



Inspecting policing
in the public interest

Report on an inspection visit to police custody suites in Northumbria

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by

HM Inspectorate of Prisons and

HM Inspectorate of Constabulary

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1. Introduction

This report is one of a series on police custody carried out jointly by our two inspectorates. These inspections form an important part of the joint work programme of the criminal justice inspectorates. They also make a key contribution to the United Kingdom's response to its international obligation to ensure regular and independent inspection of all places of detention¹. The inspections look at strategy, treatment and conditions, individual rights and health care.

This unannounced inspection looked at the custody suites run by Northumbria Police. At the time of the inspection the force operated eight 24-hour suites designated under the Police and Criminal Evidence Act (PACE). The force also had three standby suites used as overspill, and three part-time suites. In total the force had a total cell capacity of 259.

There was good strategic leadership of the custody function with an ongoing review looking at the medium- to long-term plan for the custody estate. Oversight of the function was provided by the force's Criminal Justice Department, which implemented a validation programme every six months as part of the quality assurance process. There were, however, inadequacies evident in day to day management of custody and in some quality assurance procedures. Staffing of custody suites was adequate, as was the training provided.

Staff were respectful in their interactions with detainees. There was limited attention to diversity although some very good work was being done at Bedlington. Risk assessments of detainees received into custody were completed inconsistently and did not always reflect the level of observation required. The booking-in arrangements allowed only limited privacy. Use of handcuffs was disproportionate with little consideration of risk and, as we have found elsewhere, there was a lack of appropriate monitoring of the use of force. The physical environment of the suites was mixed. Newer facilities provided generally good conditions but some older suites were dirty, had graffiti on walls and were poorly ventilated. Some elements of care and welfare relied too heavily on detainees making requests.

There was an appropriate balance between progressing cases and the rights of individuals, and PACE was normally adhered to. Immigration detainees were too often held for long periods. Arrangements for providing appropriate adults were good for juveniles but less so for vulnerable adults. The necessity test to detain was not actively implemented by custody officers, but senior managers were seeking to address this. Information about rights and entitlements was not universally provided and the process for making complaints needed improvement. Arrangements for managing DNA and forensic samples were good.

Health care provision was good and medications management was excellent, although the condition of medical rooms was generally poor. Substance use services were well developed, but there were gaps in provision for alcohol misuse. Mental health diversion services varied, with some significant gaps, but Section 136 mental health provision was adequate.

Overall, police custody in Northumbria was adequate, but problems were evident in some important areas. Detainees were generally treated respectfully and their basic needs were provided for, but this was too often at the initiative of the detainee rather than custody staff. Conditions varied from good to poor, and the inconsistent application of risk assessment

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

processes was a significant area of concern. We consider the routine use of handcuffing to be disproportionate, and more needs to be done to support those with mental health issues. This report provides a number of recommendations to assist the force and the Police Authority to improve provision further. We expect our findings to be considered in the wider context of priorities and resourcing, and for an action plan to be provided in due course.

Sir Denis O'Connor
HM Chief Inspector of Constabulary

Nick Hardwick
HM Chief Inspector of Prisons

October 2011

2. Background and key findings

- 2.1 HM Inspectorates of Prisons and Constabulary have a programme of joint inspections of police custody suites, as part of the UK's international obligation to ensure regular independent inspection of places of detention. These inspections look beyond the implementation of the Police and Criminal Evidence Act 1984 (PACE) codes of practice and *Safer Detention and Handling of Persons in Police Custody* 2006 (SDHP) guide, and focus on outcomes for detainees. They are also informed by a set of *Expectations for Police Custody*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, Northumbria Police had eight custody suites designated under PACE for the reception of detainees, operating 24 hours a day. These dealt with detainees arrested as a result of mainstream policing. The force also had three standby suites, which it used to provide overspill capacity for the main suites (termed resilience), and three part-time rural suites to cover Northumberland. All custody suites were visited during the inspection. There was a total cell capacity of 259, with 71,980 detainees held in the year to June 2011. In the same period, 125 detainees had been held for immigration matters.
- 2.3 The designated custody suites and cell capacity of each was as follows:

Custody suite	Area command	Number of cells
Newcastle Etal Lane	Newcastle	28
Newcastle Clifford Street (known as Byker)	Newcastle	8
Sunderland Gillbridge	Sunderland	20
Washington	Sunderland	14
Southwick (part-time resilience suite)	Sunderland	29
South Shields	South Tyneside	30
Gateshead	Gateshead	18
Whickham (part-time resilience suite)	Gateshead	10
Bedlington	Northumberland	20
Hexham (part-time rural suite)	Northumberland	7
Alnwick (part-time rural suite)	Northumberland	8
Berwick (part-time rural suite)	Northumberland	7
Wallsend	North Tyneside	40
North Shields (part-time resilience suite)	North Tyneside	20
Total		259

We also visited custody facilities within two premier football stadiums that were used only on match days.

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

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

³ **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)

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

Strategic overview

- 2.6 There was good strategic leadership. An ongoing review of custody included a medium to long-term plan about how the estate should be developed. Relationships between the Northumbria Police Authority and the force were positive and there was an active independent custody visitors (ICV) scheme.
- 2.7 There was a decentralised management model of custody, although there were advanced plans to change this to a centralised one. Day-to-day management of custody was devolved to the area commanders. There was oversight from the criminal justice department (CJD), including a six-monthly validation process, but line management arrangements and oversight arrangements for custody varied and there were no dedicated local custody managers. Staff working in custody were mainly permanent and staffing levels were adequate and use was made of temporary staff to cover for absences. All staff had custody-specific training and refresher training. Partnership arrangements were well developed.
- 2.8 'Learning the lessons' information was disseminated to staff. Use of force information was not collated from custody. Arrangements for storing and managing DNA and forensic samples were good.

Treatment and conditions

- 2.9 Interactions with detainees were friendly. Awareness of some diversity issues was limited, although there were pockets of good practice. Many aspects of privacy were poor, which had implications for respectful treatment and the safety of detainees.
- 2.10 Initial risk assessments varied in quality. Risk management arrangements were proportionate. Arrangements for handovers were not sufficiently robust. The management of cell keys needed to be improved and the custody record system was confusing and could impact on risk management of detainees. Handcuffs were used routinely and often not proportionately.
- 2.11 The physical environment of custody suites varied greatly and some were dirty and had graffiti in cells. We found some ligature points in cells. Staff were aware of fire evacuation arrangements but these had not been practised. Health and safety walk-throughs were underdeveloped. Many elements of care were by request only.
- 2.12 We saw limited evidence that showers, outside exercise or reading materials were offered. The food provided was poor and a significant number of custody records indicated that it had not been offered.

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 Towel et al (eds), *Dictionary of Forensic Psychology*.)

Individual rights

- 2.13 Custody sergeants were authorising custody but there was little critical examination of the necessity test. In most places we visited, there was only limited focus on alternatives to custody. PACE was generally adhered to but some detainees were not given a written notice of their rights and entitlements. Few detainees were offered a free telephone call.
- 2.14 Detainees were not routinely asked if they had any dependency obligations. Pre-release risk assessments were always completed, but limited action was taken. Detainees held for immigration matters were often held for over 24 hours. Arrangements for providing appropriate adults were good for juveniles but there were sometimes difficulties out of hours and more generally for supporting vulnerable adults.
- 2.15 Court cut-off times were generally reasonable. Detainees were not told how to make a complaint and when they did, the arrangements for dealing with them were poor.

Health care

- 2.16 Primary care services were provided by contracted forensic medical examiners (FMEs) and clinical governance arrangements were limited. Most clinical rooms were in a poor condition and some equipment was missing or out of date. The management of medications was robust. All the custody suites had full resuscitation kits and staff were trained in their use. Detainee health care provision was generally good. Waiting times were reasonable but delays sometimes occurred.
- 2.17 Arrangements for providing methadone and symptomatic relief for substance users were good and detainees could continue to receive their prescribed medications. Substance use services were well developed.
- 2.18 Mental health diversion services were embryonic and needed further development. Relatively few detainees were held in police custody under section 136 of the Mental Health Act 1983.⁴ Staff had received mental health awareness training.

