



Inspecting policing  
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# Report on an inspection visit to police custody suites in Hertfordshire

26–28 January 2009

by HM Inspectorate of Prisons and  
HM Inspectorate of Constabulary

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# 1. Introduction

This is the latest in a series of reports of inspections of police custody suites carried out by our two inspectorates. These inspections form a key part of the joint work programme of the criminal justice chief inspectors. They also contribute to the United Kingdom's compliance with its international obligations to ensure regular and independent inspection of all places of detention<sup>1</sup>. In each inspection, we examine force-wide strategies, the treatment and conditions of detainees, individual rights and the healthcare provision.

Hertfordshire Constabulary has seven custody suites designated under the Police and Criminal Evidence Act 1984 (PACE) for the reception of detainees. This inspection examined the four with the greatest throughput – Hatfield, Watford, Stevenage and Hoddesdon – all of which operate 24 hours a day. We also carried out a short visit to the other 24-hour custody suite at Hemel Hempstead. In addition, we surveyed prisoners at HMPs Bedford and Woodhill, to obtain additional evidence from prisoners who had been detained in one of these five locations.

We found that there was a good strategic lead from an assistant chief constable, with custody services being treated as part of core business, and an active support and oversight role being played by the Police Authority. Operational accountability for custody provision was devolved to three basic command unit (BCU) commanders and, although we have some concerns about this model – which can create significant variations in regimes - it seemed to be working well in practice in most custody suites, with the exception of Watford. We did, however, have some concerns about the regular rotation of dedicated custodial staff with those from intervention teams in all BCUs. As we have found in other inspections, there were no specific policies and procedures for dealing with women detainees and young people, and once again we were concerned at the inadequate arrangements for storing DNA and forensic samples.

In three of the four suites, conditions for and treatment of detainees were broadly good. Two were new and purpose-built, with good facilities and equipment. Staff showed an understanding of safer custody issues, though they did not routinely explain the use of cell call bells to detainees, and the CCTV coverage in two suites, both newly purpose-built, was intrusive and degrading, with unscreened toilets clearly visible. The suite at Watford was, however, ageing and very unsatisfactory, with limited natural light and ligature points in cells. Detainees requiring observation were watched via CCTV, sometimes not sufficiently often to meet accepted safety standards. Records did not show that food, exercise or showers had been offered, and no clothing other than paper clothing was provided if needed.

PACE procedures were properly followed in three of the suites, and in two there were good processes for managing the release of vulnerable detainees. Procedures in Watford were less satisfactory, with a variable quality of assessments and initial treatment, limited awareness of potential childcare issues, and little apparent understanding of the effect of custody on women.

The quality of healthcare services was in general good, with good links between the healthcare provider and custodial staff. However, the overall level of cleanliness in medical rooms was unsatisfactory and the standard of clinical record keeping was variable. Mental health provision was inconsistent between different custody suites, with two of the four having no dedicated mental health support. Substance use services were good.

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

This inspection, like previous inspections, showed clear discrepancies between the experience of detainees in different custody suites. It is important, in particular in a devolved operational regime, that senior managers ensure that the quality of provision in all suites is of a consistently high standard. This report contains a number of recommendations for improvement, and we hope it will assist the Chief Constable and the Police Authority in developing best practice.

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HM Chief Inspector of Constabulary

**Anne Owers**  
HM Chief Inspector of Prisons

**July 2009**

## 2. Background and key findings

- 2.1 HM Inspectorates of Prisons and Constabulary have begun a programme of joint inspections of police custody suites, as part of the UK's international obligation to ensure regular independent inspection of places of detention. These inspections do not look only at the implementation of the Police and Criminal Evidence Act (PACE) codes. They are also informed by *Expectations* about the appropriate treatment of detainees and conditions of detention, which have been developed by the two inspectorates to assist best custodial practice.
- 2.2 The Hertfordshire Constabulary has seven custody suites designated under the Police and Criminal Evidence Act 1984 for the reception of detainees. Hatfield, Hemel Hempstead, Hoddesdon, Stevenage and Watford operate 24 hours a day and deal with detainees arrested as a result of mainstream policing. Bishops Stortford is a part-time custody suite, which is open from 3pm on Thursday to 3pm on Sunday. It is used by both Essex and Hertfordshire Constabulary but staffed by Hertfordshire. Rickmansworth is a reserve suite used for special operations or at times of abnormally high demand. Hertford custody suite was the designated Operation Safeguard facility throughout 2008, but this operation has ended and the suite is no longer operational.
- 2.3 This inspection was conducted in the four busiest custody suites: Hatfield in the central area, Watford in the western area and Stevenage and Hoddesdon in the eastern area. A short visit was paid to Hemel Hempstead in the western area. We examined force-wide custody strategies, as well as treatment and conditions, individual rights and healthcare in each of the four suites inspected. A survey of prisoners at Bedford and Woodhill prisons, who had formerly been detained at Hatfield, Stevenage, Hoddesdon, Watford or Hemel Hempstead custody suites, was conducted by HM Inspectorate of Prisons researchers to obtain additional evidence (see Appendix IV).
- 2.4 Hatfield was the busiest station and had held 3,975 detainees in the previous four months. Stevenage was the second busiest, at 2,761 detainees in the same period. Hoddesdon had held 2,198 and Watford 2,063 detainees in the same period. Detainees in all suites were a mixture of adults, juveniles and immigration detainees.

### Strategic overview

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- 2.5 Hertfordshire custodial suites benefited from a good strategic lead. There were good relationships with the UK Border Agency (UKBA), which was working to reduce the time held in custody for immigration detainees, although the links into communities were poor. Despite National Policing Improvement Agency (NPIA) concerns that the devolution of responsibility for the management of custody suites to boroughs and borough commanders might increase risk across custody suites, the model was working in the majority of the custodial suites in Hertfordshire and a high level of care was delivered to detainees. However, we had concerns that redeploying staff from intervention teams to work in custody suites risked losing custodial skills specialisation and militated against ownership of custody suites by committed staff. The detention and escort officers (DEOs) and custody assistants (CAs) clearly felt they had a dedicated role and an investment in the suites in which they worked. Watford custody suite needed a thorough review.

## Hatfield

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### **Treatment and conditions**

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- 2.6 This was a good purpose-built facility, which was clean, bright and generally well laid out, although the booking-in area did not allow for privacy. All cells were equipped with pillows, mattresses, toilet paper and strip blankets. All but the dry cells had toilets and sinks, but no soap or towels. The cell call bell system was answered promptly and politely, and cells were visited where necessary. The two exercise yards were caged over and bleak, and dirty with bird excrement. There was little evidence of them being used or exercise being offered. Staff did not routinely explain the cell call bell system and closed-circuit television (CCTV) coverage to detainees. The CCTV coverage was intrusive and degrading, with toilets being unscreened and clearly visible onscreen during use. All staff carried anti-ligature knives and CAs carried keys, with a spare set behind the custody desk, enabling a swift response if necessary. Custody records showed some lengthy periods where detainees were not offered food. A variety of clothing was available. Reading material was available and often given to detainees.

### **Individual rights**

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- 2.7 Risk assessments were generic, with no special recognition for juveniles and women in custody, but there was clear evidence that staff were meticulous in gathering information from detainees and covering all aspects of safety during the booking-in process. There was good access to the appropriate adult scheme, including outside office hours and for vulnerable adults. Detainees were provided with verbal and written information about PACE. Attention was given to communication barriers; the notice of rights was available in a variety of languages and translation services were used appropriately. A member of staff, independent of the arrest and booking-in process, went through the risk assessment following completion, to confirm with detainees who could not read English that the information was correct. The method for raising complaints was not explained to detainees. There were systems in place to ensure vulnerable detainees were released safely.

## Hoddesdon

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### **Treatment and conditions**

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- 2.8 This ageing custody suite had been refurbished 18 months earlier, doubling its capacity. The 16 cells were of mixed design and size, half with in-cell washing facilities. All cells were equipped with pillows, mattresses, toilet paper and strip blankets. Some of the older cells were shabby and contained graffiti. Staff did not routinely explain the cell bell call system. The showers had not been upgraded and the single shower room was cramped, unpleasant and inadequate for the increased numbers of detainees. The reception area had not kept pace with the expansion either and offered little opportunity for privacy. Staff showed an awareness of safety issues and carried anti-ligature knives. The exercise yard doubled as a holding area, which could cause problems in access to the suite.

## **Individual rights**

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- 2.9 Staff were diligent in providing detainees with verbal and written information about PACE, including the use of translation services. Male juveniles, with the exception of appropriate adult provision and location in detention cells, were treated in the same way as other detainees. Female juveniles and vulnerable adult women were allocated a nominated carer (female member of staff) to provide support and information, to balance the lack of female custody staff. The method of raising complaints was explained to detainees. There were formal and informal processes for managing the release of vulnerable detainees. We found some evidence that delays in getting court places could lead to prolonged periods of detention.

## **Stevenage**

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### **Treatment and conditions**

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- 2.10 This purpose-built custody suite was clean, bright and generally well designed. All cells were equipped with pillows, mattresses, toilet paper and strip blankets. All but the dry cells had toilets and sinks, but no soap or towels. Cell call bells were answered promptly. The stores were well stocked with supplies of clothing and hygiene products. Staff showed awareness of fire safety and self-harm and suicide issues, and carried anti-ligature knives. Staff did not routinely explain the cell bell system and CCTV coverage. The CCTV coverage was intrusive and degrading, with toilets being clearly visible onscreen during use. Meals were not always offered routinely and their content was not adequate for longer-term residents. Showers and exercise were rarely offered.

