (0%)
I don't know	0 (0%)

Q4 How old are you?

16 years or younger	0 (0%)	*40-49 years*	4 (9%)
17-21 years	8 (18%)	*50-59 years*	4 (9%)
22-29 years	17 (38%)	*60 years or older*	1 (2%)
30-39 years	11 (24%)		

Q5 Are you:

Male	45 (100%)
Female	0 (0%)
Transgender/transsexual	0 (0%)

Q6 What is your ethnic origin?

White - British	42 (93%)
White - Irish	1 (2%)
White - other	2 (4%)
Black or black British - Caribbean	0 (0%)
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	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%)

Please specify:

Q7 Are you a foreign national (i.e. you do not hold a British passport, or you are not eligible for one)?

Yes	4 (10%)
No	37 (90%)

Q8 What, if any, would you classify as your religious group?

None	19 (45%)
Church of England	12 (29%)
Catholic	7 (17%)
Protestant	2 (5%)
Other Christian denomination	2 (5%)
Buddhist	0 (0%)
Hindu	0 (0%)
Jewish	0 (0%)
Muslim	0 (0%)
Sikh	0 (0%)
Any other religion, please specify:	

Q9 How would you describe your sexual orientation?

Straight/heterosexual	41 (98%)
Gay/lesbian/homosexual	1 (2%)
Bisexual	0 (0%)
Other (please specify):	

Q10 Do you consider yourself to have a disability?

Yes	11 (26%)
No	29 (69%)
Don't know	2 (5%)

Q11 Have you ever been held in police custody before?

Yes	38 (90%)
No	4 (10%)

Section 2: Your experience of this custody suite

Q12 How long were you held at the police station?

1 hour or less	0 (0%)
More than 1 hour, but less than 6 hours	1 (2%)
More than 6 hours, but less than 12 hours	3 (7%)
More than 12 hours, but less than 24 hours	15 (36%)
More than 24 hours, but less than 48 hours (2 days)	6 (14%)
More than 48 hours (2 days), but less than 72 hours (3 days)	14 (33%)
72 hours (3 days) or more	3 (7%)

Q13 Were you given information about your arrest and your entitlements when you arrived there?

Yes	30 (73%)
No	5 (12%)
Don't know/can't remember	6 (15%)

Q14 Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')?

Yes	23 (57%)
No	14 (35%)
I don't know what this is/I don't remember	3 (8%)

Q15 If your clothes were taken away, were you offered different clothing to wear?

My clothes were not taken	24 (57%)
I was offered a tracksuit to wear	10 (24%)
I was offered an evidence suit to wear	4 (10%)
I was offered a blanket	4 (10%)

Q16 Could you use a toilet when you needed to?

Yes	38 (90%)
No	3 (7%)
Don't know	1 (2%)

Q17 If you have used the toilet there, were these things provided?

	Yes	*No*
Toilet paper	19 (48%)	21 (53%)

Q18 Did you share a cell at the police station?

Yes	0 (0%)
No	42 (100%)

Q19 How would you rate the condition of your cell:

	Good	*Neither*	*Bad*
Cleanliness	18 (40%)	17 (38%)	10 (22%)
Ventilation/air quality	11 (28%)	14 (35%)	15 (38%)
Temperature	10 (24%)	10 (24%)	21 (51%)
Lighting	22 (54%)	8 (20%)	11 (27%)

Q20 Was there any graffiti in your cell when you arrived?

Yes	22 (50%)
No	22 (50%)

Q21 Did staff explain to you the correct use of the cell bell?

Yes	8 (18%)
No	37 (82%)

Q22 Were you held overnight?

Yes	42 (93%)
No	3 (7%)

Q23 If you were held overnight, which items of clean bedding were you given?

Not held overnight	3 (7%)
Pillow	2 (4%)
Blanket	29 (64%)
Nothing	11 (24%)

Q24 Were you offered a shower at the police station?

Yes	8 (18%)
No	37 (82%)

Q25 Were you offered any period of outside exercise while there?

Yes	4 (9%)
No	41 (91%)

Q26 Were you offered anything to:

	Yes	*No*
Eat?	36 (80%)	9 (20%)
Drink?	36 (84%)	7 (16%)

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

I did not have any food or drink	5 (12%)
Yes	19 (44%)
No	19 (44%)

Q28 If you smoke, were you offered anything to help you cope with the smoking ban there?

I do not smoke	7 (16%)
I was allowed to smoke	1 (2%)
I was not offered anything to cope with not smoking	35 (78%)
I was offered nicotine gum	1 (2%)
I was offered nicotine patches	1 (2%)
I was offered nicotine lozenges	0 (0%)

Q29 Were you offered anything to read?

Yes	12 (27%)
No	33 (73%)

Q30 Was someone informed of your arrest?

