Inspecting policing in the public interest

Report on an inspection visit to police custody suites in

Thames Valley

by HM Inspectorate of Prisons

and HM Inspectorate of Constabulary

9-19 September 2013

Glossary of terms

We try to make our reports as clear as possible, but if you find terms that you do not know, please see the Glossary of terms on our website at:
http://www.justice.gov.uk/downloads/about/hmipris/Glossary-for-web-rps_.pdf

Crown copyright 2014

You may re-use this information (excluding logos) free of charge in any format or medium, under the terms of the Open Government Licence. To view this licence, visit http://www.nationalarchives.gov.uk/doc/open-government-licence/ or email: psi@nationalarchives.gsi.gov.uk

Where we have identified any third party copyright material you will need to obtain permission from the copyright holders concerned.

Any enquiries regarding this publication should be sent to HMI Prisons at the address below, or hmiprisons.enquiries@hmiprisons.gsi.gov.uk, or
HM Inspectorate of Constabulary at 6th Floor, Globe House, 89 Eccleston Square, London SW1V 1PN, or haveyoursay@hmic.gsi.gov.uk

This publication is available for download at: http://www.justice.gov.uk/about/hmi-prisons or http://www.hmic.gov.uk

Printed and published by:
Her Majesty's Inspectorate of Prisons
Her Majesty's Inspectorate of Constabulary
Victory House
6th floor
30-34 Kingsway
London WC2B 6EX
England

Contents

Section 1. Introduction

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

Overall the care of detainees in the Thames Valley force was good, the professional attitude of custody staff and the positive culture within the custody environment towards detainee care was some of the best we have seen. There was a clear strategic focus on custody, including a five-year rationalisation of the estate that was nearing its conclusion. However, the design in some cells presented ligature points, and the force was not sighted on this. Staffing was adequate and there were good structures to manage the risks associated with custody. In our survey, prisoners who had previously been held in custody suites in Thames Valley raised concerns about some aspects of their treatment. We saw nothing while we were in the force area to substantiate these comments, but detainees in most suites were searched and put into cells by the arresting police officer, and this lack of demarcation between officers involved in the arrest and custody staff might explain some of their views.

Some aspects of the custody strategy were less developed, for example, work with strategic partners required improvement. Detainees spent too long in custody as a result of early court cut-off times and court staff refusing to accept detainees into their custody, and police did not challenge this. We will examine this further as part of our inspection of court custody, but improvements to the situation need to be made quickly.

The health services provision was some of the worst we have seen. There was insufficient governance of healthcare provisions, and the supply, storage, prescribing and administration of medications was of concern. Thames Valley police force had not opted to be at the forefront of NHS commissioning of health services, and outcomes for detainees were potentially suffering as a result. Mental health services were not well developed, despite several strategic partnerships looking at provision across the force area. Custody was used too often as a place of safety under the Mental Health Act.

This report provides a small number of recommendations to assist the force and the Police and Crime Commissioner 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.

Thomas P Winsor
HM Chief Inspector of Constabulary

Nick Hardwick
HM Chief Inspector of Prisons

February 2014

Section 2. Background and key findings

2.1 This report is one in a series relating to inspections of police custody carried out jointly by HM Inspectorates of Prisons and Constabulary. These inspections form part of the joint work programme of the criminal justice inspectorates and contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorates of Prisons and Constabulary are two of several bodies making up the NPM in the UK.

2.2 The inspections of police custody look beyond the implementation of the Police and Criminal Evidence Act 1984 (PACE) codes of practice and the Association of Chief Police Officers (ACPO) *Authorised Professional Practice - Detention and Custody* at force-wide strategies, treatment and conditions, individual rights and health care. They are also informed by a set of *Expectations for Police Custody*[1] about the appropriate treatment of detainees and conditions of detention, developed by the two inspectorates to assist best custodial practice.

2.3 Thames Valley police had nine designated custody suites with a total of 180 cells. The Oxford suite was due to close shortly after our inspection, as part of the force's strategic plan, and Milton Keynes was in a temporary building while the suite was being upgraded.

Aylesbury	24 cells
Abingdon	30 cells
Banbury	12 cells
High Wycombe	12 cells
Loddon Valley	28 cells
Milton Keynes	18 cells
Maidenhead	26 cells
Newbury	13 cells
Oxford	17 cells

2.4 This unannounced inspection was conducted across the whole force area. We examined the custody strategy, as well as treatment and conditions, individual rights and health care in the custody suites. In the financial year 2012/13, a total of 52,671 detainees had been held in the suites.

2.5 A survey of prisoners at HMP Bullingdon who had formerly been detained in custody suites in the force area was conducted by HM Inspectorate of Prisons researchers (see Appendix II).

Strategy

2.6 The assistant chief constable was the force's senior lead for custody. There was a clear senior line management structure for custody in the criminal justice (CJD) department,

---

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

which covered the five divisions in the force area. The force had a clear strategic plan for the custody estate, and its effectiveness was evident in the good standard of most suites, including the work being carried out in Milton Keynes and the planned closure of the suite in Oxford.

2.7 All the suites had adequate staffing, although the detention officers (employed by Tascor, a private sector company, who provide custodial services) were often moved between suites, which meant that they were not always familiar with them. This could affect outcomes for detainees. The force had a robust structure and processes to ensure Tascor provided what they were contracted to deliver.

2.8 There was a good meeting structure in the force to ensure all aspects of custody provision were monitored. The force risk register included the custody issues of staffing and the provision of health services. However, meetings with partner organisations needed improving. For example, custody inspectors did not attend the court users' meetings, despite major problems with court cut-off times, which were an issue of concern. Although the force was represented at some meetings with health services, this was not translated into improving physical and mental health provision for detainees. Independent custody visitors reported a good working relationship with staff in the custody suites, and there was regular and consistent police representation at their panel meetings.

2.9 There was no Thames Valley force corporate quality assurance process for sampling custody records, which was a risk for the organisation. Tascor had a process for its supervisors to sample the completion of custody record by its staff, but this was perfunctory.

2.10 All custody sergeants had undergone custody-specific and police IT records training before undertaking custody duties, but there had been no custody-specific refresher training. Detention officers received an initial training course and regular refresher training. The force needed to develop its quality assurance processes to inform the content of the refresher training, which could include the detention officers.

2.11 There was a good system for the reporting of 'near misses', and a useful site on the force intranet that gave custody staff a range of up-to-date information and links to other appropriate material.

Treatment and conditions

2.12 Detainees were treated with respect and their diverse needs were mainly met. Many custody sergeants were 'desk bound' and we had concerns that they were not always aware of the care of detainees. In our survey, respondents raised concerns about some aspects of their treatment in custody. In most suites, detainees were searched and put into cells by the arresting police officer, and this lack of clear demarcation between officers involved in the arrest and custody staff could explain some of these comments. There was little privacy in booking-in areas.

2.13 There were no disabled detainees in custody during our inspection so the information is from staff only. Staff in most suites said that they had accommodated detainees with impaired mobility with no problems. In all suites, staff were unaware of the availability of hearing loops, and there was no documentation in Braille, but a scheme for people with autism was well publicised in some suites. Religious artefacts were available, although not always stored respectfully. Staff spoke to young people in an age-appropriate manner, and were knowledgeable about the issue of searching transgender detainees.

2.14 Custody staff were competent to assess and manage risks presented by detainees. They followed the risk assessment script on the Niche police IT system but also asked appropriate supplementary questions and checked the police national computer. Most care plans were proportionate and revised regularly. Staff employed good practice in checks to rouse intoxicated detainees, varying the questions each time, although some detainees who should have been put on rousing checks were not. Call bells were answered promptly although not all detainees were told about them. Handovers between staff varied, with separate procedures for detention officers and police staff. Evidence from our analysis of custody records revealed that pre release risk assessments were completed in all cases but some were perfunctory.

2.15 Use of force was proportionate and lawful. We saw few detainees arrive in handcuffs, and those who did had these promptly removed on arrival at the custody suite. Use of force in custody was recorded by each officer involved, submitted electronically and used to inform officer training. It was good that staff were able to describe the use of de-escalation and said the use of force in custody was rare.

2.16 Most suites were clean with minimal or no graffiti. Some cells were very cold and the temperature could not be easily adjusted. The design in some cells presented ligature points. Each suite had a fire evacuation pack but there were no records of emergency evacuations taking place.

2.17 Not all detainees were able to be clean and comfortable while in custody, and not all had access to reading materials and outdoor exercise. There were good stocks of mattresses and pillows, and plenty of blankets, although not always issued as a matter of course. Most showers were well screened and reasonably private, delivering hot water, but they were not used very often. There was toilet paper in the cells in most but not all suites, and female hygiene packs, razors, soap and toothbrushes were available. Toilet areas were obscured on the CCTV screens, except in the temporary suite at Milton Keynes, but detainees were not told this. There was a good stock of clothing but underwear was not available in all suites and there was no safety clothing. All suites had good supplies of microwave meals but they were poor quality and of low calorific value.

Individual rights

2.18 Detention was appropriate and authorised, but in some cases it lasted too long. Although the number of immigration detainees detained had on average remained steady over the previous 18 months, staff reported an improving picture for the time that they stayed in custody. We observed sergeants checking grounds for detention and questioning where necessary to establish the full circumstances of arrest. Staff were able to provide historical details of cases where they had refused detention.

2.19 Staff reported and we witnessed a 'handover culture', in which detainees remained in custody longer than necessary because their cases were not managed by the arresting officers. The efficiency and provision of support provided by appropriate adults was of concern, particularly at night, which increased the length of stay for those who required one. Staff interpretation of the need to request attendance of an appropriate adult for 17-year-olds was mixed, as previously the force had treated that age group as adults.[2] Staff reported

[2] In all other UK law and international treaty obligations, 17-year-olds are treated as children. In April 2013, the High Court ruled that the PACE definition of an adult as 17 was incompatible with human rights law.

little difficulty in obtaining telephone and face-to-face interpreters, and detainees with communication difficulties were catered for well.

2.20 There was rights and entitlements information in foreign languages for detainees that needed it, but staff were unaware of the easy read format of the document on the Home Office website.