## **Individual rights**

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- 2.11 Staff followed the requirements of PACE rigorously and consistently. Juveniles, with the exception of appropriate adult provision and location in life-signs cells closer to the reception area, were treated in the same way as other detainees. Female juveniles and vulnerable adult women were allocated a nominated carer (female member of staff) to provide support or information and there were female staff regularly on duty. There were problems reported in accessing appropriate adults during the night, which led to longer periods of detention than necessary. The method of raising complaints was not explained to detainees. There were formal and informal processes for managing the release of vulnerable detainees.

## **Watford**

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### **Treatment and conditions**

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- 2.12 This ageing facility, located in a basement, had limited natural light and there was poor ventilation. Cell walls had been repainted but doors and wooden plinths remained covered in graffiti. Efforts had clearly been made to fill in areas presenting ligature points, but the sealants had been removed, and areas of risk remained around bed plinths, ventilation panels, toilet cistern covers and floor drain covers. The cells were reasonably clean apart from in corners, especially around toilets, and the toilets were dirty. The booking-in area was cramped, busy and lacked privacy. The behaviour of some staff was unprofessional. We observed good care of a female detainee on constant observation. Staff did not routinely explain the use of the cell

bell call system. There was some evidence in written records of observations of detainees being carried out using CCTV, with no personal visit. Other records showed that prescribed levels of observations were not carried out. The designated cells for female detainees were located some distance away upstairs, presenting a safety issue for those at risk located there, even with CCTV monitoring. Keys and anti-ligature knives were held behind the booking-in desk and not carried by staff, which was particularly concerning given the distance from the cells upstairs. Staff had some training in suicide and self-harm and were given updates in mental health from the mental health nurse. The exercise yard was unkempt. Records did not evidence food, exercise or showers being offered. Strip clothing, paper clothing and flip flops were provided where necessary, but no other clothing or underwear. Fire evacuation arrangements were not on display, nor had there been any recent fire drills.

### **Individual rights**

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- 2.13 The custody sergeant took responsibility for authorising detention and checking risk assessments. The quality of the assessments and the treatment of detainees on arrival varied. There was good use of translation services and availability of translated information, and good links with immigration services. A portable induction loop was available. There was evidence of good use of pre-court disposals for juveniles in appropriate cases. Consideration was given to the impact of detention on a juvenile, and in one case a juvenile was bailed to return, as the appropriate adult was not able to speak English well. There was little awareness of the impact of custody on women. Although there was a system for arranging childcare through social services, DEOs did not check whether this was an issue (for men or women), and believed that it was the responsibility of the detainee. A limited number of feminine hygiene products were available on request. The complaints process was not explained to detainees. Pre-release plans were used, and an information leaflet, with contact details for a range of agencies, given to detainees.

## **Hemel Hempstead**

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### **Treatment and conditions**

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- 2.14 Although this was an ageing station, the custody suite had been refurbished and was freshly painted and clean. All cells were equipped with pillows, mattresses, toilet paper and strip blankets. Staff did not routinely explain the use of the cell bell call system. The staff dealt well with the range of complex detainees being held at the time of the inspection. They showed a good level of care for those on close observation, and de-escalation of drunken aggression. The kitchen area and equipment were clean. Strip clothing, paper clothing and flip flops were provided where necessary, but no other clothing or underwear.

### **Individual rights**

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- 2.15 The custody sergeant had a good manner with detainees, and other staff followed his lead. Detainees were provided with verbal and written information about PACE. Access to appropriate adults was good. Detention cells were allocated for juveniles and there were specific cells for female detainees, but other than this women and juveniles were treated in the same way as other detainees.

## Healthcare

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- 2.16 Overall, the health services for detainees were good and supported by custody staff. Contract monitoring had previously over-relied on information provided by the contracted company, Hertfordshire Forensic Examiners Response Network (H-FERN), but the constabulary had recognised this and had just begun to gather its own data. There was no assessment of the continuing professional development of the medical staff employed. Medical and other professional staff were keen to become involved in custody suite training. Record keeping by doctors was unsatisfactory in some cases, with no signatures on the 'doctors' notes' book and illegible writing.
- 2.17 Mental health provision was inconsistent across the county, with particular problems with cross-border access to services provided by different mental health trusts. Owing to staff shortages, Hatfield and Hoddesdon did not have direct mental health support. Watford and Stevenage had dedicated approved mental health professionals, who attended the custody suites daily. Mental health awareness training for DEOs and CAs was limited.
- 2.18 The FME facilities varied greatly from suite to suite. None were forensically clean. Hatfield and Stevenage FME rooms were light, spacious and in good decorative order, but only superficially clean. Watford was filthy, with missing tiles on the wall and blood stains on it. The bins were not functioning and were heavily soiled externally. Hoddesdon was clean but the sharps bins were full. At all sites, the clinical waste bins overflowed. Some specimens in the FME rooms had been there for over six months. Medicine management was of concern, with a significant issue of excessive stock, particularly at Hoddesdon. At Hemel Hempstead, there were 'early evidence' samples going back to November 2007. There was no strategy for the destruction of DNA across the force.
- 2.19 Substance use services were good. Drug intervention programme (DIP) provision covered all sites and drug workers were located in all custody suites on Mondays to Fridays. Users of alcohol and non-class A drugs were signposted to appropriate providers. Appropriate methadone maintenance was facilitated. There were good links with prison counselling, assessment, referral, advice and throughcare (CARAT) teams through a prison link worker and this contact was maintained throughout the sentence. There was no substance misuse awareness training for custody staff. The needle exchange programme in custody suites was inadequate.



## 3. Strategy

- 3.1 An assistant chief constable (ACC) had portfolio responsibility for custody services, and the provision of custody services was seen as a core part of business, with chief officers taking an active interest in this area. The constabulary had recently invested sizeable amounts of money in upgrading large parts of the custody estate. The Police Authority (PA) lead for custody took an active interest in custodial matters and played a proactive role, which was seen as both supportive and challenging when appropriate. Relationships between Independent Custody Visitors (ICVs) and custody staff were good.
- 3.2 A chief inspector based at headquarters (HQ) had oversight of custody provision within Hertfordshire Constabulary and was responsible for the strategic development of custody. The management of custody policies and procedures rested with him, although he was supported by an inspector and a sergeant who dealt with quality assurance, health checks and legal issues. The team was responsible for the implementation of *Guidance on the safer detention and handling of persons in police custody* (SDHP) and they provided guidance to the constabulary with regard to the refurbishment of custody suites and future new builds.
- 3.3 Operational accountability was devolved to three basic command unit (BCU) commanders, who were chief superintendents covering the eastern, central and western areas of the constabulary, although the deputy BCU commanders were tasked with ensuring that the custody suites delivered quality services. Each BCU had a dedicated inspector as a custody manager. Strategic custody group meetings took place quarterly and were supported by monthly force-wide custody users group meetings.

### Expectation

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- 3.4 There is a policy focus on custody issues at a chief officer level that is concerned with developing and maintaining the custody estate, staffing custody suites with trained staff, managing the risks of custody, meeting the health and wellbeing needs of detainees and working effectively with colleagues in the health service, immigration service, youth offending service, criminal justice teams, Crown Prosecution Service (CPS), courts and other law enforcement agencies.

### Findings

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- 3.5 An ACC was the senior portfolio holder for custody issues within Hertfordshire Constabulary. There was evidence of strategic priority being given to custody and there was clear strategic direction in relation to the development of custody as part of the administration of criminal justice. Newly built custody suites, refurbished custody suites and future builds formed part of an ongoing estates strategy which was strongly supported by the PA. The custodial estate provision had clearly benefited from this forward-thinking approach.
- 3.6 While the model of devolving custody suites to BCUs is generally regarded as presenting a higher profile of risk than a centralised custody structure, it was evident that, with the exception of the western BCU, the current management structure was delivering the improvements required to ensure compliance with SDHP. Good leadership at most levels was focused on delivering high standards within the custody environment.