Yes	22 (49%)
No	11 (24%)
I don't know	6 (13%)
I didn't want to inform anyone	6 (13%)

Q31 Were you offered a free telephone call?

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

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

My phone call was not denied	21 (55%)
Yes	2 (5%)
No	15 (39%)

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 (7%)	27 (93%)
Contacting your partner, relative or friend	17 (46%)	20 (54%)
Contacting your employer	2 (7%)	28 (93%)
Where you were going once released	7 (23%)	24 (77%)

Q34 Were you interviewed by police officials about your case?

Yes	36 (80%)	
No	9 (20%)	If No, go to Q36

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

	Yes	*No*	*Not needed*
Solicitor	16 (44%)	12 (33%)	8 (22%)
Appropriate adult	0 (0%)	9 (43%)	12 (57%)
Interpreter	2 (9%)	8 (36%)	12 (55%)

Q36 How long did you have to wait for your solicitor?

I did not requested a solicitor 17 (43%)
2 hours or less 9 (23%)
Over 2 hours but less than 4 hours 3 (8%)
4 hours or more 11 (28%)

Q37 Were you officially charged?

Yes 35 (80%)
No 8 (18%)
Don't know 1 (2%)

Q38 How long were you in police custody ***after*** being charged?

I have not been charged yet 8 (19%)
1 hour or less 5 (12%)
More than 1 hour, but less than 6 hours 7 (16%)
More than 6 hours, but less than 12 hours 3 (7%)
12 hours or more 20 (47%)

Section 3: Safety

Q40 Did you feel safe there?

Yes 27 (61%)
No 17 (39%)

Q41 Had another detainee or a member of staff victimised (insulted or assaulted) you there?

Yes 16 (36%)
No 28 (64%)

Q42 If you have felt victimised, what did the incident involve? (Please tick all that apply to you.)

I have not been victimised	28 (42%)	*Because of your crime*	6 (9%)
Insulting remarks (about you, your family or friends)	9 (14%)	*Because of your sexuality*	1 (2%)
Physical abuse (being hit, kicked or assaulted)	8 (12%)	*Because you have a disability*	4 (6%)
Sexual abuse	1 (2%)	*Because of your religion/religious beliefs*	1 (2%)
Your race or ethnic origin	1 (2%)	*Because you are from a different part of the country than others*	4 (6%)
Drugs	3 (5%)		

Please describe:

Q43 Were you handcuffed or restrained while in the police custody suite?

Yes	21 (48%)
No	23 (52%)

Q44 Were you injured while in police custody, in a way that you feel was not your fault?

Yes	12 (27%)
No	32 (73%)

Q45 Were you told how to make a complaint about your treatment here if you needed to?

Yes	2 (5%)
No	40 (95%)

Section 4: Healthcare

Q47 When you were in police custody were you on any medication?

Yes	19 (42%)
No	26 (58%)

Q48 Were you able to continue taking your medication while there?

Not taking medication	26 (58%)
Yes	9 (20%)
No	10 (22%)

Q49 Did someone explain your entitlements to see a healthcare professional if you needed to?

Yes	15 (33%)
No	25 (56%)
Don't know	5 (11%)

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

	Yes	*No*
Doctor	18 (40%)	27 (60%)
Nurse	2 (6%)	30 (94%)
Paramedic	2 (6%)	29 (94%)
Psychiatrist	3 (9%)	29 (91%)

Q51 Were you able to see a healthcare professional of your own gender?

Yes	10 (23%)
No	15 (35%)
Don't know	18 (42%)

Q52 Did you have any drug or alcohol problems?

Yes	16 (36%)
No	28 (64%)

Q53 Did you see, or were offered the chance to see a drug or alcohol support worker?

I didn't have any drug/alcohol problems	28 (65%)
Yes	4 (9%)
No	11 (26%)

Q54 Were you offered relief or medication for your immediate symptoms?

I didn't have any drug/alcohol problems	28 (64%)
Yes	6 (14%)
No	10 (23%)

Q55 Please rate the quality of your healthcare while in police custody:

	I was not seen by healthcare	*Very good*	*Good*	*Neither*	*Bad*	*Very bad*
Quality of healthcare?	27 (61%)	0 (0%)	4 (9%)	2 (5%)	5 (11%)	6 (14%)

Q56 Did you have any specific <u>physical</u> healthcare needs?

No	28 (65%)
Yes	15 (35%)
Please specify:	

Q57 Did you have any specific <u>mental</u> healthcare needs?