2.21 All detainees were offered legal representation, but the duty solicitor was sometimes overwhelmed by the number of cases, which also affected detainees' length of stay. Criminal defence posters were not displayed in all suites. Detainees were informed that they may have someone told of their whereabouts but they were not always told about the outcome of the contact made. There was a good supply of up-to-date PACE codes of practice in each custody suite, and detainees were routinely offered and accepted a copy to read. PACE reviews were often carried out by telephone, although the use of mobile handsets gave detainees some privacy.

2.22 We found staff holding DNA samples with the bag unsealed in suites until the end of a shift, which was unusual. We advised the force that it needed to be assured about the integrity of the whole process.

2.23 Not all detainees were able to appear in court promptly. There was a lack of clarity about court cut-off times, which were mostly far too early. In High Wycombe, we witnessed a detainee taken in handcuffs through the main police station reception on to the public highway to the court building, which we were told was normal practice; this was clearly unacceptable. Staff did not escalate these matters to senior managers but accepted these practices as the status quo.

2.24 Not all detainees were made aware of how to make a complaint, or enabled to do so while in custody. However, the professional standards department was sent a copy of all complaints recorded, which was positive.

Health care

2.25 Health services were provided only by forensic medical examiners (FMEs). The force had no health needs assessment, governance or general health care policies. There was no monitoring of the FME attendance at custody suites, and custody staff did not report late attendance to their managers. There were limited training opportunities, and there was no formal appraisal scheme.

2.26 Most of the clinical rooms were satisfactory, but many are untidy. Not all sites complied with infection control standards or had suitable storage for medications. The storage, prescribing, supply and monitoring of medications were of great concern. Detainees were generally able to receive prescribed medications as needed, except opiate substitution therapy. FMEs kept their own clinical records, and most had no awareness of the Caldicott guidelines on the security of confidential clinical information.

2.27 Access to substance misuse services for adults was reasonably good, but insufficient for young people. All suites, except Aylesbury, had daily access to a custody intervention worker, who could also undertake learning disability and mental health screening. There were good links with community services.

2.28 There was an overall lack of mental health services for those in custody. Commissioning arrangements for mental health services were haphazard and ineffective. The absence of mental health liaison and diversion services denied detainees the opportunity for diversion

from police cells. Access to an approved mental health professional varied. One-third of detainees detained under section 136 of the Mental Health Act[3] were admitted to police custody. Although there was good monitoring of the use of custody suites for section 136 purposes, this was not used effectively to facilitate improvements.

Main recommendations

2.29 The force should use meetings with partner organisations to drive forward improvements in detainee care, particularly in their attendance at court.

2.30 The force should expedite NHS commissioning of both physical and mental health services for detainees as a matter of urgency.

2.31 The force should work with all relevant organisations to ensure there is sufficient capacity for detainees to receive prompt assessment under section 136 of the Mental Health Act 1983.

[3] Section 136 of the Mental Health Act 1983 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.

Section 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 well-being of detainees.

Strategic management

3.1 An assistant chief constable (ACC) provided strategic leadership on custody issues, with a centralised custody function through the criminal justice department (CJD). A superintendent, head of CJD, line managed the chief inspector head of custody. This provided a clear line management structure.

3.2 The five-year force estates strategy was nearing completion, with refurbishment of the Milton Keynes custody suite and the planned closure of the Oxford (St Aldates) suite in November 2013. The effectiveness of the estates strategy was evident in the good standard of the remaining suites. There were no standby or non-designated suites.

3.3 Detainees were generally conveyed to a custody facility in the area where they were arrested. Custody staff at most suites were informed in advance of the arrival of detainees.

3.4 Staffing levels in custody suites during the inspection were adequate. Staffing comprised permanent custody sergeants and detention officers (DOs) provided through a contract with Tascor. Cover for custody sergeants was provided by sergeants from other business areas who had been custody trained. The contract with Tascor ensured the provision of DOs where cover was required, although this was rare as custody sergeants and DOs moved between suites to provide cover if necessary. Staff expressed some concerns about their lack of familiarity with procedures when they worked at suites where they were not usually based, and we witnessed this during the inspection. This situation could affect outcomes for detainees.

3.5 Custody sergeants had operational line management of DOs who looked after the care and welfare of detainees. DOs also undertook booking-in duties in support of the custody sergeants. However, DOs were not used to search detainees or take or bring them to or from cells, which was generally done by officers involved in the arrest. This had the potential to affect the detainee experience because of inconsistent information and process, and the blurring of the delineation between arrest and custody. In some suites, DOs were allocated specific roles, but this was not consistent at all suites. DOs provided a good standard of care for detainees, and all custody staff were professional in carrying out their role and had a positive morale. The staff shift handover did not include all staff, which was not in line with national guidance and meant that some staff were potentially not fully informed of detainee risk at the point of handover (see recommendation 4.32).

3.6 There were five dedicated custody inspectors, under the line management of the head of custody. The head of custody also had a dedicated inspector deputy and a sergeant. A Police and Criminal Evidence Act (PACE) inspector rota, which included the head of custody and custody inspectors, ensured PACE coverage for the custody suites, although custody staff told us that they did not always know who the duty PACE inspector was. The five custody inspectors line managed the custody sergeants. While custody sergeants had operational line management of DOs, Tascor also provided a supervisory and management structure for them through five supervisors and four managers. Custody inspectors and Tascor supervisors were visible and active in custody suites, as was the head of CJD, staff reported.

3.7 Custody matters were discussed and reviewed at a number of internal meetings .These included a custody strategy group, chaired by the ACC custody lead, which reviewed corporate risks relating to custody provision. The ACC also chaired the force mental health steering group. The ACC custody lead met the head of CJD weekly. The head of custody chaired a range of meetings that monitored all aspects of custody provision. Centrally produced and detailed monthly performance data were discussed at these meetings and used to manage performance. There was no user group for custody staff.

Recommendation

3.8 Detention Officers should be deployed effectively in a consistent way.

Housekeeping point

3.9 The force should introduce a user group for custody staff to give them the opportunity to discuss and raise issues with managers.

Partnerships

3.10 There were partnership arrangements and strategic engagement with relevant criminal justice partners. The ACC custody lead was vice-chair of the local criminal justice board (LCJB), which was also attended by the head of CJD, and chaired its mental health provision subgroups. However, the opportunity these strategic structures provided needed to be translated into improving mental health provision for detainees across the Thames Valley Police area (see main recommendation 2.30).

3.11 There were meetings with criminal justice partners at area level, but these could have been better used to resolve issues, such as court cut-off times – custody staff were just accepting refusals to accept detainees from the court as the norm when this should have been escalated and challenged by managers to ensure detainees were not unnecessarily detained in police cells. We were told that with one exception custody inspectors did not attend the court user group meetings.

3.12 There were robust policies and procedures to hold Tascor to account for service delivery in the provision of DOs. The relationship between the force and Tascor was professional and positive.

3.13 We were told that voluntary attendance was used where appropriate,[4] and management information data supported this. The current year-to-date performance data showed that voluntary attendance made up almost 10% of the total detainee throughput. While all 17-year-olds were offered the services of an appropriate adult, in line with a recent judicial review, there was inconsistent application of the Association of Chief Police Officers (ACPO) guidance.

3.14 There was an independent custody visitors (ICV) coordinator in the Police and Crime Commissioner (PCC) office. The ICV scheme consisted of five panels and was active, providing a regular schedule of visits. ICVs said that they were generally admitted into

[4] Usually for lesser offences, where suspects attend by appointment at a police station to be interviewed about alleged offences. This avoids the need for an arrest and subsequent detention in police custody.

custody suites quickly and were challenging. ICVs had not identified any particular trends or problems, and ad hoc issues were dealt with and communicated effectively through panel meetings. There was regular and consistent police representation at ICV meetings. ICVs commented on the improvement and increased professionalism in custody provision over the past five years.

Recommendation

3.15 The force should encourage staff to refer to managers any issues that affect detainees adversely, and ensure that such issues can be raised with partners through attendance at local criminal justice meetings.

Learning and development

3.16 All custody sergeants had undergone an initial two-week custody-specific training course and one-week Niche police IT records management system training before undertaking custody duties. The course was linked to the national custody officer learning programme (NCOLP) of the College of Policing. The initial training was supplemented by a one-week period of on-the-job mentoring. DOs were given a five-week initial custody course by Tascor, based on safer detention principles. The initial training programme was good.

3.17 There was no custody-specific refresher training for custody sergeants. This was a risk, particularly for sergeants providing cover who seldom undertook the role and had the potential to adversely affect outcomes for detainees. The force was developing a custody refresher course for custody sergeants, due to commence in January 2014. Tascor provided DOs with refresher training.

3.18 There was a comprehensive force custody policy based on the College of Policing authorised professional practice (APP), which was accessible on the custody intranet site. This included a comprehensive and dynamic custody briefing document that was updated daily, providing staff with immediate updates and information. We saw staff using this at the start of their shift, which was good practice.

3.19 A comprehensive 'near miss' process involved the completion of an IT form by the custody sergeant, which was forwarded through the custody inspector and health and safety coordinator. The coordinator had oversight of all near misses and provided analysis and management information for quarterly health and safety and monthly management meetings. The issues remained on the agenda until they were finalised. This was a good system and ensured that issues were fully discussed and action taken. Immediate issues were communicated through the intranet, although not all staff knew how to access the Independent Police Complaints Commission (IPCC) 'learning the lessons' document (see housekeeping point 4.37).

3.20 There was no corporate, structured quality assurance process for custody sergeants to sample custody records, in order to improve the services provided to detainees, which was a risk for the organisation. We were told that custody inspectors carried out ad hoc sampling and feedback to custody sergeants on an individual basis. By contrast, Tascor had a process for its supervisors to sample the completion of custody records by its DOs, based on a corporate template and overseen by managers. However, Tascor staff we spoke to could not cite any occasions when they had been given feedback from this process.

Recommendation

3.21 There should be a quality assurance process for sampling custody records, which is corporate, recorded, has an audit trail of feedback and dissemination to staff, and which informs refresher training. The process should also include cross-referencing to person escort records and CCTV. There should be a similar provision for shift handovers.