- 3.7 We found comprehensive policies relating to issues in SDHP, and this assisted custody staff in discharging their duties effectively. All custody sergeants and detention staff had received approved custody training before their deployment into custody suites, although a need for ongoing refresher training was identified and staff also required mental health awareness training, and training to identify potential ligature points. The regular rotation of dedicated custodial staff with those from intervention teams was not supportive of an environment in which custodial work is seen as a dedicated role with specialist skills, and made a sense of ownership of custody suites by committed staff more difficult to achieve.
- 3.8 Comprehensive risk assessments were carried out by custody staff and there was a recognition that the risk assessment started with the arresting officer. This awareness of risk and welfare featured consistently in the culture and working practices of custody staff in northern and central BCUs, who carried out their functions in a thoroughly respectful, polite and professional manner. This was less evident at Watford, and we also noted that custody staff at Watford did not routinely carry anti-ligature knives. Pre-release risk assessments were consistently carried out in respect of detainees who were identified as vulnerable during their stay in custody, and we were impressed with the level of commitment given by the force and individual staff members to this important area.
- 3.9 The need for custody suites to be compliant with SDHP had been acted on at force level with due diligence. Random quality assurance checks were carried out by the HQ team at various times of the day and night. Audit trails of findings and issues to be addressed by BCUs were detailed. However, a number of the cells we inspected at Watford were not suitable for use, owing to ligature points. We saw this as a local issue rather than a force-wide problem, but it showed that some staff did not understand what to look for in terms of ligature points.
- 3.10 Observations and interviews at all levels of custody staff demonstrated sensitivity to, and a professional focus on, the health needs of detainees. Health service professionals were coordinated in their approach to treating detainees, and there were good links with partner agencies.
- 3.11 We talked to the chair of the ICV scheme operating in Hertfordshire who acknowledged the hard work done by all in developing a positive working relationship between ICV visiting members and custody staff. Suggestions made by ICVs were being listened to and, when appropriate, acted upon to improve conditions for detainees.
- 3.12 A sound professional working relationship had been developed between custody suites and the UK Border Agency (UKBA) with regard to immigration detainees. Few immigration detainees were held for two to three days, with many detainees being processed in less than 24 hours.
- 3.13 The picture across the constabulary was mixed in relation to accessing the appropriate adult scheme. In some BCUs there was limited ability to access appropriate adults during the night. However, access to appropriate adults during the day was prompt, and appropriate adults had good access to juveniles.
- 3.14 We were told that the constabulary's relationship with the Crown Prosecution Service (CPS) was improving, with ongoing partnership work being developed at local criminal justice board level. Relationships with defence solicitors and the constabulary were described by both the constabulary and solicitors as being professional and respectful.

- 3.15 On a couple of occasions, we were concerned with early cut-off times being enforced by the courts, which meant that detainees spent longer in detention than was necessary, although we were told that this was an uncommon occurrence.

### **Expectation**

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- 3.16 There is an effective management structure for custody that ensures that policies and protocols are implemented and managed and that there are mechanisms for learning from adverse incidents, rubbing points or complaints.

### **Findings**

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- 3.17 Strategic custody group meetings took place quarterly and were supported by monthly force-wide custody users group meetings. Force policies were used to inform and drive the practices of staff at ground level and there were good links between the HQ team and BCUs, with deputy BCU commanders being viewed as supportive of the HQ team. However, in the absence of any quality assurance of local guidance, there was a risk that this could conflict with standard operating procedures. Further quality assurance was required to ensure the maintenance of corporate standards.
- 3.18 Hertfordshire Constabulary utilised custody sergeants, detention escort officers and custody assistants (CAs) in the processing and detention of detainees. While there were concerns that this structure could lead to a division of labour or gaps in addressing the needs of detainees, we found no evidence of this. The system was effective and the CAs in particular were concerned with looking after the welfare of detainees, with particular attention been given to juvenile and female detainees.
- 3.19 There were no specific policies dealing with the needs of juvenile and female detainees held beyond 24 hours, or any guidance to custody staff about the different impact of custody on juvenile and female detainees, although many staff seemed to be aware of the impact of custody on these specific groups and paid extra attention to them.
- 3.20 No information was provided to detainees about how they could make a complaint while they were in custody, although inspector reviews asked detainees if they had any complaints.

### **Expectation**

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- 3.21 Maintenance of facilities only occurs when the suite is closed down.

### **Findings**

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- 3.22 Due to the age and limited capacity of cell provision in the west of Hertfordshire Constabulary, maintenance work was completed when facilities were open. Increased capacity as a result of recent builds elsewhere will allow future planned refurbishment of custody suites to take place when they have been closed.

## Recommendations

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### To the Hertfordshire Constabulary

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- 3.23 The provision of custody services at Watford should be overhauled at the earliest opportunity to ensure the consistent application of corporate standards.
- 3.24 An ongoing regime of refresher training should be implemented which addresses core skills and knowledge. This should be centrally managed on behalf of BCUs.
- 3.25 The risk posed by ligature points should be understood by staff, and detainees supervised according to risk while in custody.
- 3.26 BCU policies which offer local guidance should be validated to ensure that they do not conflict with force policies.
- 3.27 Specific policies in relation to the treatment of female detainees and young people under 18 years of age should be introduced.
- 3.28 The roles of custody sergeant and detention escort officer should be dedicated for a reasonable length of time and staff specially selected for the role based on motivation and suitability.

## 4. Treatment and conditions

- 4.1 Hatfield custody suite was clean, bright and in good repair. Most cells had in-cell sanitation, although toilets were not screened and were clearly visible on the closed-circuit television (CCTV) screens. Cell bells were answered promptly but their use was not explained to detainees. Showers were available in all the cell areas. The booking-in area was large and busy, with some difficulties in providing privacy for detainees. Custody staff had all received initial training and some follow-up training in safety issues, and standards of care were adequate. Custody records showed that some detainees were left for long periods without food. Exercise and showers were rarely offered. Visits could be facilitated.
- 4.2 Hoddesdon custody suite had been refurbished 18 months earlier to expand its capacity, but the original cells were in a poor state of decoration. The booking-in area was cramped and offered little privacy. The use of the call bell system was not explained to new detainees. Meals were provided, but these were not adequate for longer-term residents. Showers and outside exercise were not always offered to detainees held for more than 24 hours. Toilet paper, a mattress, pillow and blanket were routinely available, and the view of toilets was appropriately obscured on the CCTV. Visits could be facilitated for long-stay residents, but visitors were strip searched. Staff had not received fire safety or refresher suicide self-harm training. The level of professionalism of staff when dealing with detainees was excellent.
- 4.3 Stevenage custody suite was bright, clean and well equipped. Cell bells were answered promptly but their use was not explained to new detainees. Meals were provided, but these were not adequate for longer-term residents, and were not always offered routinely. Showers and outside exercise were not always offered to detainees held for more than 24 hours. Suitable clothing, toilet paper, a mattress, pillow and blanket were routinely available, but toilets were in full view on the CCTV. Visits could be facilitated for long-stay residents. Staff had not received fire safety or refresher suicide self-harm training. The level of professionalism of staff when dealing with detainees was excellent.
- 4.4 Watford custody suite was in a poor state of repair and was located in a basement with an outside holding area. There was little natural light inside, poor ventilation and the accommodation had ligature points, graffiti and was uninviting. Most cells had in-cell sanitation but cells and toilets were filthy. Custody staff had received some recent training in mental health issues. Some detainee observations were carried out using the CCTV, and others were not undertaken as often as risk assessment had determined. Anti-ligature knives and cell keys were kept behind the booking-in desk and not carried by staff. The booking-in area was cramped, often crowded and lacked privacy. Only strip or paper clothing was available. Custody records showed little evidence of food, exercise and showers being offered. Visits were not facilitated. Fire evacuation plans were not on display, nor was there evidence of recent fire drills.

### **Expectation**

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- 4.5 Custody staff are aware of the risk of self-harm from:
- attempted suicide
  - drugs ingestion

- medical conditions
- alcohol

and these risks are assessed, monitored and managed appropriately.

## Findings

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### *Hatfield*

- 4.6 A generic reception risk assessment was used for all detainees, irrespective of gender, age or risks posed. The assessment covered the risks of suicide, drugs and alcohol use, medical conditions and medications. Information was gathered from the detainee and the escorting officer. Staff were meticulous in gathering information from detainees and ensuring that all aspects of safety were covered during the booking-in process.
- 4.7 The custody sergeant authorised detention in all cases, and risk assessments were generally carried out by detention and escort officers (DEOs). The level of observations carried out for detainees reflected the risks posed and records were kept of the observations carried out by staff. Staff were clear about the different levels of care and understood what was required for detainees who needed to be roused regularly. Those being held in custody for the first time were identified and hourly observations were carried out routinely, unless the risk assessment suggested that more frequent observations were required. All detainees had their shoes removed and were provided with a pair of flip-flops.
- 4.8 CCTV was installed in all cells, and eight had life-signs monitoring, which provided additional observation tools for staff. We did not observe an over-reliance on these for observing detainees. Custody assistants (CAs) were responsible for all matters relating to the care of detainees and they were diligent in carrying out observations and attending to the needs of detainees. All staff carried anti-ligature knives and all CAs carried cell keys, with a spare set being available behind the custody desk.

### *Hoddesdon*

- 4.9 A generic reception risk assessment was used for all detainees, irrespective of gender, age or risks posed. Custody staff were aware of the risks posed by some detainees, questioning all new detainees to establish any issues of vulnerability, including whether they had any history of self-harm or suicidal ideation, substance abuse, medical issues or learning disabilities. Each detainee was assessed against a 1–4-point scale, with level 1 being no or minimal risk and level 4 requiring constant observation. Those rated as being at levels 3 or 4 were routinely located in one of the four life-sign cells, which, in addition to normal physical checks, provided ongoing information to staff about movement in the cell. We saw custody staff carrying out half-hourly checks on a detainee assessed to be at level 3. All detainees had their shoes removed and were provided with a pair of flip-flops, and any cords in clothing were also removed. All cells were monitored by CCTV, which could be observed by custody staff at the booking-in desk, although this was not routinely explained to new detainees. All staff carried anti-ligature knives and were familiar with their use.
- 4.10 Although custody staff received suicide and self-harm training as part of their induction to custody work, no programme of refresher training was offered.