Main recommendations

- 2.19 **A comprehensive risk assessment should in all instances be completed on arrival in custody and this should be reflected in the level of observations undertaken.**
- 2.20 **Detainees should be handcuffed only when a risk assessment indicates that this is necessary.**
- 2.21 **Cells and corridors should be clean, free from graffiti and properly ventilated.**
- 2.22 **There should be mental health diversion schemes that enable detainees with mental health problems to be identified and diverted expeditiously into appropriate services.**

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

3. Strategy

Expected outcomes:

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

- 3.1 An assistant chief constable provided strategic leadership on custody issues and chaired the local criminal justice board (LCJB). The force operated a devolved custody model and six area commands had day-to-day responsibility for staffing and estates. A chief superintendent led the criminal justice (CJ) department at headquarters (HQ), which provided oversight and support and had responsibility for custody policies.
- 3.2 The force was reviewing custody provision, with the intention of centralising custody resources under the command of the CJ department. An estates strategy included plans for a new 50-cell suite at Newcastle in 2014. A new 40-cell facility had opened in North Tyneside in late 2010. The force had identified that some of these part-time suites did not meet current standards and had put measures in place to mitigate the identified risks.
- 3.3 The force had introduced a centralised management process for the allocation of custody space to minimise delays, maximise operational effectiveness and make best use of custody capacity. This was supported by agreed protocols between area commands to allow detainees to be moved across command boundaries.
- 3.4 Staffing within full-time custody suites was adequate and comprised permanent custody sergeants supported by detention officers (DOs), who looked after the ongoing care and welfare of detainees. Custody-trained sergeants from other duties provided cover where required. Staffing of part-time suites was generally provided by response team staff. PC gaolers were used to cover for DO abstractions
- 3.5 Each area command had a chief inspector, inspector and sergeant with responsibility for CJ matters, which included custody. There were good relationships between the HQ CJ department and areas commands, although they reported it was often complex and time consuming to get change embedded across the force.
- 3.6 The CJ inspector's role varied across the six area commands but they did not have direct management of custody functions and all had numerous other portfolio responsibilities and could dedicate only a limited amount of their time to custody matters. Line management of custody officers was the responsibility of response shift inspectors. DOs were line managed by the custody sergeants. There were clear problems in not having dedicated custody managers in place, which had resulted in a lack of clarity in the way custody services were delivered in area commands and introduced additional risk. The force acknowledged this and was looking to introduce full-time custody managers when custody provision was centralised.
- 3.7 The CJ department chief superintendent chaired a bi-monthly Criminal Justice Group, attended by the six CJ chief inspectors, where custody issues were discussed. The HQ CJ department chief inspector also visited area commands and met with CJ chief inspectors bi-monthly. With the exception of Sunderland and Bedlington, there were no formal meetings in area commands where custody practitioners and managers could share information.
- 3.8 The Police Authority did not have a specific member with responsibility for custody but was well engaged with custody matters and supported the estates strategy. There was a Police

Authority lead for the ICV scheme, which was seen as an important independent oversight mechanism. The authority had recently carried out an equality impact assessment of the ICV scheme and was in the process of implementing proposals to improve it. This included targeted advertising and recruitment of under-represented groups and the introduction of a custody newsletter for ICVs in March 2011. There was an active and well-supported ICV scheme, made up of eight panels, which were administered by the police authority and well responded to by the force

- 3.9 Partnership arrangements were described as good, with active engagement with relevant CJ and health partners.
- 3.10 All custody sergeants and DOs had received role-specific custody training prior to working in custody. Although the content of the two courses varied, both included PACE legal responsibilities, risk assessments and handovers. The custody sergeant's course included two days shadowing at different sites and at different times of the day. PC gaolers received a one-day course before working in custody. All staff who worked in custody, including PC gaolers, received one-day refresher training annually. Custody sergeants and DOs had received custody-specific first aid and personal safety training, which was refreshed annually.
- 3.11 The force had comprehensive custody procedures, with policies accessible to all staff through the force IT system. The HQ CJ department managed an intranet-based central repository, containing custody-related information, including policies, guidance, good practice and Independent Police Complaints Commission (IPCC) Learning the Lessons bulletins. Information was disseminated to staff by the HQ CJ department as well as through face-to-face briefings where appropriate. CJ inspectors assisted in cascading information to relevant staff but not all custody sergeants were aware of the IPCC briefings. There was a good centrally managed process for the recording of adverse incidents and self-harm in custody, with data collated and reviewed daily by the HQ CJ department. Where learning points were identified, these were fed into the training programme and disseminated to staff by the most appropriate means. An overview report was published annually and made available to staff.
- 3.12 The HQ CJ department carried out regular six-monthly validation inspections of custody facilities. These were conducted against a set of standards, with findings and suggested actions provided to the area command CJ chief inspector. Although the content of these inspections was comprehensive, they were overly focused on processes rather than outcomes for detainees.
- 3.13 There was little evidence that regular and formal quality assurance checks, such as the dip sampling of custody records or closed-circuit television (CCTV) recordings, were carried out in area commands (apart from those carried out as part of the six-monthly validation checks). The approach to dip-sampling was inconsistent and at Gateshead, where there was an expectation that it would be done weekly, it had not been carried out in the previous three months.

Recommendation

- 3.14 **The day-to-day management arrangements in custody should be sufficient to provide the required oversight of staff, clarity around roles and responsibilities and adequate quality assurance of outcomes for detainees.**

Housekeeping points

- 3.15 Staff should be encouraged to access and use the information in the IPCC Learning the Lessons briefings.
- 3.16 A formal meeting structure for custody practitioners and managers to discuss custody issues should be introduced in area commands.

Good practice

- 3.17 *There were protocols between area commands allowing detainees to be moved across command boundaries, coupled with a centralised management process for the allocation of custody space thereby minimising delays, maximising operational effectiveness and making best use of custody capacity.*
- 3.18 *The police authority had recently carried out an equality impact assessment of the independent custody visitor scheme to identify areas for improvement, including recruitment of members from under-represented groups.*

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 We examined several vehicles used to bring detainees to the custody suite and all were in a satisfactory condition. We were generally impressed by the positive staff culture found in custody. Custody staff treated detainees with respect, showed an interest in their welfare and were friendly and professional. First names were routinely used.
- 4.2 Many of the booking-in areas were cramped and offered little privacy. At Sunderland and Clifford Street (Byker), for example, the cramped conditions meant detainees were asked about issues such as mental health and self-harm in the hearing of the many police personnel and solicitors in the area at the time. By contrast, the booking-in area at North Tyneside was spacious with a large gap between desks and detainees could be booked in with reasonable privacy.
- 4.3 Detainees being booked in were usually asked whether they had any 'cultural or religious needs' but it was not always clear that they understood the question. Holy books such as a Qu'ran, a Torah and a Bible were available, as were prayer mats. These were mostly kept in clearly labelled boxes but in some suites were stored on a shelf alongside non-religious items, which was disrespectful. Staff in some custody suites did not know where such items were kept. Only the cells at North Tyneside indicated the direction of Mecca. The inspection took place during Ramadan and good provision had been made at North Tyneside for two Muslim detainees to pray and take their meals after sunset.
- 4.4 There was little specific provision for women or juveniles. Seven of the 60 custody records we analysed related to female detainees, none of whom had been offered the opportunity to speak in private with a female member of staff. Women were usually expected to ask for hygiene products rather than being offered them automatically.
- 4.5 Staff could not recall having received child protection training. They were aware of the need to ensure that children under the age of 17 were accompanied by an appropriate adult but there was little evidence that the distinct needs of children in custody were otherwise addressed. We saw one 12 year old in tears in a detention room but staff made no attempt to reassure him or keep him occupied. Another 12 year old boy appeared bewildered as he was being booked in and he was treated much as an adult would have been. We also saw a 14 year old arriving in handcuffs and remaining in these for a considerable time while other detainees were dealt with. By contrast, we saw some good examples of appropriate handling of juveniles at Bedlington, where two young people attending by appointment arrived with an appropriate adult, were interviewed quickly and were allowed to wait with their appropriate adult in a consultation room while decisions were made on how to proceed.
- 4.6 Some cell doors were wide enough for wheelchairs but otherwise there was limited provision for detainees with disabilities. There were no hearing loops for hard of hearing detainees and no information in Braille. However, we observed a profoundly deaf detainee being booked in at

Etal Lane where the custody sergeant wrote information down and spoke clearly so the detainee could lip read.

Recommendations

- 4.7 **Booking-in areas should provide enough privacy to allow effective communication between staff and detainees.**
- 4.8 **There should be a clearer focus on the specific needs of juvenile, female and disabled juvenile detainees; staff should be trained to deal effectively with these detainees.**

Housekeeping point

- 4.9 Items used for religious observance should be stored respectfully.