Housekeeping point

3.22 The force should deliver its plans to introduce regular custody refresher training for custody sergeants and explore opportunities for joint training with Tascor DOs.

Good practice

3.23 *Staff used a comprehensive and dynamic custody briefing document that was on the force intranet, updated daily and provided immediate information.*

Section 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

> *'I woke up after drinking heavily wondering how I ended up here. From then on the staff were friendly and accommodation was good; the custody sergeant – excellent!'*
>
> (Detainee survey comment, Abingdon suite)

4.1 Detainees were treated with respect and their diverse needs were mainly met. We observed positive and courteous interactions between custody staff and detainees, with staff using detainees' title or forename as appropriate. We saw some very challenging detainees brought into custody suites who staff dealt with professionally and used good de-escalation techniques.

4.2 However, our survey results showed that detainees were dissatisfied with some aspects of their care – for example, 54% said that another detainee or member of staff had victimised them, against the comparator of 34%, and significantly more respondents than the comparators said that the victimisation concerned insulting remarks, physical and/or sexual abuse, their disability or sexuality, in addition to other equally concerning issues.

> *'They spoke to me with terrible attitudes and presumed me guilty before charging me.'*
> *'I puked up blood in the toilet and I called an officer to get medical help; he came to the cell and flushed the toilet and said "I'm going for my interview".'*
>
> (Detainee survey comments, Abingdon suite)

4.3 During the course of the inspection we did not observe any adverse interactions between custody staff and detainees and none of the detainees we spoke to told us they had been unfairly treated. However, Thames Valley police allowed non-custody police officers significantly more access to detainees in cells than we see in many other police areas (see paragraph 4.24). This lack of demarcation between arrest and custody could perhaps explain some of the comments and results in the survey. We also noted that many custody sergeants were often 'desk bound' and not always aware about the care of detainees.

4.4 In some suites, such as Newbury, Abingdon and Banbury, detention officers (DOs) undertook some booking in under the supervision of the custody sergeant. There was little privacy in any booking-in area, none of which had screens to separate the terminals. Indeed, in some suites the terminals were very close together with two custody sergeants often booking in simultaneously – most people in the booking-in area, as well as other detainees, could hear the conversation between the custody staff and the detainee, including information of a confidential nature. We also saw staff discussing detainees in the sight and hearing of other detainees. At Maidenhead, there was a further booking-in room that could have been used to ensure privacy but, we were told, it was rarely used. Most suites had separate searching rooms, which we do not usually see in other forces. Detainees were mostly searched and put in cells by the arresting police officer.

4.5 With the exception of Milton Keynes, CCTV images of cell toilet areas were obscured, although detainees were not informed of this.

4.6 Custody sergeants told us that, where appropriate, they would let young people wait with their appropriate adult in a consultation room, or sometimes in a holding room, to avoid long periods in cells. All women detainees were asked if they wanted to speak with a female officer, but they were not routinely offered sanitary products. Custody staff were vague about whether girls under 16 should be allocated a named officer. At Maidenhead, the custody sergeant was considerate in offering a cell with a glass door to a detainee who complained of claustrophobia, but at Loddon Valley a detainee who told staff he had back pain following surgery was not offered a thick mattress, although one was available.

4.7 Staff in most suites said that they had accommodated detainees with impaired mobility with no problems. Many suites had an adapted toilet for use by detainees with disabilities.

4.8 No staff at any of the suites were aware of the availability of hearing loops, and there was no documentation in Braille. However, a scheme for people with autism was well publicised in some suites. Religious books and artefacts were available at all suites, although not always stored respectfully. Some cells in all suites (except Milton Keynes and Oxford) had an arrow on the ceiling indicating the direction of Mecca. One Muslim detainee told us that he did not know that holy books or prayer mats were available and had not been offered any, even though he would have liked to have used these during his detention.

4.9 Most DOs, but not custody sergeants, were aware that transgender detainees could be allowed a preference about the gender of the officer searching them.

Recommendations

4.10 Booking-in desks should allow effective and private communication between detainees and staff.

4.11 Staff in custody suites should have a clearer focus on the needs of all detainees, particularly children, women and those with disabilities.

Housekeeping points

4.12 CCTV images of the cell toilet areas at Milton Keynes should be obscured.

4.13 Staff should be made aware of the availability of hearing loops.

4.14 Detainees should be made aware of the availability of religious books and artefacts, which should be stored respectfully.

Safety

4.15 At most suites, we were told that arresting officers always informed custody staff when they were bringing a detainee into custody, which enabled the suite to prepare for their arrival and any special measures, if appropriate – for example, clearing the suite if the detainee was extremely violent. Loddon Valley had safety mats in the area where detainees were taken from vans into the custody suite.

4.16 We saw many custody sergeants carry out very good risk assessments. Sergeants mainly followed a list of questions on the Niche police custody IT system, and asked appropriate supplementary questions when detainees disclosed illness, self-harm or other potential risks. The police national computer (PNC) was checked in every case, but the results sometimes appeared after the risk assessment was completed, which might have necessitated revisions.

4.17 Force records showed that approximately 3% of all detainees had been strip searched in the previous 12 months, and custody officers told us that they used this power sparingly. We saw only one authorisation made during the inspection – in this case, the custody sergeant told the detainee that he would turn off the CCTV camera in the cell in which he would be searched to protect his dignity.

4.18 Some detainees were allowed to keep clothes that had cords, and most who wore spectacles could keep them. However, at Newbury we observed an arresting officer taking the decision to remove a detainee's tracksuit bottoms because they contained a cord, whereas this risk management should have been determined by the custody sergeant. This example illustrated our wider concerns about the lack of control and direction by some custody sergeants over police officers in the suites.

4.19 The risk assessments contained within care plans were proportionate and revised where necessary. Rousing checks on detainees brought into police custody while intoxicated were lifted when detainees became sober. Staff used good practice in rousing checks, varying the questions asked each time, DOs were very knowledgeable and vigilant in this area. However, we saw an exception in the case of an intoxicated detainee who had been vomiting who was put in a cell shortly after midnight without his record marked for rousing. When asked about this, the custody sergeant said, 'he seems reasonably compos mentis', which was not our view.

4.20 Although we did not observe this, we were told that detainees who would not cooperate with the risk assessment were taken straight to a cell, placed on 30-minute observations and watched on CCTV. Images of cells on the CCTV monitors at Loddon Valley were indistinct when the cell lights were dimmed. In all suites, close proximity observations involved an officer sitting at the cell door, and custody sergeants gave them a detailed briefing about the detainee.

4.21 In our analysis of 60 custody records, we found that not all observations were appropriate. One detainee for whom a health care practitioner had recommended 30-minute visits part way through detention was checked at 60-minute intervals thereafter, with no explanation of why that advice was not followed. Three detainees should have been on 30-minute checks due to intoxication, but instead were put on 60-minute visits.

4.22 Detainees were not specifically asked about dependants, although custody sergeants asked each detainee if there was anything else that might affect their stay in custody. In one custody record, the detainee disclosed that she had a young child, but this was identified later on during her detention, not in the initial risk assessment. On this occasion, custody staff asked social services to look after her child.

4.23 We noted that it was common practice for arresting officers to take detainees to cells once they had been booked in, and they did not always explain the cell facilities, such as the call bell, toilet flush and handwashing. Several detainees also told us that the use of the call bell had not been explained to them. However, we did see the bells answered promptly.

4.24 We also saw police officers freely taking cell keys from custody officers to collect and return detainees for interview and charging. This was poor practice as police officers were not trained in detainee care and were not part of the handover process. On most occasions,

DOs appeared free to undertake this task but told us that it was common for police officers to do so.

4.25 The information passed between staff at handover periods was reasonably thorough, although custody sergeants and DOs had separate handovers. This was also poor practice as it meant that staff information about a detainee might not have been shared as widely as it could have been. In addition, we observed a handover immediately next to a detainee being booked in, who was clearly listening in to the information passed between the custody officers.

4.26 At some suites, custody sergeants used a handover sheet that gave details of each detainee, including any risk factors, medical issues and any matters that were outstanding. Custody sergeants saw this as a useful tool, but it was unclear why it was needed, as handovers took place around a computer terminal and all the necessary information was accessible on the Niche system.

4.27 Most custody staff used the regular custody briefing on the force intranet to update themselves about adverse incidents, IPCC 'learning the lessons' documents and other news. However, some staff found it difficult to find the IPCC briefings and some custody sergeants were unfamiliar with their content.

4.28 Most DOs carried anti-ligature knives. Maidenhead had additional anti-ligature knives in the cell corridors, and at Loddon Valley and Aylesbury heavy duty anti-ligature shears were kept at the booking-in desk.

4.29 Staff undertook pre-release risk assessments (PRRAs) when releasing detainees, but the quality was variable. For example, we observed a DO carry out a PRRA that consisted of just two questions: had the detainee had sufficient cups of tea and how was he getting home? PRRAs at Maidenhead were better, culminating in the overall question: 'Have you got any questions or concerns before you leave us?' Our custody record analysis found that many PRRAs were very brief. In three cases, detainees were identified as having vulnerabilities but it was not clear if these had been addressed.

4.30 At all suites, we observed young people who were released only into the care of their appropriate adult. Few suites had travel warrants or money for detainees' transport home apart from Newbury, which served a largely rural area and sometimes gave out bus fares or rail warrants. However, at many suites detainees were asked how they were planning to get home and we were told that, if necessary and appropriate, police officers were asked to take them home.

4.31 Most suites had a list of support agencies although it had very little information, some of which was out of date, and custody sergeants in some suites did not know of the leaflet.

Recommendations

4.32 Custody sergeants and detention officers should receive their handovers together, in an area cleared of other staff and detainees.

4.33 Custody sergeants and custody staff should ensure that non-custodial staff do not visit detainees in cells unsupervised.

4.34 The quality of pre-release risk assessments should be improved.

Housekeeping points

4.35 The quality of the CCTV images at Loddon Valley should be improved.

4.36 Detainees should be asked during the risk assessment if they have dependants or if there is anyone about whom they have concerns.

4.37 Staff should be reminded how to access information on the intranet, such as the Independent Police Complaints Commission (IPCC) 'learning the lessons' document.