### *Stevenage*

- 4.11 A generic reception risk assessment was used for all detainees, irrespective of gender, age or risks posed. Custody staff were aware of the risks posed by some detainees, questioning all new detainees to establish any issues of vulnerability, including whether they had any history of self-harm or suicidal ideation, substance abuse, medical issues or learning disabilities. Each detainee was assessed against a 1–4-point scale, with level 1 being no or minimal risk and level 4 requiring constant observation. Those rated as being at levels 3 or 4 were routinely located in one of the six life-sign cells, which, in addition to normal physical checks, provided ongoing information to staff about movement in the cell. We saw custody staff carrying out half-hourly checks on a detainee assessed to be at level 3. All detainees had their shoes removed and were provided with a pair of flip-flops, and any cords in clothing were also removed. All cells were monitored by CCTV, which could be observed by custody staff at the booking-in desk, although this was not routinely explained to new detainees. All staff carried anti-ligature knives and were familiar with their use. All CAs carried cell keys, and a spare set was available behind the custody desk.
- 4.12 Although custody staff received suicide and self-harm training as part of their induction to custody work, no programme of refresher training was offered.

### *Watford*

- 4.13 A generic reception risk assessment was used for all detainees, irrespective of gender, age or risks posed. The custody sergeant authorised detention in all cases and carried out the risk assessments on most occasions. The assessment covered the risks of suicide, drugs and alcohol use, medical conditions and medications. Assessments were carried out to an acceptable level and observation levels were clearly recorded in most custody records. However, examination of many custody records showed that these levels were not always adhered to. For example, we found two instances of drunken individuals requiring half-hourly observations who were checked hourly. There was an over-reliance on CCTV for carrying out observations and we were concerned to find a juvenile record showing that two consecutive observations had been carried out using CCTV and not by a personal visit to the detainee. All detainees had their shoes removed and were provided with a pair of flip-flops.
- 4.14 Staff had recently received some mental health training from the in-house mental health nurse. We observed a female detainee under constant observation because of mental health problems and a possible risk of self-harm. Interaction between staff and the detainee was impressive and detailed records were kept.
- 4.15 Staff were repeatedly interrupted by telephone calls from personal mobile telephones while booking in detainees and carrying out care duties, and we also saw staff making personal calls. We were concerned that full attention was not being paid to detainees at these times.
- 4.16 Female cells were located in a separate area upstairs, at some distance from the main cell area, which would have hindered staff accessing them quickly in the event of an emergency. Anti-ligature knives and cell keys were kept behind the booking-in desk and were not carried by staff.

### **Expectation**

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- 4.17 Custody staff are aware of any risk of harm to others and this is managed appropriately. Detainees are not placed in cells together unless a risk assessment indicates that it is

safe to do so, Risk assessments include whether the detainee has previous convictions for racially aggravated offences.

## **Findings**

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### *Hatfield*

- 4.18 There was one general holding area and staff told us that detainees of all ages could be held there, with an officer supervising them when there was more than one detainee present.
- 4.19 Detainees were not routinely expected to share cells, although staff said that they would consider allowing family members to share where appropriate. There was a written risk assessment for such occasions, which covered relevant matters, although we found no evidence that this had occurred.
- 4.20 Staff said that they would sometimes use the Global Solutions Limited (GSL) cells when the courts were closed, if the police cells were full. There were clear tensions between GSL and police staff regarding the movement of detainees from police to court cells to free up space in the police cells.

### *Hoddesdon*

- 4.21 Detainees were not placed in cells together. Custody staff risk assessments included consideration of any convictions for racially motivated offences, with the Police National Computer (PNC) and local nominal records being routinely checked for each new detainee.

### *Stevenage*

- 4.22 Detainees were not placed in cells together. Custody staff risk assessments included consideration of any convictions for racially motivated offences, with the PNC and local nominal records being routinely checked for each new detainee.

### *Watford*

- 4.23 Staff told us that they did not generally place detainees in cells together, but that they might consider it in cases where family members, particularly in immigration cases, were detained together. There was no written risk assessment for use in these instances.

## **Expectation**

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- 4.24 Holding cells are equipped with call bell systems and their purpose is explained to detainees. They are responded to within a reasonable time.

## **Findings**

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### *Hatfield*

- 4.25 All cells had working call bells with an integral intercom, which when pressed resulted in an audible alarm in the booking-in area. Staff responded quickly by using the intercom, and were polite and respectful, but the system was not explained to new detainees during the booking-in process. Staff visited detainees when their request warranted personal contact. Many calls

were to ask for details of progress on an individual's detention – for example, asking when solicitors would be attending. Cell bells were only tested once a week.

#### *Hoddesdon*

- 4.26 All cells were equipped with a call bell system, which activated a visual and audible alarm at the custody front desk. These were responded to promptly, but the system was not explained to new detainees during the booking-in process.

#### *Stevenage*

- 4.27 All cells were equipped with a two-way intercom call bell system. This enabled detainees and custody staff to have conversations without staff having to visit the cell. The system could not be diverted, which meant that cell bell warning lights and intercom terminals at the custody desk could not be switched off. We observed a few exchanges between detainees and staff using the system, and these were responded to promptly. The system was not explained to new detainees during the booking-in process.

#### *Watford*

- 4.28 All cells had call bells and these were answered promptly by staff. Detainees told us that they had been shown how to use them.

### **Expectation**

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- 4.29 Holding areas, cells, interview rooms and detention rooms are:

- clean
- free from graffiti
- in good decorative order
- of a suitable temperature
- well ventilated
- well lit
- equipped with somewhere to sit
- free of ligature points.

### **Findings**

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#### *Hatfield*

- 4.30 Hatfield was a new, purpose-built custody suite. The cells were clean, bright, well ventilated and in good repair. All had low-level plinths, with no additional seating facilities. There were no obvious ligature points. Interview and consultation rooms were also in good condition. Cleaners attended daily, with cleaning schedules which were adhered to.
- 4.31 There were 40 cells across four wings, with 10 being managed by GSL for the adjoining remand court and 30 by police staff. We did not inspect the GSL cells.
- 4.32 There were three cells, one in each spur, that were dry cells – that is, with no sink or toilet. All cells were designated as general purpose and could be used to accommodate any detainee.

### *Hoddesdon*

- 4.33 The custody suite had been refurbished and expanded 18 months before the inspection, resulting in a doubling of its capacity, from eight to 16 cells. The eight newer cells were large, bright and well decorated, although staff told us about a number of problems with the cell fabric which had recently been rectified (for example, crumbling window sills). The older eight cells were smaller and in a poor state of decoration, with cracked paint on floors and some graffiti. The four life-sign cells were older cells, as were the two detention rooms for juveniles. These had a shared toilet outside of the detention rooms which could only be accessed with supervision from staff. With the exception of the detention rooms, all cells had a metal toilet and low-level plinth for sleeping, but no other seating. There were no obvious ligature points in cells.

### *Stevenage*

- 4.34 The custody facility was relatively new, having opened in July 2008. It had 24 cells, with 23 containing a metal toilet, hand-washing facilities and a low, solid plinth bed, with no other seating facilities. Cell 24 had no toilet or washing facilities, and was used to hold detainees for short periods if they were refractory or subject to forensic observation. Six cells had the life-sign system installed. There were no detention rooms for juveniles.
- 4.35 The two holding rooms had safety glass fronts, and were used primarily to accommodate newly arrived detainees. The suite had seven interview rooms and two private consultation rooms, which were mainly used for legal visits for detainees. Cells and holding rooms were bright, in good decoration and free of graffiti, with no obvious ligature points. Cell lighting was adequate, and neither detainees nor staff reported any issues with ventilation. Some detainees complained about being cold on the night before our visit, despite the blankets provided.

### *Watford*

- 4.36 This ageing facility was located in a basement, and the main holding area for detainees coming into custody was outdoors (under a plastic cover), dark, dirty and at the base of a steep staircase. The roof leaked and the area was cramped.
- 4.37 There were 11 cells: eight for men, one detention cell and two for women. The detention cell and one of the male cells had no integral sanitation. There was CCTV in two male, one female and the detention cells. The cells were dimly lit, with little natural light, and were poorly ventilated. An attempt had been made to improve the cells by painting the walls, but the corners of cells, and particularly the toilets, were filthy and doors and bed plinths were covered in graffiti. We noted that some of the graffiti referred to gang activity and some was abusive. No attempt had been made to remove it.
- 4.38 Ligature points were obvious around some of the metal toilet cistern covers and ventilation grilles, between beds and walls where sealant had been removed, and in the drain cover on the floor of the detention cell.
- 4.39 There had been a recent incident where a detainee had carried out a 'dirty protest', covering his cell with urine and food. There was no protocol detailing the management of such an incident and what was required to protect staff and the detainee.

## **Expectation**

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- 4.40 A smoking policy for staff and detainees is enforced that respects the right of individuals to breathe clean air in the custody suite.

## **Findings**

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### *Hatfield*

- 4.41 The entire custody suite was a no-smoking area, except for the exercise area. Detainees who were being held for extended periods (up to three days) and those brought in from prisons for interviews were permitted to smoke in the exercise area. Alternatives to smoking, such as nicotine patches, were not routinely offered, although detainees who had been prescribed nicotine replacement could have it brought in from home. Otherwise, advice was sought from the forensic medical examiner (FME).

### *Hoddesdon*

- 4.42 Smoking was not permitted anywhere in the custody suite. Detainees who were being held for three or more days were allowed to smoke in the enclosed external exercise yard.