Safety

- 4.10 We observed risk assessments taking place when detainees were booked in. The quality of these varied considerably and some were basic and unsatisfactory. Some custody officers hurried through the process without building a sufficient rapport to encourage the detainee to disclose any concern, particularly about mental health or self-harm. Custody officers did not explain some of the terms used and several times we heard detainees being asked simply 'any mental health?'
- 4.11 It was not clear that the police national computer (PNC) was always checked for warning markers. Our custody record analysis identified one instance when a previous suicide attempt in prison highlighted by the CIS booking in computer system had not been noted in the risk assessment. Not all custody sergeants appeared familiar with the CIS software and some could not return to the risk assessment screen on the custody management system. Some complained that the small amount of space given for free text entries meant that in complex cases they had to complete the risk assessment by hand on the custody record. Our custody record analysis also identified two instances where a medical assessment had picked up further risks, including self-harm, but the risk assessment had not been updated accordingly. Some custody sergeants said the training on CIS software was too brief.
- 4.12 We were told that the force's PNC bureau decided whether to upload new information about risk on to the PNC and if it did not meet the national criteria for inclusion it was returned to the officer with an explanation.
- 4.13 A suitable range of observations was used and staff were aware of the need to get a response when rousing detainees. However, some custody records contained poor records of checks, including one at Gateshead that had a gap of over two hours without entries on a night when the detainee concerned was on 30-minute checks. Anti-ligature knives and cutters for thick ligatures were kept in the booking in area but were not carried by staff and were not always quickly available. At North Tyneside, the knives were stored a long way from many of the cells and the blade of one ligature knife was clogged with debris. Most cells across the force were covered by CCTV but this was not used to replace personal checks.
- 4.14 We saw examples of non-custody staff getting cell keys to take detainees to and from the cells and we were not convinced that accurate records would be kept of detainees' welfare and rights (see also section on rights relating to PACE). This was poor practice.

- 4.15 Handovers were reasonable with good information exchanges between custody sergeants but did not include detention officers, who had their own separate handover. We did not see incoming custody sergeants visit all the cells to see or speak to the detainees for whom they were accepting responsibility.

Recommendations

- 4.16 **Anti-ligature knives should be carried.**
- 4.17 **Custody sergeants and detention officers should attend the same handover briefings wherever possible.**

Housekeeping point

- 4.18 Cell keys should be made more secure and visits to cells should be by custody staff or accompanied by them.

Use of force

- 4.19 There was no central recording of the use of force, with records made only in the custody record and officers' notebooks. This meant that the force could not analyse use of force in custody to identify trends and the effectiveness of use of force techniques. All staff had been trained in approved use of force techniques and received regular refresher training.
- 4.20 Most detainees arriving in the custody suites were handcuffed. Handcuffs were usually removed when detainees arrived at the booked in desk, although only when authorised by the custody officer so some remained in handcuffs for longer periods at busy times. We were told that many suites could be very busy, particularly at weekends, so waits could be excessive. Staff said force policy was that everyone arrested should be handcuffed and the many police officers we spoke to said they would do so regardless of the alleged offence, the compliance of the arrested person or whether the officer was alone or with a colleague. This had resulted in children, pregnant women and compliant detainees being handcuffed, which was disproportionate and unlikely always to be justifiable. In our survey, 65% of respondents, significantly worse than the comparator, said their handcuffs had been removed on arrival at the police station.
- 4.21 We observed some proportionate use of force, including on a detainee at North Tyneside who was briefly restrained after throwing food around his cell but released as soon as he calmed down. We were told that detainees subject to force were not routinely seen by a health care professional and that doctors were called only if the detainee had an evident injury or complained of one.

Recommendation

- 4.22 **Northumbria Police should collate the use of force in accordance with the Association of Chief Police Officers policy and National Policing Improvement Agency guidance.**

Physical conditions

- 4.23 The quality and condition of cells varied. The newer suites, such as North Tyneside, and the lesser used suites, such as Berwick, Alnwick and Hexham, were particularly clean and well kept but others were run down and dirty. The entrance to the Sunderland suite was strewn with rubbish, including a discarded examination glove. The cell floors, walls and around the toilets had ingrained dirt that appeared to include blood and faeces, and problems with the lights in several cells meant staff had to switch them on and off repeatedly to make them work. The suites at Etal Lane and Bedlington contained a lot of graffiti, including swastikas, scratched on the walls and backs of cell doors. Much of this had been painted over but was still visible. At the custody suite at Clifford Street (Byker) the shower floors were dirty, the water was cold and there appeared to be a drainage problem, the exercise yard was dismal and strewn with litter and there were piles of clothing and discarded blankets in cell corridors awaiting laundry collection. Ventilation overall was poor and particularly bad at Washington where the drains smelt strongly.
- 4.24 Several suites had cells containing ligature points, most of which were minor and had already been identified by the force through its inspection regime. However, we found a number of doors with T-bar handles, which posed a significant risk should the cell door hatch fail or be left open.
- 4.25 There was an expectation from the HQ CJ department that regular health and safety checks would be carried out to identify health and safety or maintenance issues. Daily checks were carried out to a consistent standard across the six area commands but there were inconsistencies in the way completed forms were dealt with. It was disappointing to find that the identification of ligature points did not form part of the daily checks. Weekly and monthly checks were done but not in all area commands. Weekly checks that were carried out included a quality assurance process for ensuring that defects identified during daily checks had been addressed. The estates department carried out thorough quarterly health and safety inspections where risks, such as ligature points, were identified, prioritised and allocated an owner. After each inspection, a custody building condition survey was published and circulated to area commands and HQ CJ department staff. Reports highlighted where custody suites did not conform to current Home Office standards and included an action plan for identified risks and recommendations.
- 4.26 We found fire evacuation plans in a few of the suites but there was no record that any fire drills had taken place. Only staff at Etal Lane could recall ever having a fire evacuation drill. We saw many staff explaining the use of the call bells to detainees but this was not universal. Most staff responded to call bells promptly.

Recommendation

- 4.27 **Rigorous health and safety walk-through arrangements should be applied consistently at all custody suites and should include the identification of ligature points. Records should be kept of these and remedial action taken, especially in relation to deep cleaning.**

Housekeeping point

- 4.28 Fire evacuation drills should be carried out in all custody suites.

Personal comfort and hygiene

- 4.29 All cells contained mattresses that were wiped down daily but not necessarily between use. Pillows were available only at North Tyneside. All suites appeared to have enough blankets but in some cases these were supplied only when requested by detainees.
- 4.30 There was an unacceptable lack of privacy in some shower areas. The screen doors at North Tyneside were so small that some female detainees were likely to feel unable to use them even though staff said they would clear the corridor of male staff and detainees if a woman did want to shower. In our survey, only 6% of respondents, against a comparator of 9%, said they had been offered a shower and our custody record analysis showed that one detainee had been held for 56.5 hours before going to court without being offered a shower. Cotton towels were available.
- 4.31 Apart from at the Bedlington suite, no toilets were obscured on the CCTV monitoring system and it was not clear that detainees were always told that cells were covered by CCTV. Staff said some detainees complained that they could be seen using the toilet and we saw one man trying to shield himself with a blanket. Toilet paper was available only on request.
- 4.32 Most suites had a reasonable stock of track suit bottoms, T-shirts, paper suits and plimsolls but underwear was not provided. Staff said they encouraged detainees' families to bring in replacement clothing and that no detainee was ever released in a paper suit.

Recommendations

- 4.33 **All detainees held overnight, or who require one, should be offered a shower and should be able to use one in reasonable privacy.**
- 4.34 **Toilet areas should be obscured on closed-circuit television monitoring.**

Housekeeping points

- 4.35 Mattresses should routinely be wiped down after each use.
- 4.36 All detainees should be given a pillow.
- 4.37 Toilet paper should be provided in each cell.
- 4.38 Replacement underwear should be available.

Catering

- 4.39 Halal, vegan and vegetarian diets were catered for but the microwave meals provided had a low calorific value. Some detainees said they were poor quality and refused to eat them. Staff said food was distributed at the appropriate times and we saw it being served but some detainees complained that meals were irregular or were given only on request. Our custody record analysis showed that 38 detainees (63%) had not been offered a meal. Of these, 13 had been in custody for more than six hours, including two held more than 12 hours and one held for 32 hours. Some kitchen areas had temperature probes but the serving temperature of microwave meals was not tested and some detention officers were unaware that the probes

existed. Few detention officers had received food hygiene training. Hot and cold drinks were offered at regular intervals.

Recommendation

- 4.40 **Food should routinely be offered at meal times and provided at other times on request and should be of sufficient quality and calorific content to sustain detainees for the duration of their stay.**

Housekeeping point

- 4.41 The serving temperature of microwave meals should be taken and recorded.

Activities

- 4.42 In our custody record analysis, outside exercise had been provided on only one occasion even though six of the detainees concerned had been in custody for more than 24 hours. In our survey, only one out of 47 detainees said they had been offered exercise. Staff said exercise would be considered on request but detainees were not told that outdoor facilities existed and some exercise yards were dirty and littered. Staff at Sunderland said detainees were allowed in the exercise yard only if staff were available to provide constant supervision. At North Tyneside, two immigration detainees had been in custody for 41 hours without being offered exercise.
- 4.43 None of the suites contained enough adequate reading material, other than a few magazines. There was nothing suitable for younger detainees or for detainees with little or no English.
- 4.44 There was no provision for visits.