4.38 All detainees should be told about relevant available support agencies.

Use of force

4.39 Use of force in the suites was proportionate. We saw few detainees arrive in handcuffs, and those who did had them promptly removed when they were brought before the custody sergeant. Some suites had small holding booths for detainees waiting to be booked in. Next to these booths were large signs reminding arresting officers not to leave detainees in the booth in handcuffs.

4.40 We saw examples of custody staff using good de-escalation skills. We were told that the use of force in custody was rare. Any such use was recorded by each officer involved on a form that was submitted to police HQ to inform staff training. Custody staff were not aware of any analysis of use of force to identify trends.

4.41 DOs told us they had annual personal defence refresher training and were examined on it afterwards, with failure resulting in them repeating the course.

Physical conditions

4.42 All custody suites were very clean with minimal graffiti; the suite at Oxford was in need of refurbishment but, as part of the estate strategy was due to close imminently. All suites had a thorough weekly cell check with the results submitted to force HQ. We were told that faults were rectified promptly, and we saw maintenance taking place during the inspection. There were also daily checks of cells but the records of these were not always available in every suite. The design of some cells presented ligature points, and the force was not sighted on this.[5]

4.43 Some of the cells at Abingdon, Loddon Valley and Newbury were very cold, and we were told that the temperature could not be adjusted. During a night visit at Loddon Valley, we saw detainees huddled in blankets who told us they were cold. Staff were aware they were in the 'cold corridor' but had not offered to move them to warmer cells. At Newbury, a detainee was shivering in a cold cell and not given a blanket until we requested one for him.

4.44 Cells were cleaned daily by a contracted cleaner and for deep cleaning, such as for bodily fluids, we were told that an external contractor usually arrived in less than two hours.

---

[5] We have made the force aware of the details of these faults.

4.45 Each suite had a fire evacuation box containing the evacuation policy, sufficient handcuffs, reflective tabards etc. However, there were no records of emergency evacuation drills, although in some suites we were told there had been `walk-through` drills in the previous 12 months. In addition staff expressed concern that when working away from their normal place of work they were not always familiar with procedures.

Recommendations

4.46 The force should address the design issues that have raised potential ligature points.

4.47 The heating and ventilation of cells in the Abingdon, Loddon Valley and Newbury suites should be improved.

Housekeeping points

4.48 There should be clear records of daily cell checks.

4.49 Regular fire evacuation drills should take place at all suites and be recorded.

Detainee care

'*I did request for fresh air/walk in the yard – but did not happen as short staffed.*'
'*I had to request several times for a shower and to brush my teeth.*'

(Detainee survey comments, Maidenhead suite)

4.50 Not all detainees were able to be clean and comfortable while in custody. There were good stocks of mattresses and pillows, and plenty of blankets, although these were not always routinely offered (see paragraph 4.43). All suites had at least one thicker mattress, although these seemed rarely used. At Maidenhead, the thick mattress was dirty and stored outside in a garage. Some staff told us they wiped down mattresses and pillows between use with anti-bacterial products, but this did not happen at all suites

4.51 Most showers were well screened, reasonably private and had hot water, and cotton towels were available, but they were not used very often. One of five foreign national detainees held at Newbury after two weeks travelling from Syria told us he would like a shower and exercise, but neither had been offered. He was later given a shower. Although staff told us they would facilitate showers and exercise for all of them, none were offered during the 27 hours they spent in police custody. In our survey, only 4% of respondents said they had been offered a shower, although 99% said they had been held overnight.

4.52 There was toilet paper in the cells in most but not all suites, and female sanitary packs, razors, soap and toothbrushes were available, although women were not routinely told about the sanitary packs. Detainees whose clothing had been seized or was soiled were given plimsolls, tracksuit tops and bottoms, and T-shirts, with good stocks in a range of sizes, but underwear was rarely available and there was no specific safety clothing.

4.53 All suites had good supplies of microwave meals, including halal and vegetarian options. The meals were of low calorific value, but DOs told us they would give extra meals on reasonable request, and porridge was also an option. However, one detainee who had been in custody almost 40 hours told us that he had received just one microwave meal per

mealtime, despite requesting more. Drinks were offered, and we were told that relatives could bring in food if it was in factory-sealed packaging. In our custody record analysis, we found no records of meals offered to two detainees held for over eight hours.

4.54 Not all suites had exercise yards, Loddon Valley, which was a relatively modern suite, had two enclosed areas that were not open to the air but were designated as exercise yards, although they were used as storage areas. The temporary suite at Milton Keynes had no exercise area at all. Many detainees said that they had not been offered any exercise and, although we saw exercise yards in use, DOs acknowledged that they often struggled to find time to offer detainees exercise.

4.55 We saw very few detainees offered anything to read. All suites had a reasonable supply of books and magazines including, at Abingdon, Maidenhead and Oxford, some for younger readers, but, in general, magazines were old and in English only. In our custody record analysis, we found that 16 detainees were held in custody for between 12 and 48 hours and were offered no reading material, and only four detainees were offered books or magazines. Most detainees had nothing with which to occupy their time.

4.56 Staff in at all suites told us they would, in exceptional circumstances, allow social visits.

Recommendations

4.57 All detainees held overnight, or who require one, should be offered a shower, which they should be able to take in private.

4.58 All detainees who require food should be offered meals that are of good quality and sufficient calorific content.

4.59 Detainees should be offered outside exercise if they are held for long periods or overnight.

Housekeeping points

4.60 Mattresses and pillows should always be wiped down between use, and spare mattresses should be kept clean.

4.61 All detainees should be offered a blanket.

4.62 Female detainees should routinely be offered sanitary packs.

4.63 Replacement underwear should be available at all suites.

4.64 Reading material should be actively offered to detainees.

Section 5. Individual rights

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

Rights relating to detention

5.1 Custody sergeants checked the reasons for detention with arresting officers to ensure that there were appropriate grounds. Sergeants told us that they were confident in refusing detention when the circumstances did not merit arrest, and could provide details of such cases. Several custody sergeants also told us they had seen an increase in the number of officers seeking advice before making a potential arrest (to determine whether or not it would be appropriate), and we saw this taking place several times.

5.2 In addition, alternatives to custody, such as voluntary attendance, were available and many custody sergeants said that the use of this was increasing. Force data supported this, and showed that the throughput of detainees had, on average, slightly reduced over the previous 18 months.

5.3 Although we saw detainees being booked in promptly after arrival at the custody suite, their subsequent detention was not always handled as efficiently. Many detainees appeared confused and uninformed about what was happening to them, including one in custody for over 15 hours who had not yet been interviewed.

> *'It took a long time after my interview to be told I was charged.'*
> *'My solicitor was also told I would be released on bail, but I was remanded by a different officer after shift change.'*
>
> (Detainee survey comments, Banbury suite)

5.4 We observed detainees whose cases were not progressed promptly and consequently were held in custody too long. Staff and some solicitors reported, and we witnessed, a 'handover culture' in which investigations for many detainees were not progressed by arresting officers but were passed on to the following shift or another department for completion. We were told this situation was primarily due to financial constraints, as overtime was not available for officers beyond their rostered finishing times.

5.5 On one morning at Oxford custody suite, we noted that eight detainees had been arrested during the night but there was only one member of staff in the custody investigation unit. He was immediately allocated five of these cases, and the others went to officers in a different unit. It was clear that these detainees experienced a longer detention than necessary due to having to wait to be interviewed.

5.6 At Loddon Valley, we saw two young people who were arrested late into the night shift. Although a solicitor and an appropriate adult were in attendance and the arresting officers were ready for interview, we were told that, as the night shift was almost over, a `handover package` was created for the following shift. This delayed the interviews by several hours.

5.7 There was further evidence of this handover culture in our detainee survey and custody record analysis. In our survey, 99% of respondents, against the comparator of 92%, said they had been held in custody overnight, and 80%, against 69%, said they had been held for over

24 hours. Our custody record analysis showed that 47% of detainees had been detained overnight, with just 33% for less than six hours, and that the average time spent in custody was 12 hours 19 minutes. Force data showed the average detention time was approximately 10 hours.

5.8 Staff reported a good relationship with Home Office Immigration Enforcement, particularly at Oxford, where an immigration enforcement officer was based in the police station. Custody staff said that immigration detainees who were to be transferred to immigration removal centres rarely remained in the suite for longer than 24 hours. Staff at all suites told us that they believed there had been a general improvement in the time taken to process immigration detainees, but that it sometimes took a long time for immigration officers to attend. We saw examples of prompt responses. Thames Valley police had dealt with an average of 68 immigration detainees a month over the previous 18 months.

5.9 There was a useful language identification leaflet in all the suites to help determine a detainee's language. A professional telephone interpreting service was available to book in detainees with poor English, with double-handset telephones in most custody suites to aid this. Staff understood when and how to use the service, but Milton Keynes had only a single handset telephone that had to be passed backwards and forwards between staff and detainees. Aylesbury and Loddon Valley had only loudspeaker telephones, which lacked privacy and could be noisy when the suites were busy. Staff told us that a good face-to-face interpreter service was available for interviews.

5.10 Staff assured us the custody suites were never used as a place of safety for children under Section 46 of the Children Act 1989.

5.11 The force had previously adhered to the PACE definition of a child instead of that in the Children Act 1989, which meant that those aged 17 had not been provided with an appropriate adult (AA) unless they were otherwise deemed vulnerable.[6] However, following the judicial review of April 2013, the force had adopted ACPO guidance and now contacted AAs on behalf of all young people under 18, although this was applied inconsistently by custody sergeants. For example, at some suites we were told that they would not contact an AA if a 17-year-old declined the service, whereas other suites said they would ask the AA to attend the suite and then ask the young person if they wished to use the service (which is the expected practice).