### *Stevenage*

- 4.43 Smoking was not permitted anywhere in the custody suite. Detainees who were being held for three or more days were allowed to smoke in the enclosed external exercise yard.

### *Watford*

- 4.44 The entire custody suite was a no-smoking area. Alternatives to smoking, such as nicotine patches, were not routinely offered, and staff would seek advice from the FME if necessary. However, the female detainee on constant watch during the inspection was permitted to smoke in the exercise area.

## **Expectation**

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- 4.45 Detainees are provided with suitable meals that cater for special dietary requirements, and drinks at appropriate intervals.

## **Findings**

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### *Hatfield*

- 4.46 Microwave meals catering for all dietary requirements were available. We noticed that the calorie content of these meals was low, and staff told us that they often gave more than one if requested by the detainee. We observed lunchtime meals given without being requested on one day but, overall, our observations and custody records showed that food was generally only given on request, despite the fact that staff told us that meals and drinks were offered at set times throughout the day. There were some instances of detainees being in custody for over six hours without being given food. Hot and cold drinks were freely available.

- 4.47 There was confusion over whether food could be brought in for detainees when specific dietary or religious requirements could not be met. Some staff said that it could, whereas others were adamant that this would not be allowed. In these circumstances, staff were able to request specialist meals from a local hospital or would arrange to buy food if detainees had sufficient funds to do so.

*Hoddesdon*

- 4.48 A range of drinks and microwave meals were available and regularly offered to detainees. Options were available to meet most dietary and religious requirements. However, the calorie content of meals was low and the quality basic, which made them only suitable for detainees being held for short periods of time. Detainees were not allowed to have food sent in for them by friends or relatives.

*Stevenage*

- 4.49 A range of drinks and microwave meals was available to detainees, but custody records indicated that these were sometimes provided on request rather than routinely. Options were available to meet most dietary and religious requirements. However, the calorie content of meals was low and the quality basic, which made them only suitable for detainees being held for short periods of time. Detainees were not allowed to have food sent in for them by friends or relatives.

*Watford*

- 4.50 Microwave meals catering for all dietary requirements were available, but the calorie content of these meals was low. Our observations, interviews with detainees and custody records showed that food was generally only given on request, and there were often long periods between meals. In the two days before our inspection, there were 44 detainees held in custody. The food log showed that only 14 meals had been served during this time.
- 4.51 The DNA and sample freezers and refrigerators were in the food preparation area. The DNA freezer resembled a DNA filing cabinet, with over 60 samples, dating back up to six months, stored in there instead of being sent off (see healthcare section).
- 4.52 Food was not accepted from family or friends under any circumstances, and staff would buy food in at the detainee's expense if no suitable alternative was available in-house.

**Expectation**

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- 4.53 Detainees are provided with a mattress, pillow and clean blankets if held overnight.

**Findings**

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*Hatfield*

- 4.54 Mattresses, pillows and tear-resistant blankets were available in all cells. Laundry was collected daily and there were sufficient stores of these items to ensure that they were always available.

*Hoddesdon*

- 4.55 All cells contained a suitably covered mattress, pillow and blanket. Detainees could request additional blankets if needed, but these were not routinely provided for those held overnight.

*Stevenage*

- 4.56 All cells contained a suitably covered mattress, pillow and tear-resistant blanket. Detainees could request additional blankets if needed, but they were not routinely provided for those held overnight.

*Watford*

- 4.57 Mattresses, pillows and tear-resistant blankets were available in all cells. Laundry was collected twice weekly and there were sufficient stores of these items to ensure that they were always available.

**Expectation**

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- 4.58 Detainees are able to use a toilet in privacy, and toilet paper and washing facilities are provided.

**Findings**

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*Hatfield*

- 4.59 All but the three dry cells had in-cell sanitation but with no screening, and all were visible on the CCTV cameras. There were washing facilities in these cells. Detainees were able to flush their own toilets and toilet paper was provided in cells. Towels and soap were not made available as a matter of course but were available on request.

*Hoddesdon*

- 4.60 Detainees using the toilet could not be observed by staff on the CCTV system, with the area around it being electronically obscured. There were hand-washing facilities in eight of the 16 cells. Toilet paper was routinely provided to all detainees unless a risk assessment indicated that this should not be the case.

*Stevenage*

- 4.61 Detainees using the toilet could be observed by staff on the CCTV system. Toilet paper was routinely provided to all detainees unless a risk assessment indicated that this should not be the case.

*Watford*

- 4.62 All the cells with integral sanitation had unscreened toilets, and the attempt to block them out on CCTV cameras was largely ineffective. Toilet paper was available in most cells. Washing facilities were available in the main and female cell areas. We observed a Muslim detainee being allowed to wash before saying prayers in his cell.

## **Expectation**

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- 4.63 Detainees whose clothing is taken for forensic examination are provided with suitable alternative clothing before being released or transferred to court.

## **Findings**

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### *Hatfield*

- 4.64 Detainees whose clothing had been taken and who were being released or transferred to court were given tracksuits to wear. White paper forensic suits were also available, and also green two-piece paper suits and anti-tear clothing. Staff were clear that detainees would not be released in inappropriate clothing. Clothing could be left by family or friends for detainees attending court or being released.

### *Hoddesdon*

- 4.65 Detainees whose clothing was taken for any reason were provided with green anti-tear suits. Tracksuit bottoms and tops were provided to detainees being released or transferred to court.

### *Stevenage*

- 4.66 Detainees whose clothing was taken for any reason were provided with green anti-tear suits. Tracksuit bottoms and tops were provided to detainees being released or transferred to court.

### *Watford*

- 4.67 Detainees whose clothing had been taken and who were being released or transferred to court had to have clothing brought in for them, as there was no suitable clothing available. Only white paper forensic suits, green two-piece paper suits and anti-tear clothing were provided.

## **Expectation**

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- 4.68 Detainees who are held for more than 24 hours are able to take a shower and a period of outdoor exercise.

## **Findings**

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### *Hatfield*

- 4.69 Two showers on each cell spur were half-screened with wooden doors. There were sinks on each spur. We were told that detainees could take showers or exercise on request. The custody records we checked showed that no detainees had been given or offered exercise or showers. We observed that one shower was littered with dirty towels, soap and other items, suggesting that it had been used but not cleaned afterwards.
- 4.70 The two exercise yards were caged-over and dirty with bird excrement.

### *Hoddesdon*

- 4.71 Only one small enclosed shower was available. This was used for male, female and juvenile detainees and was in a poor state of repair. There was evidence in some custody records of detainees being offered a shower before a court appearance, after being held overnight. However, we were told by staff that showers would normally only be facilitated if a detainee requested one.
- 4.72 The exercise yard contained recently installed seating and was adequate, but doubled as a holding area for newly arrived detainees. Although this could potentially cause difficulties, in reality the area was not frequently used as an exercise yard. None of the detainees we spoke to, including some who had been held overnight, had been offered outdoor exercise.

### *Stevenage*

- 4.73 Separate male and female showers were located in the same corridor linking the two rows of custody cells. It was possible to see into the showers from the main corridors where cells were located, and staff told us that they were aware of this and restricted access to prevent this from occurring. There was evidence in some custody records of detainees being offered a shower before a court appearance, after being held overnight. However, this appeared to be in part determined by how busy the custody staff were, and we were told by staff that showers would normally only be facilitated if a detainee requested one.
- 4.74 The exercise yard was completely enclosed by high walls and open to the elements. We did not see it being used, and none of the detainees we spoke to, including some who had been held overnight, had been offered outdoor exercise. One custody record showed that the detainee had requested exercise but this had not been facilitated.

### *Watford*

- 4.75 There was a shower in both cell areas, and an exercise area. We were told that detainees could take showers or exercise on request. The exercise area was dirty, with weeds growing across it. There was a small covered area at one end. The custody records we checked showed little evidence that detainees had been given or offered exercise or showers, although staff said that they were available on request.

## **Expectation**

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- 4.76 Detainees who are held in custody for several days are provided with suitable reading material. Visits are also allowed, and changes of clothing, especially underwear, are facilitated.

## **Findings**

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### *Hatfield*

- 4.77 We were shown a range of suitable reading material, including books, magazines and religious texts, but saw little evidence of reading matter being given to detainees. We were told by staff that visits could be facilitated. Underwear was not provided.

### *Hoddesdon*

- 4.78 A limited range of reading materials was available to detainees who requested them. We did not observe visits taking place but were told by staff that, subject to risk assessment, they would be facilitated in the consultation room. We were told by one custody sergeant that visitors were usually strip searched before the visit. Staff said that they would offer detainees tracksuits to wear during visits if their own clothing had been removed for any reason. No underwear was available.

### *Stevenage*

- 4.79 A limited range of reading materials was available to detainees who requested them. We did not observe visits taking place but were told by staff that, subject to risk assessment, they would be facilitated in the consultation or holding rooms. Staff said that they would offer detainees tracksuits to wear during visits if their own clothing had been removed for any reason, and that they would allow clothing to be brought in by friends or relatives if needed. No underwear was available.

### *Watford*

- 4.80 A range of reading materials, including books, magazines and newspapers, were held, but we saw few items being given to detainees. We were told by staff that visits could not be facilitated but that clothes could be brought in when required. No underwear was available.