Recommendation

- 4.45 **Detainees, particularly those held for more than 24 hours, should be offered exercise and the exercise yards should be made fit for purpose.**

Housekeeping points

- 4.46 Reading material suitable for a range of detainees, including young people and those who cannot read English, should be available.
- 4.47 Visits should be allowed where appropriate, particularly for juveniles and those detained for longer periods.

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 Most custody sergeants said they checked that detention was appropriate before authorising it, although we did not see any examples where detention was refused and custody sergeants said this rarely happened. Not all custody sergeants asked arresting officers about the 'necessity test' for arrest and when they did it appeared perfunctory, with little real effort made to ensure the test had actually been met. One man who had attended the police station voluntarily with his solicitor by appointment was arrested and the custody officer appeared surprised and uncertain on the legal position when the solicitor challenged the necessity of the arrest. Nevertheless, detention was authorised and the man was briefly detained and interviewed. Apart from the Northumberland Area Command, there was little emphasis on alternatives to arrest such as restorative justice or voluntary attendance.
- 5.2 Detainees were rarely asked any questions about dependents or caring responsibilities and the few occasions these were asked were restricted to female detainees. Custody suites were not used as a place of safety for children and young people under Section 46 of the Children Act 1989⁵.
- 5.3 Staff described good working relationships with the UK Border Agency (UKBA) despite some delays in serving IS91s (authorities to detain) and some long delays of three to five days between the IS91 being served and the immigration detainee being collected. One extremely distressed detainee at Sunderland who had been in custody for three days with no information about what was going to happen to him said he 'just wanted to die'.
- 5.4 Detainees were routinely told of their rights when booked in. Staff were polite and friendly and detainees were asked if they understood what they had been told but the information was explained very quickly without much opportunity to ask questions. Detainees were usually offered a leaflet outlining their rights and entitlements and this was available on the intranet in languages other than English, although not all custody staff were aware of this. In some cases, detainees were not allowed to take the leaflet to their cell and one member of staff said this was because 'they would flush it down the toilet'. At Sunderland, we saw only one detainee offered a leaflet. In our survey, 58% of respondents, against a comparator of 74%, said they had been given information about their arrest and entitlements. Our survey also indicated that significantly fewer detainees than the comparator had been offered a free telephone call and this was also evident in the custody records we looked at.
- 5.5 An interpreting service was used extensively and staff said it was very efficient. We also saw a custody sergeant at North Tyneside trying to locate a Punjabi interpreter through his contacts at the UKBA when he could not get one through the normal service.

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

- 5.6 All detainees were told they had an ongoing right to a solicitor but when detainees declined to exercise this right the reasons were not always explored or recorded. One detainee told about his right to a solicitor was also told 'to be honest you won't be here for more than a few hours', which was inappropriate. There was little provision for detainees to have a private telephone conversation with their solicitor.
- 5.7 Pre-release risk assessments were completed in every case and it was not possible to close a custody record electronically unless this has been done. However, those we saw were basic and at best comprised a simple strategy to transport a detainee home. Action taken appeared to be based solely on the initial risk assessment made at reception and we did not observe any conversations where risk was reassessed before release. There were no leaflets detailing local support services that could be given to detainees on release.

Recommendations

- 5.8 **Northumbria Police should further develop and promote alternative to custody approaches and custody officers should ensure that the 'necessity test' for arrest is meaningfully undertaken.**
- 5.9 **Custody staff should ensure that detainee dependency obligations are routinely identified and, where possible, addressed.**
- 5.10 **Northumbria police should liaise at a senior level with UKBA to ensure there are no undue delays in transporting immigration detainees to placements identified in the Immigration Custody Estate.**
- 5.11 **Pre-release risk assessments should be detailed and meaningful, based on an ongoing assessment of detainees needs while in custody, and leaflets giving details of local support services should be provided for detainees.**

Housekeeping point

- 5.12 Detainees should be offered a free telephone call.

Rights relating to PACE

- 5.13 The procedural requirements of PACE were applied efficiently and custody reviews were carried out in person, usually at the specified times. Staff said that, apart from the rural stations, it was rare that an inspector was not available to carry out a face-to-face review. In the cases we looked at, many of the detainees arrested under the influence of alcohol or drugs were asleep at the point of the review and were spoken to when they were fit to understand.
- 5.14 Detainees were not interviewed if under the influence or thought to be under the influence of alcohol or drugs. However, one detainee at Etal Lane was recorded as entering custody intoxicated and was not deemed fit for interview by the doctor until after 7am. At 1.33am, an apparently unaccompanied officer entered his cell and offered him the opportunity to sign his pocket note book presumably detailing events surrounding the arrest. The detainee read the document and agreed to sign it. This was poor practice. Detainees were given adequate breaks between formal interviews.

- 5.15 Detainees could consult a copy of the PACE codes of practice. We did not see custody sergeants explaining what the codes of practice were or why the detainee might want to consult them, so were not surprised they were rarely requested. In our survey, just 36% of respondents, against a comparator of 62%, said they had been told about PACE when brought to the custody suite.
- 5.16 Staff said the duty solicitor scheme worked well and detainees could speak to their legal representative in an adequately equipped interview room. We were told that legal representatives were given copies of custody records on request in writing, and one solicitor said he did not have a problem getting a copy immediately. Staff said it was difficult to get access to solicitors for immigration detainees.
- 5.17 Children and young people under the age of 17 years were not interviewed without an appropriate adult. The force adhered to the PACE definition of a child (as a person under 17) instead of the Children Act definition, which meant those aged 17 were not given an appropriate adult unless they were otherwise deemed vulnerable⁶. Custody sergeants had clear and realistic criteria for assessing the suitability of proposed appropriate adults. Parents and carers who acted as an appropriate adult were given written information explaining their role and we heard one custody sergeant at Bedlington explaining the role very clearly to a woman who was an appropriate adult for her child.
- 5.18 Professionally qualified workers from the local youth offending teams (YOT) generally provided the appropriate adult service between 9am and 5pm, after which the social services emergency duty team (EDT) provided the service. Staff said appropriate adult provision for children and young people was quick and effective and described good working relationships between custody suites and the YOT but said the EDT was slow to respond to calls and often did not attend. We were told that there had been one occasion at North Tyneside when a PACE bed had been provided for a child but this was noteworthy because of its rarity. The EDT also provided appropriate adult support for vulnerable adults but custody staff said this service was unsatisfactory.
- 5.19 Court cut-off times varied depending on the court and were occasionally unpredictable, ranging from between 2pm and 4pm on weekdays and 10am to noon on Saturdays. Custody staff reported reasonably good working relationships with the courts but some found the unpredictability of cut-off times prevented them dealing efficiently with detainees and resulted in detainees having unnecessarily long stays in police detention.
- 5.20 The force had clear policies on the management of DNA and forensic samples in custody. We found no issues in respect of detainee DNA samples and, with the exception of some volunteer DNA samples being left in custody freezers, they were well managed and there was an effective process for transporting detainee samples to HQ.

Recommendations

- 5.21 **Appropriate adults should be provided to 17-year-olds and vulnerable adults.**
- 5.22 **Northumbria Police should engage with the local authority to ensure the provision of secure beds for juveniles who have been charged but cannot be bailed to appear in court.**

⁶ 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.

Housekeeping point

- 5.23 Northumbria Police should liaise with court managers to ensure that cut-off times do not result in unnecessarily long stays in custody.

Rights relating to treatment

- 5.24 There was a general expectation that complaints should be taken while detainees were still in custody but this did not happen in practice and staff said complaints were usually taken once detainees had been released. There was no procedure to take complaints from detainees who were taken to court and remanded in custody and therefore not released from police custody. Detainees were not told how to make a complaint and there was no information about the procedure on display. The force collated information on complaints and examined trends but was unable to extrapolate data and trends relating to complaints made in custody.