5.12 Family or friends were usually contacted in the first instance to act as an AA, and the force had an informative leaflet clarifying their role and rights as an AA, which we observed was issued as required. When it was not possible to contact a relative or friend, the police used a scheme operated by social services, which provided cover for both young people and vulnerable adults. In our custody record analysis, we were unable to determine the time taken for an AA to attend the custody suite as there was no record of their arrival, which was poor record keeping

5.13 Custody staff reported that social services AAs would not attend after 11pm, but custody sergeants told us that, if appropriate, they would bail a young person to a time when an AA was available. However, at Milton Keynes we observed a 15-year-old arrested at 9.15pm for alleged threats against family members, ruling out their use as AAs, who was not released until 11.30am the following morning as no AA from the social services scheme was available until 9am. There was an attempt to find him alternative accommodation overnight through

---

[6] In all other UK law and international treaty obligations, 17-year-olds are treated as children. In April 2013, the High Court ruled that the PACE definition was incompatible with human rights law.

the local authority, but none was available. Staff said they would request secure accommodation from the local authority in all cases where a young person had been charged and could not be bailed, but most reported they had never known this to be available.

5.14 During booking in, staff gave detainees a detailed leaflet summarising their rights and entitlements. However, not all detainees accepted a copy. A similar version could be downloaded from the custody intranet and printed for non-English-speaking detainees in their own language. Custody staff were well informed of how to access translated documents. At Loddon Valley, staff referred to a folder that contained copies of foreign nationals' rights and entitlements, but these were out of date. In our custody record analysis, only one of the two foreign national cases was recorded as having been informed of their relevant rights.

5.15 None of the custody staff were aware that there was an easy-read pictorial format version of detainees' rights and entitlements on the Home Office website. The rights and entitlements documentation was not available in Braille in any custody suites. Staff were aware of the sign language interpreting service available.

Recommendations

5.16 Appropriate adults should be available out of hours for young people and vulnerable adults.

5.17 Thames Valley Police should engage with the local authorities to ensure the provision of safe beds for young people who have been charged but cannot be bailed.

Housekeeping points

5.18 Detainees should be kept informed of the progress of their case where possible.

5.19 Thames Valley police should ensure that there are no unnecessary delays in progressing detainees' cases because of 'handovers'.

5.20 The force should reiterate to staff the ACPO guidance about 17-year-old detainees being offered the services of an appropriate adult.

5.21 Attendance times for appropriate adults should be clearly recorded on custody records for monitoring purposes.

5.22 Double-handset telephones should be provided in all suites to facilitate telephone interpreting.

Rights relating to PACE

5.23 Custody sergeants routinely and clearly informed detainees of their three main rights (to have legal representation, someone notified of their whereabouts and read a copy of the PACE codes of practice). There was a good supply of up-to-date PACE codes of practice in each suite. In our custody record analysis, most records of the detainees who wished to have someone told about their detention clearly recorded whether the nominated person was informed. Additionally, seven detainees were able to make a telephone call while

detained. In our survey, only 24% of respondents, against the comparator of 50%, said they had been offered a free telephone call.

5.24 All detainees were offered legal representation. However during the inspection, in Oxford the duty solicitor had five detainees to deal with at the same time and was already at another custody suite representing a detainee; the custody sergeant had requested that another solicitor be brought in to prevent detainees remaining in custody too long. This situation needed to be monitored as it was clear that detention had been extended as a result.

5.25 We found Criminal Defence Service posters advising detainees of their right to free legal advice displayed in only half the custody suites. Where displayed, they were usually supported by an additional poster in several languages explaining the right for legal advice. All custody suites had a cordless telephone that could be taken to a detainee's cell or a glass-fronted holding room to allow private telephone consultation between a detainee and their solicitor. There was an exception to this in Milton Keynes, where a telephone in the breath test equipment room was used for this purpose.

5.26 We saw solicitors routinely offered the front sheet or non-police view printout of their client's custody record without having to request this. There were sufficient consultation and interview rooms.

5.27 In our custody record analysis, all detainees had routinely been offered legal advice and 32 (53%) accepted this offer. All the records indicated that solicitors were contacted shortly after they were requested. We also observed custody sergeants asking detainees why they had declined legal advice.

5.28 Reviews of detainees in custody were undertaken by several custody and operational inspectors across the force area. We observed some very good reviews by inspectors. Staff in outlying stations reported that many PACE reviews were carried out over the telephone because of the distances between custody suites, although we saw a mix of face-to-face and telephone reviews during the inspection. We also observed detainees being advised of reviews that had taken place while they were asleep and reminded of their rights and entitlements.

5.29 Of the 36 records in our custody record analysis, 15 showed reviews that were conducted on time, 17 were early (between 50 minutes and five hours) and three were late. Most of these reviews took place face to face; 13 took place while the detainee was sleeping, and in all but two cases they were reminded of their rights and entitlements when they woke up.

5.30 There was an effective system to ensure that DNA samples taken in custody were collected regularly. However, unlike in other forces we have visited (where samples are immediately placed in a freezer), samples were kept at room temperature for several hours before they were put in a fridge outside of the custody area.

5.31 We were told that court cut-off times could be as early as noon on weekdays and 9am on Saturday, with limited flexibility each day. At Newbury custody suite, we observed staff negotiating with the local court for a detainee who had been brought in at 11.30am on a warrant to be permitted to attend court. At Loddon Valley, we saw Reading magistrates' court refuse to accept a detainee at 1.50pm, while at Milton Keynes the magistrates' court accepted a detainee at 12.45pm but insisted he was there by 1pm. These early court cut-off times contributed to detainees remaining in custody too long.

5.32 Detainees kept overnight for the morning court were mostly transported there on time, although we observed one male detainee in at Banbury was not collected until 11.35am, even though the magistrates' court was next door. Also at Banbury, the prisoner escort contractor was unable to provide transport for a pregnant female detainee, resulting in

police officers having to walk her in handcuffs from the custody suite through the street into the public entrance of the court and then into the court cell area. That same day, Banbury court staff also refused to accept a 15-year-old detainee into their custody, which meant that he too had to be walked to the court by police officers. At High Wycombe, we observed a detainee in handcuffs who was walked through the main police station reception to board the escort vehicle, which was parked on the public road outside. At Milton Keynes, we saw detainees returned from two different magistrates' courts who would not deal with them, for a further night in police custody. Although these practices were unacceptable, police custody staff accepted them as normal and rarely reported them to their management.

Recommendations

5.33 Senior police managers should engage with HM Courts and Tribunal Service and the prisoner escort contractor to ensure that detainees are not held in police custody for longer than necessary.

5.34 Where detainees are transferred, this should always be done safely and in a secure timely manner which does not involve movement through any public area.

Housekeeping points

5.35 Posters detailing detainees' right to free legal advice in a range of languages should be prominently displayed in all custody suites.

5.36 PACE reviews should be carried out on time.

5.37 The force should ensure that the way that DNA samples are handled and stored does not risk the integrity of these samples unnecessarily.

Rights relating to treatment

5.38 The notice of rights and entitlements, given to all detainees when they were booked in, detailed the processes for making a complaint. Detainees who we spoke to who had taken the notice to their cells were aware of how to make a complaint. Custody staff had a mixed response to how they would handle a detainee wishing to make a complaint – some said they would notify the PACE inspector or duty inspector immediately (and we saw this take place), while others said they would advise detainees to make a complaint at the police station front counter following their release. The latter had the potential to reduce the number of complaints made as detainees are less likely to make a complaint in their own time than while they are in custody. There was no consideration of how to take complaints from detainees who were not released from custody and taken directly to court.

5.39 Custody inspectors were aware of the process of taking complaints and said that each complaint form submitted was logged and sent to the professional standards department, where they were analysed for patterns and trends.

Housekeeping point

5.40 Custody staff should be reminded that detainees who want to make a complaint about their care and treatment should be able to do this before they leave custody.

Section 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.

Governance

6.1 Thames Valley police commissioned forensic medical examiners (FMEs), as independent contractors, to provide medical services across the custody suites. There was one principal FME, five seniors and 39 doctors who worked up to 48 hours a week. NHS England had commenced work with the force to prepare for NHS commissioning in 2014, managers told us that with hindsight they regretted that they had not done this earlier.

6.2 Clinical governance arrangements were not robust enough and we were concerned about the lack of accountability for individual clinicians. There were limited training opportunities and inconsistent arrangement for clinical supervision and appraisals. For example, the only peer group training and supervision was in Milton Keynes.

6.3 Although there were regular monthly and quarterly meetings to discuss clinical issues, there were no service monitoring meetings and attendance times of FMEs were not formally monitored or reported. The conduct and practices of some FMEs had been the subject of complaints by custody staff 15 times in the previous two years, and 11 complaints had been upheld or partially upheld. Consequent management actions were appropriate, including referral to the General Medical Council as necessary.

6.4 The clinical rooms in each custody suite were of an acceptable standard and needed minor alterations to meet current infection control guidance. There had been no infection control audits and plans for these were in their infancy. Some areas were dusty and there was a large amount of disposable equipment that was out of date, such as syringes, testing kits and hand wash materials. Not all the facilities (such as fridges and medicine cabinets) were suitable to store medical equipment. The use of refrigerators was unsatisfactory – none had thermometers or were lockable, and we saw food and drink stored in one.

6.5 Each custody suite had an emergency equipment bag that was easily accessible for all staff. It contained a range of kit, including oxygen and an automated external defibrillator. Custody staff checked all emergency equipment weekly. Detention officers were trained in intermediate life support and we were satisfied that this was yearly. Custody sergeants were trained in basic life support. All doctors were expected to be trained in intermediate life support but this was not always the case.

Recommendations

6.6 There should be robust governance arrangements to monitor health service provision, including attendance times, training, supervision and accountability of individual practitioners in their clinical practice.

6.7 There should be regular infection control audits.

Housekeeping points

6.8 All medical equipment should be fit for purpose, and expiry dates should be checked regularly and out-of-date equipment replaced.

6.9 All medical staff should be up to date with mandatory training, such as resuscitation and defibrillation.

Patient care

6.10 From our observations, detainees who saw a doctor received a reasonable service. However, not all detainees got the same level of patient care because of the differing attendance times across the force area. Under the contract, attendance was within specific time scales; however this was not sufficiently monitored and we were informed of a number of delays (see example below and recommendation 6.6). The FME service was available 24 hours a day and doctors covered identified areas as part of a 12-hour shift. We were told that some clinicians continued to work in their practice while contracted to Thames Valley, and that night shifts were occasionally followed by day shifts and work in other clinical areas. We did not have confidence in the provision of health services and the subsequent outcomes for detainees.