No	27 (63%)
Yes	16 (37%)
Please specify:	

Prisoner survey responses for North Yorkshire 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

		North Yorkshire Police	Police custody comparator
	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.		
Number of completed questionnaires returned		45	703
SECTION 1: General information			
2	Are you a Police detainee?	**94%**	**88%**
3	Are you under 21 years of age?	**18%**	**10%**
4	Are you transgender/transsexual?	**0%**	**1%**
5	Are you from a minority ethnic group (including all those who did not tick white British, white Irish or white other categories)?	**0%**	**33%**
6	Are you a foreign national?	**9%**	**14%**
7	Are you Muslim?	**0%**	**11%**
8	Are you homosexual/gay or bisexual?	**2%**	**2%**
9	Do you consider yourself to have a disability?	**26%**	**19%**
10	Have you been in police custody before?	**91%**	**91%**
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?	**55%**	**64%**
12	Were you given information about your arrest and entitlements when you arrived?	**73%**	**74%**
13	Were you told about PACE?	**58%**	**55%**
14	If your clothes were taken away, were you given a tracksuit to wear?	**55%**	**42%**
15	Could you use a toilet when you needed to?	**91%**	**90%**
16	If you did use the toilet, was toilet paper provided?	**48%**	**53%**
17	Did you share a cell at the station?	**0%**	**3%**
18	Would you rate the condition of your cell, as 'good' for:		
18a	Cleanliness?	**40%**	**32%**
18b	Ventilation/air quality?	**27%**	**21%**
18c	Temperature?	**24%**	**14%**
18d	Lighting?	**53%**	**43%**
19	Was there any graffiti in your cell when you arrived?	**50%**	**57%**
20	Did staff explain the correct use of the cell bell?	**18%**	**23%**
21	Were you held overnight?	**94%**	**90%**
22	If you were held overnight, were you given **no** clean items of bedding?	**25%**	**29%**
23	Were you offered a shower?	**18%**	**10%**
24	Were you offered a period of outside exercise?	**8%**	**6%**
25a	Were you offered anything to eat?	**80%**	**79%**
25b	Were you offered anything to drink?	**83%**	**82%**
26	Was the food/drink you received suitable for your dietary requirements?	**50%**	**44%**
27	For those who smoke: were you offered **nothing** to help you cope with the ban there?	**80%**	**79%**
28	Were you offered anything to read?	**26%**	**14%**
29	Was someone informed of your arrest?	**48%**	**42%**
30	Were you offered a free telephone call?	**38%**	**50%**

Key to tables

		North Yorkshire Police	Police custody comparator
	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.		
31	If you were denied a free call, was a reason given?	11%	15%
32	Did you have any concerns about:		
32a	Who was taking care of your children?	6%	14%
32b	Contacting your partner, relative or friend?	46%	52%
32c	Contacting your employer?	6%	20%
32d	Where you were going once released?	23%	33%
34	If you were interviewed were the following people present:		
34a	Solicitor	45%	74%
34b	Appropriate adult	0%	7%
34c	Interpreter	8%	7%
35	Did you wait over four hours for your solicitor?	48%	64%
37	Were you held 12 hours or more in custody after being charged?	56%	63%
SECTION 3: Safety			
39	Did you feel unsafe?	39%	38%
40	Has another detainee or a member of staff victimised you?	37%	43%
41	If you have felt victimised, what did the incident involve?		
41a	Insulting remarks (about you, your family or friends)	20%	23%
41b	Physical abuse (being hit, kicked or assaulted)	18%	13%
41c	Sexual abuse	2%	2%
41d	Your race or ethnic origin	2%	6%
41e	Drugs	6%	16%
41f	Because of your crime	14%	19%
41g	Because of your sexuality	2%	1%
41h	Because you have a disability	8%	3%
41i	Because of your religion/religious beliefs	2%	3%
41j	Because you are from a different part of the country than others	8%	4%
42	Were you handcuffed or restrained whilst in the police custody suite?	47%	46%
43	Were you injured whilst in police custody, in a way that you feel is not your fault?	27%	25%
44	Were you told how to make a complaint about your treatment?	4%	15%
SECTION 4: Healthcare			
46	Were you on any medication?	42%	45%
47	For those who were on medication: were you able to continue taking your medication?	48%	38%
48	Did someone explain your entitlement to see a healthcare professional if you needed to?	34%	35%
49	Were you seen by the following healthcare professionals during your time in police custody?		
49a	Doctor	40%	49%
49b	Nurse	6%	18%
49c	Paramedic	6%	4%
49d	Psychiatrist	9%	4%
50	Were you able to see a healthcare professional of your own gender?	23%	28%
51	Did you have any drug or alcohol problems?	37%	56%
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?	25%	42%
53	Were you offered relief medication for your immediate symptoms?	39%	35%
54	For those who had been seen by healthcare, would you rate the quality as good/very good?	22%	30%
55	Do you have any specific physical healthcare needs?	35%	34%
56	Do you have any specific mental healthcare needs?	38%	25%