## **Expectation**

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- 4.81 Custody suite staff have received fire safety training and evacuation procedures are practised frequently.

## **Findings**

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### *Hatfield*

- 4.82 Fire evacuation procedures were clearly displayed and an evacuation grab bag was in use. This contained sufficient sets of handcuffs and bibs for identifying detainees in the case of evacuation. One training exercise had been planned but had been superseded by a live evacuation on the same day when all power to the custody suite had been lost.

### *Hoddesdon*

- 4.83 Fire evacuation procedures had been periodically practised but staff had not attended fire safety training.

### *Stevenage*

- 4.84 Fire evacuation procedures were clearly displayed and an evacuation grab bag was in use. This contained sufficient sets of handcuffs and bibs for identifying detainees in the case of evacuation. Fire evacuation procedures had been periodically practised but staff had not attended fire safety training.

*Watford*

- 4.85 Fire evacuation procedures were not on display and there was no record of recent fire drills.

**Other findings**

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*Hatfield*

- 4.86 The purpose-built facility at Hatfield was one of the best we had seen, despite minor design faults, such as the booking-in area. This was a large open area in the middle of the custody suite and it was sometimes difficult to maintain privacy for detainees owing to the number of people working, passing through or congregating in this area. There were four booking-in desks. These had partitions between them, which provided a degree of privacy. When all desks were in use, noise levels were high and added to the difficulty in maintaining privacy. Staff were knowledgeable, polite and respectful to detainees. Daily staffing levels were adequate when all staff were on duty. We observed that staffing levels were sometimes lower than agreed levels, and this could hamper work at busy times.

*Hoddesdon*

- 4.87 The exchanges we saw between staff and detainees were professional and respectful, and demonstrative of a good level of care.
- 4.88 The front desk booking-in area was small, with two booking-in points; if they were both in use there was no means of having a private conversation with new detainees.
- 4.89 The normal staffing complement of one custody sergeant, two DEOs and one CA was frequently reduced to a single DEO. This meant that during busy times, custody sergeants were required to carry out booking-in procedures, rather than overseeing the work of DEOs. While we did not observe this happening, it would be of concern if an appropriate level of oversight of DEOs and CAs was not possible. We were also told that staff recruitment and retention of CAs was a problem, with two posts being unfilled at the time of the inspection.

*Stevenage*

- 4.90 The exchanges we saw between staff and detainees were professional and respectful, and demonstrative of a good level of care.
- 4.91 We were told that CCTV records were retained for a minimum of 30 days, but that there had been problems with the server overheating owing to poor ventilation in the server room. This had led to some records being invalidated. Work was under way during the inspection to rectify this.

*Watford*

- 4.92 Watford custody suite was located in an old building. While efforts had been made to brighten up cells, the whole area was in need of complete refurbishment. Staff we spoke to were clearly affected by their working conditions. We observed one staff member telling detainees that he did not like working in the custody suite and that he hoped he would be moved following the inspection.

## Recommendations

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- 4.93 A clear protocol for transferring detainees from police to court cells should be agreed with the escort contractor and adhered to in all custody suites, maximising the use of both sets of cells.
- 4.94 All custody suites should be refurbished and deep cleaned where necessary, with regular cell fabric checks, and removal of graffiti and any ligature points.
- 4.95 Seating should be provided in all cells.
- 4.96 Toilets in all custody suites should be adequately screened and blocked out on closed-circuit television (CCTV) screens.
- 4.97 Detainees should be offered showers and exercise at regular intervals when held for more than 24 hours. All custody suites should provide an adequate number of showers.
- 4.98 All cells should have en-suite hand washing facilities, and towels and soap should be provided when risk assessments allow.
- 4.99 All custody suites should have exercise areas cleaned at least daily.
- 4.100 Detainees should be offered regular meals. More substantial meals, with a higher nutritional value, should be available for detainees held more than 24 hours. The policy regarding food being sent in should be clarified for all staff.
- 4.101 Underwear should be available when detainees require changes of clothing.
- 4.102 A greater range of reading materials, particularly books, should be available and offered to detainees as a matter of course.
- 4.103 Female cells should never be located at a distance from the main cell area.
- 4.104 Visits should be facilitated in all custody suites, and visitors only strip searched when intelligence and risk indicate that this is necessary.
- 4.105 The booking-in area in all custody suites should offer sufficient privacy.
- 4.106 Specified observation levels for detainees should always be adhered to, and observations should be carried out in person and not through CCTV systems.
- 4.107 Staff in all custody suites should routinely explain to new detainees that in-cell CCTV monitoring will take place.
- 4.108 All staff should be issued with and carry anti-ligature knives.
- 4.109 Staff in all custody suites should attend refresher suicide and self-harm training, at least every three years.
- 4.110 Staff in all custody suites should routinely explain to new detainees how the cell call bell system operates.

- 4.111 Staff in all custody suites should undergo fire safety training, fire evacuation arrangements should be on display and there should be regular fire drills.
- 4.112 Staff in all custody suites should not use personal mobile telephones while on duty other than in exceptional circumstances.



## 5. Individual rights

- 5.1 Detention at Hatfield was authorised appropriately and reviewed by an inspector, although this sometimes took place by telephone. Detainees were informed of their rights and this information was available in a range of languages. Translation services were used when needed. Juveniles were generally dealt with in the same way as other detainees, although they could be fast tracked during busier periods, and custody assistants paid particular attention to their welfare. A female officer assisted female detainees, and there was some consideration of childcare issues. Detainees could readily access the duty solicitor scheme, and immigration detainees were also dealt with using this scheme. Detainees were provided with breaks in accordance with Police and Criminal Evidence Act (PACE) guidelines, and could read through their interview transcripts before signing them. Complaints, including those of a racist nature, were dealt with initially by the reviewing inspector, but the process was not explained to new detainees. There were systems for the safe release of vulnerable detainees
- 5.2 Detention at Hoddesdon was authorised appropriately and detainees were informed of their rights. Translation services were used when needed. There were two dedicated detention rooms for juveniles, and custody assistants paid particular attention to their welfare. The provision of an efficient appropriate adult scheme for juveniles was problematic, and there was rarely a female officer on duty, although a female member of staff based in the station was nominated to support female detainees. Childcare issues were not dealt with proactively. Complaints were dealt with initially by the reviewing inspector but this system was not explained to detainees. There were arrangements to ensure that the needs of vulnerable detainees were met on release.
- 5.3 Detention at Stevenage was authorised appropriately and detainees were informed of their rights. Translation services were used when needed. There were no dedicated detention rooms for juveniles or females. However, it was common practice for juveniles to be located in cells nearest the custody suite reception, and additional attention was given by staff. The suite was well staffed with female officers, who provided additional support to female detainees. The local youth offending service provided an appropriate adult scheme during office hours, but outside these hours delays could occur. Complaints were dealt with initially by the reviewing inspector. There were arrangements to ensure that the needs of vulnerable detainees were met on release.
- 5.4 Detention at Watford was authorised appropriately, and reviewed by an inspector. The treatment of detainees on arrival varied widely depending on who was completing the process. Good use was made of pre-court disposals with juveniles. Not all detainees had their rights explained to them orally, and translated materials were limited, although translation services were used when needed. Juveniles were generally dealt with in the same way as other detainees, but there was a designated detention room for juvenile detainees. There were no specific arrangements to manage female detainees, and childcare issues were not treated as a priority. Detainees could readily access the duty solicitor scheme; although immigration detainees were dealt with using the same scheme, and there were occasions when solicitors had refused to attend for an immigration interview. Detainees were provided with breaks in accordance with PACE guidelines, and could read through their interview transcripts before signing them. Early court cut-off times resulted in detainees spending longer in custody than would otherwise be necessary. Complaints, including those of a racist nature, were dealt with initially by the reviewing inspector, but the process was not explained to new detainees.

## **Expectation**

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- 5.5 Detention is appropriate, authorised and lasts no longer than is necessary. In the case of immigration detainees alternative disposals are expedited.

## **Findings**

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### *Hatfield*

- 5.6 Detention into custody was authorised by the custody sergeant, who heard the alleged offences presented by the arresting officer and monitored the detention and escort officers (DEOs) as they completed the risk assessments. All the custody records reviewed detailed the reason for the detention. Reviews were carried out by an inspector; however, on one day during the inspection there were no inspectors available to attend the custody suite to complete the custody reviews that were due. This therefore had to take place over the telephone. We observed the review being conducted, and the detainee became increasingly agitated as the conversation continued. The telephone call was conducted in a busy area and there was no opportunity for the detainee to discuss any complaints he might have had about his detention. The records we reviewed indicated that only two detainees had had their detention reviewed over the telephone on that particular day, and this appeared to be a rare occurrence and was appropriately recorded as having taken place remotely.
- 5.7 Records indicated that interviews were completed within the timescales specified under PACE and covered the necessary legal requirements. Detainees who were under the influence of alcohol and arrested during the night were held overnight or until they were lucid enough to be interviewed by police staff.
- 5.8 There was good liaison between custody staff and immigration services, and the latter were contacted when a non-British national was detained so that any immigration issues could be dealt with early on in their detention. We observed one Brazilian detainee having to remain in custody overnight, as staff from immigration services were not available to attend. However, police were also conducting further investigations into the alleged offences.