6.11 We observed a detainee who arrived in custody in the early hours of the morning who required a medical opinion. It was a busy weekend and the demand for the doctor was high. The doctor who was contacted at 7.34am had two other custody suites to visit in the county and did not examine the detainee until 4pm, that is eight hours 28 minutes after being called. At 4.30pm it was documented that no mental health assessment was required, and the detainee was charged and bailed at 6.26pm.

6.12 FMEs used the police Niche IT system to keep custody staff informed about the health needs of detainees, but the information was not always sufficient. Most clinicians kept records in a notebook, which they were required to store in a lockable safe at their home. However, not all doctors knew about their responsibilities under the Caldicott principles on the confidentiality of personal health information or Data Protection Act. We had concerns that at least one FME used his mobile telephones to store sensitive patient information, including photographs of injuries.

6.13 A telephone interpreting service was available for detainees who could not speak English, but not all medical rooms had access to a three-way telephone. Detainees were not told that they could request to see a health professional of their own gender. There was very little health promotion information for detainees in clinical rooms.

6.14 There were some efforts to obtain opiate substitution medication for detainees, but this was not consistent across all the custody suites. There was no consistency in the prescribing of methadone, and the draft policy was vague and relied too much on individual decision making.

6.15 A recent medication review was in draft form and had no recommendations. We identified only minor changes since its circulation, and had several concerns about the storage and management of medicines. The availability of stock varied in each area, and we found many out-of-date medicines. Some doctors carried their own medicines and we were concerned about the governance of these. There was no process to account for the stock items in suites, and ordering was inconsistent across the force area. Nobody we contacted was able to identify the accountable officer, and we were alarmed by the lack of monitoring of medications liable to abuse (such as the stimulant Ritalin, diazepam and dihydrocodeine.).

Pharmacy and medical reference literature (such as the *British National Formulary*) were out of date.

6.16 As the doctors did not use the prescribing module on Niche, detention officers transcribed prescriptions on to the system, which could have led to medication errors. Detention officers told us that they could not always read the doctor's handwriting, and multiple medications were regularly placed in envelopes and so they did not know what they were administering. This was not acceptable.

Recommendations

6.17 Clinical records should meet professional requirements and be subject to regular audit.

6.18 There should be robust audit and reporting processes to account for the ordering, storage, prescribing and administration of medications, including the recording of all medications liable to abuse.

Housekeeping points

6.19 Health promotion information should be available for detainees in clinical rooms.

6.20 All pharmacy and medical reference literature should be up to date.

Substance misuse

6.21 Access to substance misuse services for adults was reasonably good, but insufficient for young people, according to local youth offending teams. The Thames Valley police custody intervention programme (CIP) commissioned Smart (a charity offering substance misuse arrest referral teams) to provide drug and alcohol services for detainees in the custody suites. Custody intervention drug workers were based in all suites except Aylesbury, where there was a service on request. They were available from 7am until 10pm on weekdays and 7am until 3pm at the weekend. Where appropriate, adults were encouraged to engage voluntarily with services and could be offered advice, information and brief interventions or referrals to local services. Voluntary drug testing was offered and compulsory testing was available on suspicion or following risk assessment. Regular steering group meetings were held and we saw monthly data collation, which was managed reasonably well by a support officer.

6.22 Workers reported good relationships with custody staff and good systems of referral to community services. Young people were signposted to community drug and alcohol services, such as Young Addaction. There were no needle exchange schemes in the custody suites, but we were assured that such services were available locally.

Mental health

6.23 The availability of mental health services in the custody suites was poor, and too many people were detained unnecessarily under section 136 of the Mental Health Act.[7] There was an identified strategic lead police officer for mental health in Thames Valley police, who was well engaged in the review of mental health provision, partnership working and development of relevant protocols.

6.24 Berkshire Healthcare NHS Trust delivered services in Berkshire, Oxford Health NHS Trust in Buckinghamshire and Oxfordshire, and Central and North West London NHS Trust in Milton Keynes. Police work was coordinated by a health partnership board that met regularly, underpinned by a comprehensive inter-agency protocol for joint working and information sharing. Local 'problems in practice' groups met regularly and attended to day-to-day difficulties. Despite these strategic arrangements, little had developed in practice. Many plans were disjointed and commissioning arrangements were too complicated.

6.25 Custody intervention drug workers undertook mental health and learning disability screening in police custody. In April 2013, there had been 222 screens completed, which resulted in 34 referrals to mental health services. There were no liaison and diversion services in the custody suites. There was a 'Divert' scheme in Berkshire and project plans for Oxfordshire and Buckinghamshire, but the FMEs were unaware they could refer to these teams. Some custody staff said they had received instruction in mental health awareness.

6.26 Detainees requiring urgent mental state assessments saw an FME who, where necessary, referred on to an emergency duty team to undertake a formal Mental Health Act assessment. Arrival times of emergency teams varied; some assessments were prompt (within two to four hours), but custody staff said that they could wait for up to 18 hours for assessments to commence, and we saw documented evidence that confirmed these waits. Custody staff at Newbury reported that a four to six hours wait was more common. We contacted two emergency duty teams on a Saturday night and were informed that it would take two to three hours for one to arrive, which was reasonably good. There were monthly meetings attended by representatives from relevant trusts and the police to discuss issues around section 136. The meetings relied too much on the police's strategic lead, and attendance by partners varied across the force area.

6.27 There was good monitoring by the force of use of section 136 and, while there were variations between suites, it had been used on average 88 times a month in the year to the end of June 2013. A third of these detainees (33.4%) were taken to police custody, which was too many. Although 59.6% of detainees were reported as intoxicated or violent, custody staff believed that there were insufficient staff or beds in NHS places of safety to meet demand. At the time of our visit, detainees had not had access to the section 136 facility at Reading for six weeks. As a result, 18 patients were taken into police custody in Maidenhead. This was unacceptable and we were very concerned that clinical commissioning groups did not robustly monitor the use of section 136 suites (see main recommendation 2.31).

---

[7] Section 136 of the Mental Health Act 1983 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.

Recommendations

6.28 The police health partnership board should ensure that there are mental health diversion and liaison services in all police custody suites.

6.29 The force should work with all relevant organisations to ensure robust monitoring of the use of police custody and section 136 suites.

Section 7. Summary of recommendations

Main recommendations

To Thames Valley police

7.1 The force should use meetings with partner organisations to drive forward improvements in detainee care, particularly in their attendance at court. (2.29)

7.2 The force should expedite NHS commissioning of both physical and mental health services for detainees as a matter of urgency. (2.30)

7.3 The force should work with all relevant organisations to ensure there is sufficient capacity for detainees to receive prompt assessment under section 136 of the Mental Health Act 1983. (2.31)

Recommendation

To Thames Valley police and Tascor

7.4 Detention Officers should be deployed effectively in a consistent way. (3.8)

Recommendations

To Thames Valley police

Strategy

7.5 The force should encourage staff to refer to managers any issues that affect detainees adversely, and ensure that such issues can be raised with partners through attendance at local criminal justice meetings. (3.15)

7.6 There should be a quality assurance process for sampling custody records, which is corporate, recorded, has an audit trail of feedback and dissemination to staff, and which informs refresher training. The process should also include cross-referencing to person escort records and CCTV. There should be a similar provision for shift handovers. (3.21)

Treatment and conditions

7.7 Booking-in desks should allow effective and private communication between detainees and staff. (4.10)

7.8 Staff in custody suites should have a clearer focus on the needs of all detainees, particularly children, women and those with disabilities. (4.11)

7.9 Custody sergeants and detention officers should receive their handovers together, in an area cleared of other staff and detainees. (4.32)

7.10 Custody sergeants and custody staff should ensure that non-custodial staff do not visit detainees in cells unsupervised. (4.33)

7.11 The quality of pre-release risk assessments should be improved. (4.34)

7.12 The force should address the design issues that have raised potential ligature points. (4.46)

7.13 The heating and ventilation of cells in the Abingdon, Loddon Valley and Newbury suites should be improved. (4.47)

7.14 All detainees held overnight, or who require one, should be offered a shower, which they should be able to take in private. (4.57)

7.15 All detainees who require food should be offered meals that are of good quality and sufficient calorific content. (4.58)

7.16 Detainees should be offered outside exercise if they are held for long periods or overnight. (4.59)

Individual rights

7.17 Appropriate adults should be available out of hours for young people and vulnerable adults. (5.16)

7.18 Thames Valley Police should engage with the local authorities to ensure the provision of safe beds for young people who have been charged but cannot be bailed. (5.17)

7.19 Senior police managers should engage with HM Courts and Tribunal Service and the prisoner escort contractor to ensure that detainees are not held in police custody for longer than necessary. (5.33)

7.20 Where detainees are transferred, this should always be done safely and in a secure timely manner which does not involve movement through any public area. (5.34)

Health care

7.21 There should be robust governance arrangements to monitor health service provision, including attendance times, training, supervision and accountability of individual practitioners in their clinical practice. (6.6)

7.22 There should be regular infection control audits. (6.7)

7.23 Clinical records should meet professional requirements and be subject to regular audit. (6.17)

7.24 There should be robust audit and reporting processes to account for the ordering, storage, prescribing and administration of medications, including the recording of all medications liable to abuse. (6.18)

7.25 The police health partnership board should ensure that there are mental health diversion and liaison services in all police custody suites. (6.28)

7.26 The force should work with all relevant organisations to ensure robust monitoring of the use of police custody and section 136 suites. (6.29)

Housekeeping points

Strategy

7.27 The force should introduce a user group for custody staff to give them the opportunity to discuss and raise issues with managers. (3.9)

7.28 The force should deliver its plans to introduce regular custody refresher training for custody sergeants and explore opportunities for joint training with Tascor DOs. (3.22)

Treatment and conditions

7.29 CCTV images of the cell toilet areas at Milton Keynes should be obscured. (4.12)

7.30 Staff should be made aware of the availability of hearing loops. (4.13)

7.31 Detainees should be made aware of the availability of religious books and artefacts, which should be stored respectfully. (4.14)

7.32 The quality of the CCTV images at Loddon Valley should be improved. (4.35)

7.33 Detainees should be asked during the risk assessment if they have dependants or if there is anyone about whom they have concerns. (4.36)