Recommendation

- 5.25 **Detainees should routinely be told how to make a complaint in line with the Independent Police Complaints Commission statutory guidance⁷ and, unless there is a clear reason not to do so, complaints should be taken while they are still in police custody.**

⁷ IPCC statutory guidance (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 Northumbria Police employed forensic medical examiners (FMEs) to provide medical services. Our survey indicated that 63% of detainees saw a FME while in police custody. There were service level agreements with the FMEs but no regular monitoring of performance indicators. It was anticipated that a more sophisticated approach to monitoring would commence with the introduction of a new computer system later in 2011/12. Police inspectors managed the strategic approach to mental health and substance misuse services and monitored the substance use services contracts.
- 6.2 Clinical and substance use staff were respectful to detainees. They had access to interpreting services if required. Female detainees did not always have access to female FMEs, in which case female officers acted as chaperones. In our survey, only 35% of detainees seen by a FME rated the quality of care as good or very good.
- 6.3 The police checked the registration of doctors with the General Medical Council every six months. FMEs were a mix of GPs, retired doctors, locums and others. There were no checks on the mandatory training or clinical supervision of doctors. Doctors we spoke to confirmed that they fulfilled the training and updating requirements of their respective colleges. Lead FMEs in the north and south of the force provided advice to their colleagues but there was no formal system of appraisal on behalf of the police. Not all FMEs were approved clinicians under Section 12 of the Mental Health Act.
- 6.4 There were clinical rooms in the full-time and part-time custody suites but not at the football grounds of Saint James' Park or the Stadium of Light. All rooms were dedicated to health care, apart from South Shields, where the door was open as custody staff required access to the toilet, and Washington, where the custody suite photocopier was in the clinical room and accessible to all staff. The size and shape of clinical rooms varied from large at Etal Lane and South Shields to very small at Hexham. Some part-time suites such as Alnwick and Hexham appeared to be in a state of decommission. Apart from at North Tyneside, every room was untidy and cluttered.
- 6.5 We were told that there was good attention to the privacy and confidentiality of detainees during consultations with clinical room doors closed, although privacy screens were not available in every room. Paper rolls were used to cover the examination couches. There was no evidence that an infection control audit had been carried out and none of the clinical rooms met expected standards. Also apart from at North Tyneside, examination couches, fixtures and fittings were worn, torn, tarnished or badly chipped. Examination lights were not available in all clinical rooms. Hand washing materials were not available near some sinks and cotton sheet towels were used at Hexham. Rooms were grubby and several had ingrained dirt. Officers said there was daily cleaning but there was no written record of this. Several clinical rooms required deep cleaning.

- 6.6 All clinical rooms, apart from at North Tyneside, contained medical equipment and supplies that were out of date, including dressings, syringes and needles. Overall clinical stock control appeared haphazard and most cupboards were disorganised. Across the rooms, sharps bins were not secured to the wall or signed and dated when first used. Apart from rooms used by substance use workers, we did not see patient information leaflets in the clinical rooms other than at Bedlington. No health screening or promotion materials were on display. Written clinical guidelines were substantially out of date including at Hexham where we found the Sexual Offenders Training Manual from 1992 and at Southwick a St John Ambulance First Aid Manual from 1987.
- 6.7 The medicines management system was safe and effective. Stock was kept in locked cabinets and tightly controlled against a reasonable stock list. Stock cupboards were tidy and contained only full containers of medicines that were sealed by the police until used. There were daily written checks of divertible medicines, specifically diazepam and dihydrocodeine tablets. This stock was audited weekly by a non-custody senior police officer. Stock counts were accurate. FMEs could supply and administer a range of medicines and prescribe medications to be given subsequently by custody staff. Custody staff administered medications only when prescribed and dispensed by a doctor. Medicines were administered from stock from the locked cabinet and checked by two officers. Pharmacological reference materials were out of date at Bedlington (2007) and Gateshead (2005) among others. Of detainees previously on medications, 39% in our survey said they had been able to continue it in custody. Custody staff tried to retrieve medications from detainees' homes if necessary and made efforts to assist detainees on programmes of methadone maintenance, usually by escorting them to a local chemist for supervised self-administration. Symptomatic relief was prescribed for those withdrawing from substances and alcohol.
- 6.8 Emergency equipment was available and included first aid kits, limited resuscitation equipment and automated external defibrillators, which were easily accessible. The kits were regularly checked but dusty. Oxygen was not available for use yet there were ambu-bags and oxygen tubing at Etal Lane and Gateshead. Suction units were not available at all sites. Custody staff we spoke to were up to date with their resuscitation training. Eye wash fluid was out of date in the clinical rooms and other places in the custody suites, including North Tyneside. We saw opened bottles of sterile water in clinical rooms and in the cupboards at several suites, including Clifford Street and Southwick, which suggested that opened sterile fluids were being reused.

Recommendations

- 6.9 **Clinical governance arrangements should be improved, including clear lines of accountability for checking the training, clinical supervision and appraisal of all forensic medical examiners.**
- 6.10 **There should be robust infection control procedures for all clinical rooms, which should be regularly cleaned and capable of being used for taking forensic samples, and custody staff should have access to a full range of appropriate and standardised first aid and resuscitation equipment that is checked regularly.**

Housekeeping points

- 6.11 Detainees should be able to see a female health professional on request.

- 6.12 Out of date clinical reference materials should be discarded and replaced by up to date materials.
- 6.13 All used and out of date clinical stock should be disposed of and regular checks of expiry dates instigated.
- 6.14 Patient information leaflets should be accessible in the clinical rooms.
- 6.15 Out of date pharmacological reference materials should be discarded and replaced by up to date materials.

Good practice

- 6.16 *The management of medicines by the police, including stock regulation, control and monitoring of divertible medications and independent auditing, were safe, efficient and effective.*

Patient care

- 6.17 FMEs provided a 24-hour service with a minimum of one FME on call for the north and south of the force respectively. Over 20 FMEs were on a rota, which was available at the booking in desks in the custody suites. GPs undertook their FME duties, doing 12-hour shifts, at the same time as their daily surgeries. They tended to telephone the suites before starting their surgeries to see if anyone required them to avoid being called by the police during morning surgery time.
- 6.18 New detainees were asked if they wanted to see a doctor and custody officers also referred them if they presented any health-related concerns. Call out and response times were entered on the custody record. The target was 60 minutes or 90 minutes if a journey of longer than 30 miles was involved. In our sample, the average response time was 51 minutes, the longest being two hours 46 minutes. Custody staff were generally satisfied with the responsiveness of doctors (but see section on clinical governance).
- 6.19 FMEs used Northumbria Police 'Detainee Medical Care' paper pro formas to record their findings and advice to custody staff. The pro forma was concise and contained a risk assessment. One copy of the record was kept by custody staff and one by the FME. In the clinical room at Gateshead, we found assessment pro formas produced by Veritas, the previous service provider. These were more extensive than the Northumbria Police ones and could have been confusing for new FMEs. There was no auditing of clinical records and it was unclear how Northumbria Police could assure itself that all clinical records were stored in line with Data Protection requirements and Caldicott principles⁸.

Recommendation

- 6.20 **All clinical records should be stored in accordance with the Data Protection Act and Caldicott principles to ensure confidentiality of personal health information.**

⁸ The Caldicott review (1997) stipulated certain principles and working practices that health care providers should adopt to improve the quality of, and protect the confidentiality of, service users' information.

Housekeeping point

- 6.21 Medical assessment pro formas should be standardised and non-standard pro formas discarded.

Substance use

- 6.22 In our survey, 76% of respondents said they had a drug or alcohol problem. An analysis of custody records indicated that 55% of detainees were said to be intoxicated when brought into custody. At Bedlington, which served the north of the force including Alnwick, Berwick and Hexham, the North East Council on Addictions (NECA) provided drug intervention programme (DIP) services to police and court detainees. In all other parts of the county, Turning Point Criminal Justice Intervention Team was the DIP provider. There were good multi-agency working arrangements to ensure that substance users had prompt access to relevant services.
- 6.23 Arrest referral workers were based in the full-time custody suites during office hours on weekdays and regularly visited the cells to check if detainees required their services or in response to police referrals. Out of hours, custody staff made appointments for detainees to see DIP workers. At Clifford Street, Gateshead and Gillbridge Avenue, there were intensive DIPs from 7.30am to 8pm six days a week, with drug testing on arrest and access, as appropriate, to the prolific and priority offender scheme. There was an emphasis on ensuring that users of class A drugs were engaged in supportive programmes, although users of other substances were offered an extensive range of programmes following release. In our survey, 46% of detainees with drug and alcohol problems said they had been offered symptomatic relief while in custody.
- 6.24 Detainees whose problems related to alcohol were offered support and access to community programmes. In South Shields, custody staff were undertaking a 'last drink survey', a local initiative designed to identify drinkers who chose not to engage with substance use services when they were offered at booking in. In the Newcastle City area, juvenile drug workers from the Matrix service were available to detained young persons and at Bedlington, juveniles were signposted to appropriate services such as Sorted. Detainees who required it were signposted to needle exchange services in the community.