### *Hoddesdon*

- 5.9 We examined a number of custody records, and they all appeared to be completed to a satisfactory standard and were authorised by the custody officer. DEOs completed most of the booking-in process and were overseen by the custody sergeant. Staff expressed concern that at times of high demand this process was sometimes circumvented and that DEOs took too much responsibility. During the inspection, one detainee was charged at 12.30pm on one day and the court declined to hear the case until the following day.
- 5.10 There was good liaison between custody staff and immigration services, and the latter were contacted when a non-British national was detained so that any immigration issues could be dealt with early on in their detention.

### *Stevenage*

- 5.11 We examined a number of custody records, and they all appeared to be completed to a satisfactory standard and were authorised by the custody officer. DEOs completed most of the booking-in process and were overseen by the custody sergeant. Staff expressed concern that

at times of high demand this process was sometimes circumvented and that DEOs took too much responsibility, although this was not evident during the inspection.

- 5.12 There was good liaison between custody staff and immigration services, and the latter were contacted when a non-British national was detained so that any immigration issues could be dealt with early on in their detention.

#### *Watford*

- 5.13 Approaches to the booking-in of detainees ranged from rushed and dismissive to thorough and respectful. Detention into custody was authorised by the custody sergeant, who heard the alleged offences presented by the arresting officer. Both the custody sergeant and the DEOs completed risk assessments for detainees and the paperwork pertaining to their detention. Due to the cramped space of the custody suite, staff had to keep the number of people at the front desk and in the holding rooms to a minimum.
- 5.14 The custody records reviewed in detail the reason for the detention. Reviews were carried out by an inspector and records were appropriately updated.
- 5.15 The juvenile custody records we reviewed showed good use of pre-court disposals where appropriate, which meant that juveniles generally did not spend a significant period in the custody suite. In one record, a juvenile detainee's chosen appropriate adult was not able to speak English well, so, to avoid prolonging the time in custody, the juvenile was bailed to return to the custody suite with a more suitable appropriate adult.
- 5.16 Records indicated that interviews were completed within the timescales specified under the Police and Criminal Evidence Act (PACE) and covered the necessary legal requirements. However, we were unable to determine whether detention was always appropriate and lasted no longer than necessary in these circumstances.
- 5.17 Immigration services worked well with custody staff. We attended the custody suite when six immigration detainees were in custody. Immigration staff arrived within four hours and were permitted to interview each of the detainees, in the presence of an interpreter, and deal with each of the detainees expeditiously so that they spent as little time as possible in custody. Five of the detainees were released on the same day. The sixth detainee was detained in custody pending further information and/or removal to an immigration removal centre, and this was planned for the following day.

### **Expectation**

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- 5.18 Detainees, including immigration detainees, are told that they are entitled to have someone concerned for their welfare informed of their whereabouts. Any delay in being able to exercise this entitlement, such as phoning a person concerned for their welfare, is authorised at the level of Inspector or above. They are asked if they wish to see a doctor.

### **Findings**

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#### *Hatfield*

- 5.19 All detainees, including immigration detainees, were given a notice of rights and entitlements, and all the DEOs read out detainees' main rights. We observed the detention of a Brazilian

detainee, who spoke relatively good English but was unable to read English. A notice of entitlements was given to him in Portuguese and was available in a range of other languages. Once the risk assessment had been completed, a member of staff, independent of the arrest and booking-in process, went through the risk assessment to confirm that all the details were correct. However, the detainee was not required to sign any documentation until an interpreter attended the custody suite.

- 5.20 In some of the records we reviewed, detainees were not permitted to notify someone of their whereabouts, so that officers could conduct further investigations, and this was appropriately authorised. Once the investigation had been completed and the issue of preserving evidence was no longer problematic, detainees were then permitted a telephone call.
- 5.21 All detainees were asked if they had any health concerns or injuries, and where appropriate they were given the option of seeing a doctor.

*Hoddesdon*

- 5.22 All the detainees we saw, including immigration cases, were informed of their entitlements, and all the custody records we examined corroborated that this was the normal practice.
- 5.23 In some of the records we reviewed, detainees were not permitted to notify someone of their whereabouts, so that officers could conduct further investigations, and this was appropriately authorised. Once the investigation had been completed and the issue of preserving evidence was no longer problematic, detainees were then permitted to make a telephone call.
- 5.24 All detainees were asked if they had any health concerns or injuries, and where appropriate they were given the option of seeing a doctor.

*Stevenage*

- 5.25 All the detainees we saw, including immigration cases, were informed of their entitlements, and all the custody records we examined corroborated that this was the normal practice.
- 5.26 In some of the records we reviewed, detainees were not permitted to notify someone of their whereabouts, so that officers could conduct further investigations, and this was appropriately authorised. Once the investigation had been completed and the issue of preserving evidence was no longer problematic, detainees were then permitted to make a telephone call.
- 5.27 All detainees were asked if they had any health concerns or injuries, and where appropriate they were given the option of seeing a doctor.

*Watford*

- 5.28 All detainees, including immigration detainees, were given a notice of rights and entitlements, but not all DEOs or custody sergeants read out detainees' main rights, although we observed one custody sergeant who was not normally assigned to the custody suite doing so. During the inspection, six immigration detainees were brought into the custody suite and were dealt with appropriately (see paragraph 5.17). Notices of rights and entitlements were given to the detainees in their own languages (Urdu and Gujarat), and the risk assessment process was delayed until an interpreter attended. All were given the opportunity to inform someone of their whereabouts, and this was also the case in most of the custody records we reviewed.

- 5.29 In some of the records we reviewed, detainees were not permitted to notify someone of their whereabouts, so that officers could conduct further investigations, and this was appropriately authorised. Once the investigation had been completed and the issue of preserving evidence was no longer problematic, detainees were then permitted a telephone call.
- 5.30 All detainees were asked if they had any health concerns or injuries, and where appropriate were given the option of seeing a doctor.

### **Expectation**

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- 5.31 **Detainees who have difficulty communicating are adequately provided for with staff who can communicate with them or interpreters.**

### **Findings**

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#### *Hatfield*

- 5.32 There was limited translated information displayed in the custody suite, mainly concerning accessing legal advice. Records indicated that translation services (Language Line) were used and we observed interpreters attending the custody suite so that detainees could be interviewed. Care was taken to ensure that all detainees understood the questions asked of them and the information given to them. A range of translated documents was available and the DEOs had access to the Police Visual Handbook for documents in a wider range of languages.
- 5.33 Although staff we spoke to said that they had no cause to use British sign language (BSL) interpreters, there was a list that they could access.

#### *Hoddesdon*

- 5.34 Language Line was used to inform non-English speakers of their rights and explain the process, and we observed this occurring on two occasions. There was also a robust interpreter contact system, which although it took longer to arrange, appeared to operate correctly.

#### *Stevenage*

- 5.35 Language Line was used to inform non-English speakers of their rights and explain the process, and we observed this occurring on two occasions. There was also a robust interpreter contact system, which although it took longer to arrange, appeared to operate correctly.

#### *Watford*

- 5.36 There was limited translated information displayed in the custody suite, mainly concerning accessing legal advice. DEOs had access to relevant documents in a wide range of languages. Translation services (Language Line) were used.
- 5.37 A portable induction loop was available in the suite and signs were displayed at the front desk. The loop could be positioned at the front desk to support a detainee with a hearing aid. There was also a list of BSL interpreters available.

- 5.38 We observed one detainee informing the custody sergeant that he was dyslexic, and the custody sergeant took care to ensure that he was able to read the information given to him; the detainee had the opportunity to have the information read to him but declined.

### **Expectation**

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- 5.39 There are special arrangements for detained young people that cover:
- the limited use of restraints
  - the conduct of any strip search
  - location in unlocked detention rooms close to the custody desk where possible for observation purposes
  - separation from adults at all times including in showers and exercise yard
  - specially trained officers allocated until the appropriate adult arrives
  - whether appropriate adults are indeed appropriate for the task
  - the capacity for the relative, guardian or appropriate adult to remain with the detained young person during waiting periods, in the detention room if necessary.

### **Findings**

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#### *Hatfield*

- 5.40 There was no separate policy for the detention of juveniles and their treatment and custody; staff told us that all detainees were treated the same and in accordance with PACE. We were told by the custody sergeant on duty that juveniles were kept in the same holding area as adults but were supervised at all times by an officer or custody assistant. During busier periods, juveniles were fast tracked and dealt with first, to avoid them being kept in holding rooms with other detainees.
- 5.41 There were no specific juvenile detention cells; juvenile detainees could be held in any of the 30 cells in the suite. Although one custody sergeant told us that a juvenile would normally be located in the cell closest to the custody desk, this was not the protocol of the custody suite. We observed one custody sergeant taking responsibility for allocating cells to detainees, and taking any relevant issues into consideration (for example, being under the influence of alcohol).
- 5.42 Exercise and access to showers and toilets were conducted separately for all detainees. Custody staff had not received any specific child welfare or child protection training. One detention custody officer we spoke to was aware of whom to contact if there were child protection concerns, and the sensitivity with which strip searches needed to be undertaken in the case of juveniles, but we did not speak to all staff so could not ascertain if this was common practice.
- 5.43 We were told that juveniles and their appropriate adults would be permitted to wait in the detention cells with the door closed. As there was no standard practice for dealing with juvenile detainees, custody sergeants and staff dealt with them according to their individual needs.
- 5.44 An appropriate adult scheme was managed and coordinated by the local youth offending service during working hours. There was a long list of PACE-trained volunteers, and DEOs contacted the youth offending service to access them. We were told by the custody sergeant and staff that the service was effective. Outside office hours, DEOs contacted the volunteers directly and had no concerns about their availability. An out-of-hours service was provided by a

social services emergency duty team for any detainees who had mental health concerns or learning difficulties and were in need of an appropriate adult. There appeared to be good arrangements for accessing an appropriate adult, and the custody records showed that the scheme was rarely used because parents or carers generally attended the custody suite.