7.34 Staff should be reminded how to access information on the intranet, such as the Independent Police Complaints Commission (IPCC) 'learning the lessons' document. (4.37)

7.35 All detainees should be told about relevant available support agencies. (4.38)

7.36 There should be clear records of daily cell checks. (4.48)

7.37 Regular fire evacuation drills should take place at all suites and be recorded. (4.49)

7.38 Mattresses and pillows should always be wiped down between use, and spare mattresses should be kept clean. (4.60)

7.39 All detainees should be offered a blanket. (4.61)

7.40 Female detainees should routinely be offered sanitary packs. (4.62)

7.41 Replacement underwear should be available at all suites. (4.63)

7.42 Reading material should be actively offered to detainees. (4.64)

Individual rights

7.43 Detainees should be kept informed of the progress of their case where possible. (5.18)

7.44 Thames Valley police should ensure that there are no unnecessary delays in progressing detainees' cases because of 'handovers'. (5.19)

7.45 The force should reiterate to staff the ACPO guidance about 17-year-old detainees being offered the services of an appropriate adult. (5.20)

7.46 Attendance times for appropriate adults should be clearly recorded on custody records for monitoring purposes. (5.21)

7.47 Double-handset telephones should be provided in all suites to facilitate telephone interpreting. (5.22)

7.48 Posters detailing detainees' right to free legal advice in a range of languages should be prominently displayed in all custody suites. (5.35)

7.49 PACE reviews should be carried out on time. (5.36)

7.50 The force should ensure that the way that DNA samples are handled and stored does not risk the integrity of these samples unnecessarily. (5.37)

7.51 Custody staff should be reminded that detainees who want to make a complaint about their care and treatment should be able to do this before they leave custody. (5.40)

Health care

7.52 All medical equipment should be fit for purpose, and expiry dates should be checked regularly and out-of-date equipment replaced. (6.8)

7.53 All medical staff should be up to date with mandatory training, such as resuscitation and defibrillation. (6.9)

7.54 Health promotion information should be available for detainees in clinical rooms. (6.19)

7.55 All pharmacy and medical reference literature should be up to date. (6.20)

Good practice

7.56 Staff used a comprehensive and dynamic custody briefing document that was on the force intranet, updated daily and provided immediate information. (3.23)

Section 8. Appendices

Appendix I: Inspection team

Elizabeth Tysoe	HMIP team leader
Gary Boughen	HMIP inspector
Peter Dunn	HMIP inspector
Vinnett Pearcy	HMIP inspector
Fiona Shearlaw	HMIP inspector
Paul Davies	HMIC lead staff officer
Mark Ewan	HMIC staff officer
Helen Carter	HMIP health services inspector
Paul Tarbuck	HMIP health services inspector
Tim Brackpool	Care Quality Commission inspector
Ewan Kennedy	HMIP researcher
Alissa Redmond	HMIP researcher

Appendix II: Summary of detainee questionnaires and interviews

Prisoner survey methodology

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

Choosing the sample size

The survey was conducted on 2 September 2013. A list of potential respondents to have passed through Abingdon, Aylesbury, Banbury, High Wycombe, Reading, Maidenhead, Milton Keynes, Newbury and Oxford police stations was created, listing all those who had arrived from Amersham, Banbury, Bracknell, High Wycombe, Maidenhead, Milton Keynes, Newbury or Slough magistrates' courts or Aylesbury, Oxford, and Reading magistrates' or Crown courts within the past two months.

Selecting the sample

In total, 155 respondents were approached. Forty-seven respondents reported being held in police stations outside of Thames Valley. On the day, the questionnaire was offered to 108 respondents; there were six refusals, six questionnaires returned blank and 13 non-returns. All of those sampled had been in custody within the last two months.

Completion of the questionnaire was voluntary. No respondents were interviewed.

Methodology

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

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

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

Response rates

In total, 83 (77%) 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 68 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 overnight' 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 those shown in the comparison data as the comparator data have been weighted for comparison purposes.

Survey results

Section 1: About you

Q2 Which police station were you last held at?

Abingdon – 7
Aylesbury – 2
Banbury – 7
Maidenhead – 14
Newbury – 6
Oxford – 10
Reading – 31
Unknown – 6

Q3 How old are you?

16 years or younger	0 (0%)	*40-49 years*	12 (14%)
17-21 years	7 (8%)	*50-59 years*	3 (4%)
22-29 years	29 (35%)	*60 years or older*	1 (1%)
30-39 years	31 (37%)		

Q4 Are you:

Male	82 (100%)
Female	0 (0%)
Transgender/Transsexual	0 (0%)

Q5 What is your ethnic origin?

White - British	54 (66%)
White - Irish	2 (2%)
White - other	2 (2%)
Black or black British - Caribbean	5 (6%)
Black or black British - African	2 (2%)
Black or black British - other	0 (0%)
Asian or Asian British - Indian	3 (4%)
Asian or Asian British - Pakistani	5 (6%)
Asian or Asian British - Bangladeshi	1 (1%)
Asian or Asian British - other	0 (0%)
Mixed heritage - white and black Caribbean	5 (6%)
Mixed heritage - white and black African	0 (0%)
Mixed heritage- white and Asian	0 (0%)
Mixed heritage - Other	2 (2%)
Chinese	0 (0%)
Other ethnic group	1 (1%)

Q6 Are you a foreign national (i.e. you do not hold a British passport, or you are not eligible for one)?

Yes	10 (13%)
No	70 (88%)

Q7 What, if any, is your religion?

None	30 (38%)
Church of England	20 (26%)
Catholic	15 (19%)
Protestant	0 (0%)

	Other Christian denomination	1 (1%)
	Buddhist	1 (1%)
	Hindu	2 (3%)
	Jewish	0 (0%)
	Muslim	9 (12%)
	Sikh	0 (0%)
Q8	**How would you describe your sexual orientation?**	
	Straight/heterosexual	83 (100%)
	Gay/lesbian/homosexual	0 (0%)
	Bisexual	0 (0%)
Q9	**Do you consider yourself to have a disability?**	
	Yes	17 (21%)
	No	64 (79%)
Q10	**Have you ever been held in police custody before?**	
	Yes	81 (98%)
	No	2 (2%)

Section 2: Your experience of the police custody suite

Q11	**How long were you held at the police station?**	
	Less than 24 hours	16 (20%)
	More than 24 hours, but less than 48 hours (2 days)	45 (56%)
	More than 48 hours (2 days), but less than 72 hours (3 days)	13 (16%)
	72 hours (3 days) or more	6 (8%)
Q12	**Were you told your rights when you first arrived there?**	
	Yes	65 (78%)
	No	11 (13%)
	Don't know/Can't remember	7 (8%)
Q13	**Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')?**	
	Yes	48 (59%)
	No	28 (34%)
	I don't know what this is/I don't remember	6 (7%)
Q14	**If your clothes were taken away, what were you offered instead?**	
	My clothes were not taken	49 (64%)
	I was offered a tracksuit to wear	12 (16%)
	I was offered an evidence/ paper suit to wear	4 (5%)
	*I was **only** offered a blanket*	6 (8%)
	Nothing	6 (8%)
Q15	**Could you use a toilet when you needed to?**	
	Yes	80 (96%)
	No	3 (4%)
	Don't know	0 (0%)
Q16	**If you used the toilet there, was toilet paper provided?**	
	Yes	30 (37%)
	No	52 (63%)

Q17 How would you rate the condition of your cell:

	Good	*Neither*	*Bad*
Cleanliness	32 (39%)	24 (29%)	27 (33%)
Ventilation/air quality	18 (22%)	25 (30%)	39 (48%)
Temperature	13 (16%)	19 (23%)	50 (61%)
Lighting	31 (38%)	25 (31%)	25 (31%)

Q18 Was there any graffiti in your cell when you arrived?

Yes	39 (48%)
No	43 (52%)

Q19 Did staff explain to you the correct use of the cell bell?

Yes	15 (18%)
No	68 (82%)

Q20 Were you held overnight?

Yes	81 (99%)
No	1 (1%)

Q21 If you were held overnight, which items of bedding were you given? (Please tick all that apply to you.)

Not held overnight	1 (1%)
Pillow	40 (48%)
Blanket	70 (84%)
Nothing	9 (11%)

Q22 If you were given items of bedding, were these clean?

Not held overnight /Did not get any bedding	10 (13%)
Yes	39 (49%)
No	30 (38%)

Q23 Were you offered a shower at the police station?

Yes	3 (4%)
No	80 (96%)

Q24 Were you offered any period of outside exercise while there?

Yes	4 (5%)
No	79 (95%)

Q25 Were you offered anything to:

	Yes	*No*
Eat?	65 (79%)	17 (21%)
Drink?	66 (84%)	13 (16%)

Q26 What was the food/drink like in the police custody suite?

Very good	*Good*	*Neither*	*Bad*	*Very bad*	*N/A*
0 (0%)	11 (13%)	12 (14%)	19 (23%)	32 (39%)	9 (11%)

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

I did not have any food or drink	9 (11%)
Yes	36 (44%)
No	36 (44%)

Q28 If you smoke, were you offered anything to help you cope with not being able to smoke? (Please tick all that apply to you.)

I do not smoke	12 (14%)

	I was allowed to smoke	3 (4%)
	I was offered a nicotine substitute	5 (6%)
	I was not offered anything to cope with not smoking	64 (77%)

Q29 Were you offered anything to read?

Yes	14 (17%)
No	69 (83%)

Q30 Was someone informed of your arrest?

Yes	32 (39%)
No	33 (40%)
I don't know	5 (6%)
I didn't want to inform anyone	12 (15%)

Q31 Were you offered a free telephone call?

Yes	20 (24%)
No	63 (76%)

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

My telephone call was not denied	20 (29%)
Yes	7 (10%)
No	43 (61%)

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

	Yes	*No*
Who was taking care of your children	9 (15%)	53 (85%)
Contacting your partner, relative or friend	43 (56%)	34 (44%)
Contacting your employer	17 (26%)	48 (74%)
Where you were going once released	26 (36%)	47 (64%)

Q34 Were you offered free legal advice?