Mental health

- 6.25 In our survey, 30% of detainees said they had mental health problems and custody officers said many detainees had such problems. Mental health services were provided by Northumbria, Tyne and Wear Mental Health NHS Trust (NTW). Relationships between the police and NTW were described as good. We attended a custody diversion group meeting at Bedlington, which was business-focused and constructive. There were several joint operational policies and protocols for mental health working, including an information-sharing protocol, a multi-agency risk assessment conference (MARAC) protocol and a section 136 protocol. The police and partner agencies were involved in planned responses to the Bradley Report recommendations⁹¹.
- 6.26 There were few mental health in-reach services, which was inadequate. NHS legacy funding shortfalls for mental health diversion services were hampering progress. At Gateshead, a full-

⁹ Set up in response to the Lord Bradley report on people with mental health problems or learning disabilities in the Criminal Justice System (2009).

time community psychiatric nurse (CPN) worked between police custody and the courts to ensure that those with mental health problems received appropriate assessment and referral to mental health services. At Bedlington, the NTW Northumberland Criminal Justice Mental Health Liaison Team provided two community mental health workers to work in police custody and courts from 7am to noon on weekdays to identify detainees with mental health problems. The Bedlington scheme was unfunded. The workers, MHCO staff (the Northumberland IAPT provider), substance misuse staff and a youth offending team worker were generating data to support a business case for permanent funding to present to the primary care trust. There was also half the time of a CPN detailed to provide support to people detained at the courts in Newcastle. Other than these services, mental health workers did not routinely visit police custody suites. However, custody officers said that local crisis resolution teams were usually responsive to telephone referrals. NTW had applied to the Regional Offender Diversion Project for funding to introduce more equitable services across Northumbria and the outcome was awaited.

- 6.27 Section 136 guidance and protocol had recently been updated and Section 135 guidance was in draft. There were five designated NHS Section 136 suites in Northumbria. In the year to end March 2011, 234 persons had been arrested for 'mental health reasons' and Section 136 had been used 158 times. Fifty-three persons on Section 136 were detained in police custody due to being intoxicated or violent. On retrospective analysis, only one person subject to Section 136 may have been detained inappropriately in police custody. Emergency duty teams provided Mental Health Act assessments and were said to be responsive, although there were delays out of hours.
- 6.28 All custody staff received mental health awareness training during induction and all said this had been updated in the last two years. The NPIA 'NCALT' mental health awareness e-learning materials were available to staff online. Custody staff at Gateshead had received a more intensive update in the last eight months provided by the CPN and a custody sergeant with a special interest. As part of the Bradley response plan, a force-wide review of mental health awareness training was under way.

7. Summary of recommendations

Main recommendations

- 7.1 A comprehensive risk assessment should in all instances be completed on arrival in custody and this should be reflected in the level of observations undertaken. (2.19)
- 7.2 Detainees should be handcuffed only when a risk assessment indicates that this is necessary. (2.20)
- 7.3 Cells and corridors should be clean, free from graffiti and properly ventilated. (2.21)
- 7.4 There should be mental health diversion schemes that enable detainees with mental health problems to be identified and diverted expeditiously into appropriate services. (2.22)

Recommendations

Strategy

- 7.5 The day-to-day management arrangements in custody should be sufficient to provide the required oversight of staff, clarity around roles and responsibilities and adequate quality assurance of outcomes for detainees. (3.14)

Respect

- 7.6 Booking-in areas should provide enough privacy to allow effective communication between staff and detainees. (4.7)
- 7.7 There should be a clearer focus on the specific needs of juvenile, female and disabled juvenile detainees; staff should be trained to deal effectively with these detainees. (4.8)

Safety

- 7.8 Anti-ligature knives should be carried. (4.16)
- 7.9 Custody sergeants and detention officers should attend the same handover briefings wherever possible. (4.17)

Use of force

- 7.10 Northumbria Police should collate the use of force in accordance with the Association of Chief Police Officers policy and National Policing Improvement Agency guidance. (4.22)

Physical conditions

- 7.11 Rigorous health and safety walk-through arrangements should be applied consistently at all custody suites and should include the identification of ligature points. Records should be kept of these and remedial action taken, especially in relation to deep cleaning. (4.27)

Personal comfort and hygiene

- 7.12 All detainees held overnight, or who require one, should be offered a shower and should be able to use one in reasonable privacy. (4.33)
- 7.13 Toilet areas should be obscured on closed-circuit television monitoring. (4.34)

Catering

- 7.14 Food should routinely be offered at meal times and provided at other times on request and should be of sufficient quality and calorific content to sustain detainees for the duration of their stay. (4.40)

Activities

- 7.15 Detainees, particularly those held for more than 24 hours, should be offered exercise and the exercise yards should be made fit for purpose. (4.45)

Rights relating to detention

- 7.16 Northumbria Police should further develop and promote alternative to custody approaches and custody officers should ensure that the 'necessity test' for arrest is meaningfully undertaken. (5.8)
- 7.17 Custody staff should ensure that detainee dependency obligations are routinely identified and, where possible, addressed. (5.9)
- 7.18 Northumbria police should liaise at a senior level with UKBA to ensure there are no undue delays in transporting immigration detainees to placements identified in the Immigration Custody Estate. (5.10)
- 7.19 Pre-release risk assessments should be detailed and meaningful, based on an ongoing assessment of detainees needs while in custody, and leaflets giving details of local support services should be provided for detainees. (5.11)

Rights relating to PACE

- 7.20 Appropriate adults should be provided to 17-year-olds and vulnerable adults. (5.21)
- 7.21 Northumbria Police should engage with the local authority to ensure the provision of secure beds for juveniles who have been charged but cannot be bailed to appear in court. (5.22)

Rights relating to treatment

- 7.22 Detainees should routinely be told how to make a complaint in line with the Independent Police Complaints Commission statutory guidance¹⁰ and, unless there is a clear reason not to do so, complaints should be taken while they are still in police custody. (5.25)

Clinical governance

- 7.23 Clinical governance arrangements should be improved, including clear lines of accountability for checking the training, clinical supervision and appraisal of all forensic medical examiners. (6.9)
- 7.24 There should be robust infection control procedures for all clinical rooms, which should be regularly cleaned and capable of being used for taking forensic samples, and custody staff should have access to a full range of appropriate and standardised first aid and resuscitation equipment that is checked regularly. (6.10)

Patient care

- 7.25 All clinical records should be stored in accordance with the Data Protection Act and Caldicott principles to ensure confidentiality of personal health information. (6.20)

Housekeeping points

Strategy

- 7.26 Staff should be encouraged to access and use the information in the IPCC Learning the Lessons briefings. (3.15)
- 7.27 A formal meeting structure for custody practitioners and managers to discuss custody issues should be introduced in area commands. (3.16)

Respect

- 7.28 Items used for religious observance should be stored respectfully. (4.9)

Safety

- 7.29 Cell keys should be made more secure and visits to cells should be by custody staff or accompanied by them. (4.18)

Physical conditions

- 7.30 Fire evacuation drills should be carried out in all custody suites. (4.28)

¹⁰ IPCC statutory guidance (2010)

Personal comfort and hygiene

- 7.31 Mattresses should routinely be wiped down after each use. (4.35)
- 7.32 All detainees should be given a pillow. (4.36)
- 7.33 Toilet paper should be provided in each cell. (4.37)
- 7.34 Replacement underwear should be available. (4.38)

Catering

- 7.35 The serving temperature of microwave meals should be taken and recorded. (4.41)

Activities

- 7.36 Reading material suitable for a range of detainees, including young people and those who cannot read English, should be available. (4.46)
- 7.37 Visits should be allowed where appropriate, particularly for juveniles and those detained for longer periods. (4.47)

Rights relating to detention

- 7.38 Detainees should be offered a free telephone call. (5.12)

Rights relating to PACE

- 7.39 Northumbria Police should liaise with court managers to ensure that cut-off times do not result in unnecessarily long stays in custody. (5.23)

Clinical governance

- 7.40 Detainees should be able to see a female health professional on request. (6.11)
- 7.41 Out of date clinical reference materials should be discarded and replaced by up to date materials. (6.12)
- 7.42 All used and out of date clinical stock should be disposed of and regular checks of expiry dates instigated. (6.13)
- 7.43 Patient information leaflets should be accessible in the clinical rooms. (6.14)
- 7.44 Out of date pharmacological reference materials should be discarded and replaced by up to date materials. (6.15)

Patient care

- 7.45 Medical assessment pro formas should be standardised and non-standard pro formas discarded. (6.21)

Good practice

Strategy

- 7.46 There were protocols between area commands allowing detainees to be moved across command boundaries, coupled with a centralised management process for the allocation of custody space thereby minimising delays, maximising operational effectiveness and making best use of custody capacity. (3.17)
- 7.47 The police authority had recently carried out an equality impact assessment of the independent custody visitor scheme to identify areas for improvement, including recruitment of members from under-represented groups. (3.18)

Health care

- 7.48 The management of medicines by the police, including stock regulation, control and monitoring of divertible medications and independent auditing, were safe, efficient and effective. (6.16)

Appendix I: Inspection team

Sean Sullivan	HMIP team leader
Gary Boughen	HMIP inspector
Fay Deadman	HMIP inspector
Peter Dunn	HMIP inspector
Angela Johnson	HMIP inspector
Ian Macfadyen	HMIP inspector
Ian Thomson	HMIP inspector
Michael Bowen	HMIP health care inspector
Paul Tarbuck	HMIP health inspector
Paul Davies	HMIC inspector
Bob Edge	HMIC inspector
Paul Eveleigh	HMIC inspector
Mark Ewan	HMIC inspector
Mark Mullinger	HMIC inspector
Adam Altoft	HMIP researcher
Samantha Booth	HMIP researcher
Alice Reid	HMIP researcher

Appendix II: 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 Northumbria, was carried out for this inspection. The results of this survey formed part of the evidence-base for the inspection.

Choosing the sample size

The survey was conducted on 11 July 2011. A list of potential respondents to have passed through police stations in Northumbria was created, listing all those who had arrived from Alnwick, Bedlington, Sunderland, Newcastle Upon Tyne, North Tyneside, South Tyneside, Gateshead, South Shields, Berwick upon Tweed, Houghton le Spring or Hexham Magistrates' courts within the past two months.

Selecting the sample

In total, 55 respondents were approached. Two respondents reported being held in police stations outside Northumbria. On the day, the questionnaire was offered to 53 respondents; there were three refusals and three questionnaires returned blank. 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, 47 (89%) 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 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 42 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.

Survey results

Section 1: About you

Q2	What police station were you last held at?		
	Bedlington – 5; North Tyneside Area Command HQ – 4; Clifford Street – 6; Etal Lane (Area Command HQ) – 7; Gateshead – 7; South Shields – 4; Gillbridge – 7; Washington – 3; North Shields – 1; Unknown - 3		
Q3	How old are you?		
	16 years or younger.....	0 (0%)	40-49 years..... 5 (11%)
	17-21 years.....	10 (21%)	50-59 years..... 1 (2%)
	22-29 years.....	19 (40%)	60 years or older..... 0 (0%)
	30-39 years.....	12 (26%)	
Q4	Are you:		
	Male.....		47 (100%)
	Female.....		0 (0%)
	Transgender/transsexual.....		0 (0%)
Q5	What is your ethnic origin?		
	White - British.....		45 (96%)
	White - Irish.....		0 (0%)
	White - other.....		0 (0%)
	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.....		1 (2%)
	Asian or Asian British - other.....		0 (0%)
	Mixed heritage - white and black Caribbean.....		1 (2%)
	Mixed heritage - white and black African.....		0 (0%)
	Mixed heritage- white and Asian.....		0 (0%)
	Mixed heritage - Other.....		0 (0%)
	Chinese.....		0 (0%)
	Other ethnic group.....		0 (0%)
Q6	Are you a foreign national (i.e. you do not hold a British passport, or you are not eligible for one)?		
	Yes.....		4 (9%)
	No.....		41 (91%)
Q7	What, if any, would you classify as your religious group?		
	None.....		14 (30%)
	Church of England.....		27 (59%)
	Catholic.....		4 (9%)
	Protestant.....		0 (0%)
	Other Christian denomination.....		0 (0%)
	Buddhist.....		0 (0%)
	Hindu.....		0 (0%)
	Jewish.....		0 (0%)
	Muslim.....		1 (2%)
	Sikh.....		0 (0%)

Q8	How would you describe your sexual orientation?	
	<i>Straight/heterosexual</i>	46 (100%)
	<i>Gay/lesbian/homosexual</i>	0 (0%)
	<i>Bisexual</i>	0 (0%)
Q9	Do you consider yourself to have a disability?	
	<i>Yes</i>	6 (13%)
	<i>No</i>	39 (87%)
Q10	Have you ever been held in police custody before?	
	<i>Yes</i>	46 (100%)
	<i>No</i>	0 (0%)

Section 2: Your experience of this custody suite

Q11	How long were you held at the police station?	
	<i>Less than 24 hours</i>	11 (23%)
	<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>	9 (19%)
	<i>72 hours (3 days) or more</i>	6 (13%)
Q12	Were you given information about your arrest and your entitlements when you arrived there?	
	<i>Yes</i>	27 (57%)
	<i>No</i>	15 (32%)
	<i>Don't know/Can't remember</i>	5 (11%)
Q13	Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')?	
	<i>Yes</i>	17 (36%)
	<i>No</i>	28 (60%)
	<i>I don't know what this is/I don't remember</i>	2 (4%)
Q14	If your clothes were taken away, were you offered different clothing to wear?	
	<i>My clothes were not taken</i>	15 (33%)
	<i>I was offered a tracksuit to wear</i>	19 (42%)
	<i>I was offered an evidence/paper suit to wear</i>	4 (9%)
	<i>I was offered a blanket</i>	3 (7%)
	<i>Nothing</i>	4 (9%)
Q15	Could you use a toilet when you needed to?	
	<i>Yes</i>	40 (85%)
	<i>No</i>	5 (11%)
	<i>Don't know</i>	2 (4%)
Q16	If you have used the toilet there, was toilet paper provided?	
	<i>Yes</i>	17 (37%)
	<i>No</i>	29 (63%)
Q17	Did you share a cell at the police station?	
	<i>Yes</i>	0 (0%)
	<i>No</i>	47 (100%)

Q18	How would you rate the condition of your cell:					
		<i>Good</i>	<i>Neither</i>	<i>Bad</i>		
	Cleanliness	15 (32%)	12 (26%)	20 (43%)		
	Ventilation/air quality	7 (15%)	5 (11%)	34 (74%)		
	Temperature	10 (21%)	6 (13%)	31 (66%)		
	Lighting	23 (49%)	7 (15%)	17 (36%)		
Q19	Was there any graffiti in your cell when you arrived?					
	Yes			32 (70%)		
	No			14 (30%)		
Q20	Did staff explain to you the correct use of the cell bell?					
	Yes			5 (11%)		
	No			41 (89%)		
Q21	Were you held overnight?					
	Yes			44 (94%)		
	No			3 (6%)		
Q22	If you were held overnight, which items of clean bedding were you given?					
	<i>Not held overnight</i>			3 (7%)		
	<i>Pillow</i>			4 (9%)		
	<i>Blanket</i>			26 (58%)		
	<i>Nothing</i>			16 (36%)		
Q23	Were you offered a shower at the police station?					
	Yes			3 (7%)		
	No			43 (93%)		
Q24	Were you offered any period of outside exercise while there?					
	Yes			1 (2%)		
	No			45 (98%)		
Q25	Were you offered anything to:					
		<i>Yes</i>	<i>No</i>			
	Eat?	32 (70%)	14 (30%)			
	Drink?	37 (82%)	8 (18%)			
Q26	What was the food/drink like in the police custody suite?					
	<i>Very good</i>	<i>Good</i>	<i>Neither</i>	<i>Bad</i>	<i>Very bad</i>	<i>N/A</i>
	1 (2%)	2 (5%)	2 (5%)	11 (26%)	22 (51%)	5 (12%)
Q27	Was the food/drink you received suitable for your dietary requirements?					
	<i>I did not have any food or drink</i>				5 (13%)	
	Yes				13 (33%)	
	No				21 (54%)	
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>				2 (4%)	
	<i>I was not offered anything to cope with not smoking</i>				40 (89%)	
	<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	19 (41%)	
	No	17 (37%)	
	<i>I don't know</i>	3 (7%)	
	<i>I didn't want to inform anyone</i>	7 (15%)	
Q31	Were you offered a free telephone call?		
	Yes	12 (26%)	
	No	35 (74%)	
Q32	If you were denied a free phone call, was a reason for this offered?		
	<i>My telephone call was not denied</i>	18 (42%)	
	Yes	3 (7%)	
	No	22 (51%)	
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 (14%)	31 (86%)
	Contacting your partner, relative or friend	23 (59%)	16 (41%)
	Contacting your employer	6 (20%)	24 (80%)
	Where you were going once released	15 (38%)	25 (63%)
Q34	Were you interviewed by police officials about your case?		
	Yes	41 (87%)	
	No	6 (13%)	If No, go to Q36
Q35	Were any of the following people present when you were interviewed?		
		Yes	No
	Solicitor	33 (80%)	5 (12%)
	Appropriate Adult	2 (11%)	6 (33%)
	Interpreter	0 (0%)	4 (22%)
			Not needed
			3 (7%)
			10 (56%)
			14 (78%)
Q36	How long did you have to wait for your solicitor?		
	<i>I did not requested a solicitor</i>	8 (18%)	
	<i>2 hours or less</i>	8 (18%)	
	<i>Over 2 hours but less than 4 hours</i>	5 (11%)	
	<i>4 hours or more</i>	24 (53%)	

Section 3: Safety

Q38	Did you feel safe there?	
	Yes	25 (56%)
	No	20 (44%)
Q39	Had another detainee or a member of staff victimised (insulted or assaulted) you there?	
	Yes	23 (51%)
	No	22 (49%)

Q40 If you have felt victimised, what did the incident involve? (Please tick all that apply to you.)