Yes	73 (88%)
No	10 (12%)

Q35 Did you accept the offer of free legal advice?

Was not offered free legal advice	10 (12%)
Yes	56 (69%)
No	15 (19%)

Q36 Were you interviewed by police about your case?

Yes	76 (93%)
No	6 (7%)

Q37 Was a solicitor present when you were interviewed?

Did not ask for a solicitor / Was not interviewed	8 (10%)
Yes	59 (72%)
No	15 (18%)

Q38 Was an appropriate adult present when you were interviewed?

Did not need an appropriate adult / Was not interviewed	47 (59%)
Yes	11 (14%)
No	22 (28%)

Q39 Was an interpreter present when you were interviewed?

Did not need an interpreter / Was not interviewed	48 (60%)

Yes	1 (1%)
No	31 (39%)

Section 3: Safety

Q41 Did you feel safe there?

Yes	45 (56%)
No	36 (44%)

Q42 Did a member of staff victimise (insulted or assaulted) you there?

Yes	44 (54%)
No	38 (46%)

Q43 If you were victimised by staff, what did the incident involve? (Please tick all that apply to you.)

I have not been victimised	38 (47%)	*Because of your crime*	22 (27%)
Insulting remarks (about you, your family or friends)	31 (38%)	*Because of your sexuality*	10 (12%)
Physical abuse (being hit, kicked or assaulted)	23 (28%)	*Because you have a disability*	15 (19%)
Sexual abuse	17 (21%)	*Because of your religion/religious beliefs*	7 (9%)
Your race or ethnic origin	26 (32%)	*Because you are from a different part of the country than others*	3 (4%)
Drugs	10 (12%)		

Q44 Were your handcuffs removed on arrival at the police station?

Yes	62 (77%)
No	16 (20%)
I wasn't handcuffed	3 (4%)

Q45 Were you restrained whilst in the police custody suite?

Yes	14 (18%)
No	65 (82%)

Q46 Were you injured while in police custody, in a way that was not your fault?

Yes	17 (21%)
No	65 (79%)

Q47 Were you told how to make a complaint about your treatment if you needed to?

Yes	8 (10%)
No	74 (90%)

Q48 How were you treated by staff in the police custody suite?

Very well	*Well*	*Neither*	*Badly*	*Very badly*	*Don't remember*
6 (7%)	20 (24%)	22 (27%)	12 (15%)	20 (24%)	2 (2%)

Section 4: Health care

Q50 Did someone explain your entitlements to see a health care professional, if you needed to?

Yes	24 (29%)
No	54 (65%)
Don't know	5 (6%)

Q51 Were you seen by the following health care professionals during your time there?

	Yes	*No*
Doctor	42 (53%)	38 (48%)
Nurse	3 (5%)	54 (95%)
Paramedic	1 (2%)	53 (98%)

Q52 Were you able to see a health care professional of your own gender?

Yes	28 (34%)
No	42 (51%)
Don't know	13 (16%)

Q53 Did you need to take any prescribed medication when you were in police custody?

Yes	46 (55%)
No	37 (45%)

Q54 Were you able to continue taking your prescribed medication while there?

Not taking medication	37 (46%)
Yes	11 (14%)
No	33 (41%)

Q55 Did you have any drug or alcohol problems?

Yes	44 (53%)
No	39 (47%)

Q56 Did you see, or were you offered the chance to see a drug or alcohol support worker?

I didn't have any drug/alcohol problems	39 (47%)
Yes	17 (20%)
No	27 (33%)

Q57 Were you offered relief or medication for your immediate withdrawal symptoms?

I didn't have any drug/alcohol problems	39 (48%)
Yes	12 (15%)
No	30 (37%)

Q58 Please rate the quality of your health care while in police custody:

I was not seen by health care	*Very good*	*Good*	*Neither*	*Bad*	*Very bad*
38 (46%)	3 (4%)	9 (11%)	13 (16%)	7 (8%)	13 (16%)

Q59 Did you have any specific <u>physical</u> health care needs?

Yes	35 (43%)
No	47 (57%)

Q60 Did you have any specific <u>mental</u> health care needs?

Yes	19 (23%)
No	64 (77%)

Q61 If you had any mental health care needs, were you seen by a mental health nurse / psychiatrist?

I didn't have any mental health care needs	64 (77%)
Yes	0 (0%)
No	19 (23%)

Prisoner survey responses for Thames Valley Police 2013

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

		Thames Valley Police 2013	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		83	2535
SECTION 1: General information			
3	Are you under 21 years of age?	**8%**	**11%**
4	Are you transgender/transsexual?	**0%**	**0%**
5	Are you from a minority ethnic group? (Including all those who did not tick white British, white Irish or white other categories)	**29%**	**29%**
6	Are you a foreign national?	**13%**	**16%**
7	Are you Muslim?	**12%**	**10%**
8	Are you homosexual/gay or bisexual?	**0%**	**2%**
9	Do you consider yourself to have a disability?	**21%**	**20%**
10	Have you been in police custody before?	**98%**	**92%**
SECTION 2: Your experience of this custody suite			
11	Were you held at the police station for over 24 hours?	**80%**	**69%**
12	Were you told your rights when you first arrived?	**78%**	**79%**
13	Were you told about PACE?	**59%**	**51%**
For those who had their clothing taken away:			
14	Were you given a tracksuit to wear?	**42%**	**42%**
15	Could you use a toilet when you needed to?	**96%**	**91%**
16	If you used the toilet, was toilet paper provided?	**37%**	**48%**
17	Would you rate the condition of your cell, as 'good' for:		
17a	Cleanliness?	**38%**	**34%**
17b	Ventilation/air quality?	**22%**	**23%**
17c	Temperature?	**16%**	**17%**
17d	Lighting?	**38%**	**44%**
18	Was there any graffiti in your cell when you arrived?	**48%**	**53%**
19	Did staff explain the correct use of the cell bell?	**18%**	**24%**
20	Were you held overnight?	**99%**	**92%**
For those who were held overnight:			
21	Were you given any items of bedding?	**89%**	**87%**
For those who were held overnight and were given items of bedding:			
22	Were these clean?	**57%**	**61%**
23	Were you offered a shower?	**4%**	**10%**
24	Were you offered a period of outside exercise?	**5%**	**6%**

Key to tables

		Thames Valley Police 2013	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		
25a	Were you offered anything to eat?	**80%**	**81%**
25b	Were you offered anything to drink?	**83%**	**84%**
For those who had food/drink:			
26	Was the quality of the food and drink you received good/very good?	**15%**	**13%**
27	Was the food/drink you received suitable for your dietary requirements?	**50%**	**44%**
For those who smoke:			
28	Were you offered anything to help you cope with not being able to smoke?	**8%**	**6%**
29	Were you offered anything to read?	**17%**	**14%**
30	Was someone informed of your arrest?	**39%**	**44%**
31	Were you offered a free telephone call?	**24%**	**50%**
If you were denied a free telephone call:			
32	Was a reason given?	**13%**	**14%**
33	Did you have any concerns about:		
33a	Who was taking care of your children?	**15%**	**13%**
33b	Contacting your partner, relative or friend?	**56%**	**52%**
33c	Contacting your employer?	**26%**	**18%**
33d	Where you were going once released?	**36%**	**30%**
34	Were you offered free legal advice?	**88%**	**88%**
For those who were offered free legal advice:			
35	Did you accept the offer of free legal advice?	**79%**	**72%**
For those who were were interviewed and needed them:			
37	Was a solicitor present when you were interviewed?	**80%**	**80%**
38	Was an appropriate adult present when you were interviewed?	**33%**	**28%**
39	Was an interpreter present when you were interviewed?	**3%**	**11%**
SECTION 3: Safety			
41	Did you feel unsafe?	**56%**	**62%**
42	Has another detainee or a member of staff victimised you?	**54%**	**34%**
43	If you have felt victimised, what did the incident involve?		
43a	Insulting remarks (about you, your family or friends)	**38%**	**17%**
43b	Physical abuse (being hit, kicked or assaulted)	**28%**	**11%**
43c	Sexual abuse	**20%**	**2%**

Key to tables

		Thames Valley Police 2013	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		
43d	Your race or ethnic origin	**32%**	**3%**
43e	Drugs	**12%**	**11%**
43f	Because of your crime	**27%**	**12%**
43g	Because of your sexuality	**12%**	**1%**
43h	Because you have a disability	**18%**	**2%**
43i	Because of your religion/religious beliefs	**8%**	**1%**
43j	Because you are from a different part of the country than others	**4%**	**3%**
44	Were your handcuffs removed on arrival at the police station?	**80%**	**72%**
45	Were you restrained while in the police custody suite?	**18%**	**19%**
46	Were you injured whilst in police custody, in a way that was not your fault?	**20%**	**23%**
47	Were you told how to make a complaint about your treatment?	**10%**	**13%**
48	Were you treated well/very well by staff in the police custody suite?	**32%**	**35%**
SECTION 4: Health care			
50	Did someone explain your entitlements to see a health care professional, if you needed to?	**29%**	**34%**
51	Were you seen by the following health care professionals during your time in police custody?		
51a	Doctor	**52%**	**42%**
51b	Nurse	**6%**	**23%**
	Percentage seen by either a doctor or a nurse	**54%**	**50%**
51c	Paramedic	**2%**	**4%**
52	Were you able to see a health care professional of your own gender?	**34%**	**25%**
53	Did you need to take any prescribed medication when you were in police custody?	**56%**	**42%**
For those who were on medication:			
54	Were you able to continue taking your medication while in police custody?	**25%**	**32%**
55	Did you have any drug or alcohol problems?	**53%**	**52%**
For those who had drug or alcohol problems:			
56	Did you see, or were offered the chance to see a drug or alcohol support worker?	**39%**	**41%**
57	Were you offered relief or medication for your immediate withdrawal symptoms?	**28%**	**25%**
For those who were seen by health care:			
58	Would you rate the quality as good/very good?	**26%**	**31%**
59	Did you have any specific physical health care needs?	**43%**	**31%**
60	Did you have any specific mental health care needs?	**23%**	**25%**
For those who had any mental health care needs:			
61	Were you seen by a mental health nurse/psychiatrist?	**0%**	**13%**