<i>I have not been victimised</i>	22 (48%)	<i>Because of your crime</i>	10 (22%)
<i>Insulting remarks (about you, your family or friends)</i>	14 (31%)	<i>Because of your sexuality</i>	4 (9%)
<i>Physical abuse (being hit, kicked or assaulted)</i>	15 (33%)	<i>Because you have a disability</i>	4 (9%)
<i>Sexual abuse</i>	3 (7%)	<i>Because of your religion/religious beliefs</i>	2 (4%)
<i>Your race or ethnic origin</i>	2 (4%)	<i>Because you are from a different part of the country than others</i>	2 (4%)
<i>Drugs</i>	11 (24%)		

Q41 Were your handcuffs removed on arrival at the police station?

<i>Yes</i>	29 (64%)
<i>No</i>	16 (36%)
<i>I wasn't handcuffed</i>	0 (0%)

Q42 Were you restrained whilst in the police custody suite?

<i>Yes</i>	12 (27%)
<i>No</i>	32 (73%)

Q43 Were you injured while in police custody, in a way that you feel was not your fault?

<i>Yes</i>	13 (30%)
<i>No</i>	31 (70%)

Q44 Were you told how to make a complaint about your treatment if you needed to?

<i>Yes</i>	5 (12%)
<i>No</i>	38 (88%)

Section 4: Health care

Q46 Did you need to take any prescribed medication when you were in police custody?

<i>Yes</i>	25 (56%)
<i>No</i>	20 (44%)

Q47 Were you able to continue taking your prescribed medication while there?

<i>Not taking medication</i>	20 (45%)
<i>Yes</i>	9 (20%)
<i>No</i>	15 (34%)

Q48 Did someone explain your entitlements to see a health care professional, if you needed to?

<i>Yes</i>	11 (26%)
<i>No</i>	28 (67%)
<i>Don't know</i>	3 (7%)

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

	<i>Yes</i>	<i>No</i>
Doctor	29 (63%)	17 (37%)
Nurse	0 (0%)	28 (100%)
Paramedic	1 (3%)	28 (97%)
Psychiatrist	0 (0%)	28 (100%)

Q50	Were you able to see a health care professional of your own gender?					
	Yes					19 (43%)
	No					15 (34%)
	Don't know					10 (23%)
Q51	Did you have any drug or alcohol problems?					
	Yes					35 (76%)
	No					11 (24%)
Q52	Did you see, or were offered the chance to see a drug or alcohol support worker?					
	<i>I didn't have any drug/alcohol problems</i>					11 (24%)
	Yes					12 (26%)
	No					23 (50%)
Q53	Were you offered relief or medication for your immediate symptoms?					
	<i>I didn't have any drug/alcohol problems</i>					11 (25%)
	Yes					15 (34%)
	No					18 (41%)
Q54	Please rate the quality of your health care while in police custody:					
	I was not seen by health care	<i>Very good</i>	<i>Good</i>	<i>Neither</i>	<i>Bad</i>	<i>Very bad</i>
	16 (37%)	0 (0%)	9 (21%)	5 (12%)	8 (19%)	5 (12%)
Q55	Did you have any specific <u>physical</u> health care needs?					
	No					32 (80%)
	Yes					8 (20%)
Q56	Did you have any specific <u>mental</u> health care needs?					
	No					28 (70%)
	Yes					12 (30%)



Prisoner survey responses for Northumbria Police 2011

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

Key to tables

		Northumbria Police Custody	Police custody comparator
	Any percentage highlighted in green is significantly better		
	Any percentage highlighted in blue is significantly worse		
	Any percentage highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
Number of completed questionnaires returned		47	1502
SECTION 1: General information			
3	Are you under 21 years of age?	22%	9%
4	Are you transgender/transsexual?	0%	1%
5	Are you from a minority ethnic group? Including all those who did not tick white British, white Irish or white other categories.	4%	30%
6	Are you a foreign national?	9%	14%
7	Are you Muslim?	2%	11%
8	Are you homosexual/gay or bisexual?	0%	2%
9	Do you consider yourself to have a disability?	13%	20%
10	Have you been in police custody before?	100%	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?	76%	67%
12	Were you given information about your arrest and entitlements when you arrived?	58%	74%
13	Were you told about PACE?	36%	52%
14	If your clothes were taken away, were you given a tracksuit to wear?	63%	42%
15	Could you use a toilet when you needed to?	86%	90%
16	If you did use the toilet, was toilet paper provided?	37%	49%
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?	32%	32%
18b	Ventilation/air quality?	15%	22%
18c	Temperature?	22%	15%
18d	Lighting?	49%	43%
19	Was there any graffiti in your cell when you arrived?	69%	54%
20	Did staff explain the correct use of the cell bell?	10%	22%
21	Were you held overnight?	94%	93%
22	If you were held overnight, were you given no clean items of bedding?	35%	29%
23	Were you offered a shower?	6%	9%
24	Were you offered a period of outside exercise?	2%	7%
25a	Were you offered anything to eat?	69%	81%
25b	Were you offered anything to drink?	83%	84%
	For those who had food:		
26a	Was the quality of the food and drink you received 'good'/very good'?	8%	10%
26b	Was the food/drink you received suitable for your dietary requirements?	39%	44%
27	For those who smoke: were you offered nothing to help you cope with the ban there?	96%	93%
28	Were you offered anything to read?	8%	14%
29	Was someone informed of your arrest?	41%	42%
30	Were you offered a free telephone call?	26%	50%

Key to tables

	Any percentage highlighted in green is significantly better	Northumbria Police Custody	Police custody comparator
	Any percentage highlighted in blue is significantly worse		
	Any percentage highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
31	If you were denied a free call, was a reason given?	12%	14%
32	Did you have any concerns about:		
32a	Who was taking care of your children?	13%	14%
32b	Contacting your partner, relative or friend?	59%	52%
32c	Contacting your employer?	19%	20%
32d	Where you were going once released?	37%	31%
34	If you were interviewed were the following people present:		
34a	Solicitor	81%	73%
34b	Appropriate adult	11%	7%
34c	Interpreter	0%	6%
35	Did you wait over 4 hours for your solicitor?	64%	65%
SECTION 3: Safety			
39	Did you feel unsafe?	44%	39%
40	Has another detainee or a member of staff victimised you?	51%	41%
41	If you have felt victimised, what did the incident involve?		
41a	Insulting remarks (about you, your family or friends)	31%	20%
41b	Physical abuse (being hit, kicked or assaulted)	33%	13%
41c	Sexual abuse	6%	2%
41d	Your race or ethnic origin	4%	5%
41e	Drugs	25%	14%
41f	Because of your crime	23%	17%
41g	Because of your sexuality	9%	1%
41h	Because you have a disability	9%	3%
41i	Because of your religion/religious beliefs	4%	2%
41j	Because you are from a different part of the country than others	4%	4%
42a	Were your handcuffs removed on arrival at the police station?	65%	76%
42b	Were you restrained whilst in the police custody suite?	28%	18%
43	Were you injured whilst in police custody, in a way that you feel is not your fault?	30%	24%
44	Were you told how to make a complaint about your treatment?	11%	13%
SECTION 4: Health care			
46	Did you need to take any prescribed medication when you were in police custody?	56%	47%
47	For those who were on medication: were you able to continue taking your medication?	39%	36%
48	Did someone explain your entitlement to see a health care professional if you needed to?	27%	35%
49	Were you seen by the following health care professionals during your time in police custody:		
49a	Doctor	63%	47%
49b	Nurse	0%	21%
	Percentage seen by either a doctor or a nurse	63%	54%
49c	Paramedic	3%	4%
49d	Psychiatrist	0%	3%
50	Were you able to see a health care professional of your own gender?	43%	27%
51	Did you have any drug or alcohol problems?	76%	54%
For those who had drug or alcohol problems:			
52	Did you see, or were offered the chance to see a drug or alcohol support worker?	35%	43%
53	Were you offered relief medication for your immediate symptoms?	46%	31%
54	For those who had been seen by health care, would you rate the quality as good/very good?	35%	29%
55	Do you have any specific physical health care needs?	19%	33%
56	Do you have any specific mental health care needs?	30%	24%