#### *Hoddesdon*

- 5.45 There were two dedicated detention rooms for juveniles, located separately from other cells. These were locked cells and, although not close to the custody desk, they were continuously monitored through closed-circuit television (CCTV). Custody assistants were tasked with paying particular attention to detained juveniles. There was no formal appropriate adult service through agencies such as the youth offending team, but local managers were satisfied with an unofficial arrangement with a retired social worker, who was helpful in volunteering her services on an almost 24/7 basis. We examined several custody records, and they corroborated this arrangement. However, although the system appeared to work well, the appropriate adult service was vulnerable to the availability of this sole person.
- 5.46 We were told that juveniles and their appropriate adults would not be permitted to wait in the detention cells with the door closed. As there was no standard practice for dealing with juvenile detainees, custody sergeants and staff dealt with them according to their individual needs.

#### *Stevenage*

- 5.47 There were no dedicated juvenile detention rooms. Juveniles were usually put into cells immediately adjacent to the custody reception desk. These were locked cells and were continuously monitored through CCTV. Custody assistants were tasked with paying particular attention to detained juveniles. There were formal appropriate adult arrangements with the youth offending team, although these generally operated during normal office hours only. We examined several custody records, which corroborated this arrangement. Out-of-hours provision of an appropriate adult could be difficult, potentially compromising the expeditious processing of a juvenile.
- 5.48 We were told that juveniles and their appropriate adults would not be permitted to wait in the detention cells with the door closed, but that, depending on a risk assessment, the latter might be allowed to wait in holding rooms with the detained person. As there was no standard practice for dealing with juvenile detainees, custody sergeants and staff dealt with them according to their individual needs.

#### *Watford*

- 5.49 There was no separate policy for the detention of juveniles and their treatment and custody; staff told us that all detainees were treated the same and in accordance with PACE. There was one designated detention room for juvenile detainees, located closest to the custody desk, which was monitored by CCTV and had the life-sign system installed. In all the records we saw for juvenile detainees, they had been located in this designated detention room. Exercise and access to showers and toilets were conducted separately for all detainees. Custody staff had not received any specific child welfare or child protection training, but showed some awareness of their vulnerabilities and had links with the local social services department.
- 5.50 We were told by a DEO that juveniles and their appropriate adults were permitted to wait in the detention room with the door closed, to separate them from other detainees. However, another DEO told us that they would not be located in the detention room together, and that if it was necessary for the appropriate adult to have continued access to the juvenile they would be

placed in the consultation room. There were few other options for locating a juvenile and their appropriate adult, as the holding room was small and lacked privacy.

- 5.51 An appropriate adult scheme was managed and coordinated by the local youth offending service during Monday to Friday working hours. There was a long list of PACE-trained volunteers, and DEOs contacted the youth offending service to access them. We were told by the custody sergeant and staff that the service was effective. Outside office hours, the DEOs had a list of volunteers' contact details and availability, so they could contact them directly. Additionally, an out-of-hours service was provided by a social services emergency duty team for any detainees who had mental health concerns or learning difficulties and were in need of an appropriate adult. There appeared to be good arrangements for accessing an appropriate adult, but the custody records showed that the scheme was rarely used because parents or carers generally attended the custody suite.

### **Expectation**

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- 5.52 Female detainees are able to be dealt with by female staff, or where this is not possible, hygiene packs for women are routinely provided. Staff are aware that the impact of detention on women is different to the impact on men, and adapt their level of observation and support appropriately.

### **Findings**

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#### *Hatfield*

- 5.53 A female DEO was always profiled to be available in the custody suite. Custody staff said that, apart from female members of staff dealing with female detainees (and this was largely limited to searching), they treated female detainees according to the PACE code of conduct. Staff we spoke to had some understanding of the impact of detention on women and generally regarded them as vulnerable detainees, much the same as juvenile detainees. Staff ensured that female detainees were not located with male detainees in the holding room unsupervised.
- 5.54 Hygiene products were available in the custody suite, although female detainees were not routinely informed of their availability and had to ask staff if they required them.

#### *Hoddesdon*

- 5.55 During the inspection, no female members of custody staff were evident (nor were there any female detainees). Female juveniles and vulnerable adult women were allocated a nominated carer (female member of staff) to provide support and information, although the impact of this was negated by the staff member not being based in the custody suite. A check of the store cupboard indicated that there was a good supply of female hygiene packs, and the custody assistants said that these would be provided on request, but that they did not routinely inform female detainees that they were available – stating that it would be embarrassing to do so. We were told that female detainees were searched by female officers, who would be brought to the custody suite from elsewhere to do so. Staff did not demonstrate an understanding of the differential impact of detention on females.

#### *Stevenage*

- 5.56 There were several female members of custody staff, all of whom said that they paid particular attention to the needs of female detainees. Female juveniles and vulnerable adult females

were allocated a nominated carer (female member of staff) to provide support and information during their time in the custody suite. A check of the store cupboard showed that there was a good supply of female hygiene packs, and the custody assistants said that they routinely advised female detainees that these were available if required. Female detainees were searched by female officers. Staff demonstrated an understanding of the differential impact of detention on females.

#### *Watford*

- 5.57 Apart from female members of staff dealing with female detainees (and this was largely limited to searching), female detainees were treated according to the PACE code of conduct. During the inspection, two male members of staff were working at the custody suite and a male officer was assisting with the constant supervision of a female detainee and appeared to be engaging well with her.
- 5.58 Staff we spoke to had little understanding of the impact of detention on women. The two female detention cells were located on the first floor, next to the medical room and in a remote part of the custody suite. Appropriately, the female detainee who was on constant supervision during the inspection had been placed in a cell on the ground floor.
- 5.59 A limited number of hygiene products were available in the medical room, but female detainees were not routinely informed of their availability and had to ask staff if they required them.

### **Expectation**

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- 5.60 Persons detained who have dependency obligations are catered for.

### **Findings**

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#### *Hatfield*

- 5.61 Although it was not routinely asked, we observed one DEO enquiring about a female detainee's childcare arrangements. We were informed that female detainees tended to alert either the arresting officers or the custody suite staff if they were carers, and custody staff said that they would attempt to contact family and friends and/or social services to ensure that childcare arrangements were in place during the detention period.

#### *Hoddesdon*

- 5.62 There were no specific arrangements or scripted questions about childcare.

#### *Stevenage*

- 5.63 There were no specific arrangements or scripted questions about childcare.

#### *Watford*

- 5.64 We were told that female detainees tended to alert either the arresting officers or the custody suite staff if they were carers, and custody staff said that they would attempt to contact family and friends and/or social services to ensure that childcare arrangements were in place during

the detention period. Staff did not see the significance of raising childcare issues with detainees.

## **Expectation**

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- 5.65 Detainees are able to have a solicitor present when interviewed by police officers. Those under the age of 17 or vulnerable adults or those with learning disabilities are not interviewed without a relative, guardian or appropriate adult present. Solicitors and advocates arrive promptly so as not to unnecessarily prolong the period in custody. Detainees are able to consult with legal representatives in privacy.

## **Findings**

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### *Hatfield*

- 5.66 The custody records we reviewed confirmed whether detainees had requested a solicitor. When they declined legal representation, detainees were not always asked why but were informed that they could request one at any point during their detention. Access to duty solicitors was managed through the central duty solicitors (CDS) scheme. If a detainee required a solicitor, the CDS service was contacted and a reference number obtained; this was recorded in custody records as confirmation that a solicitor had been requested. Custody staff were satisfied with this system and said that solicitors attended promptly. This was also confirmed by legal advisers and solicitors we spoke to, who also told us that they found custody staff to be professional.
- 5.67 There were eight interview rooms, with good access to them. There were also three consultation rooms (one was a closed visits room), which were used by solicitors to consult with their clients but they were located a long distance from the custody desk. We were told that either a member of staff supervised the use of the rooms and waited outside during interviews, or solicitors consented to being locked in with their clients. We were told that this was the only design fault of the new custody suite.
- 5.68 During the inspection, we saw two solicitors being told that they could not see their clients in the custody suite, as they had been charged and were waiting for transfer to court cells. The solicitors had been told at the court that they needed to see their clients in the custody suite. We were told by an inspector that this was an ongoing issue that was being addressed with Global Solutions Limited (GSL) and that the arrangement was that detainees who had been charged and were waiting to be transferred to court cells could not be seen by their solicitors until in the court cells.
- 5.69 Custody records and our observations indicated that juveniles were not interviewed unless a relative, guardian or appropriate adult was present.

### *Hoddesdon*

- 5.70 Staff told us that relations with local solicitor firms were good, and this was confirmed by a legal representative we spoke to. There was no undue delay in solicitors attending the suite, and there was a dedicated consultation room available for solicitors to consult their clients in private.

### *Stevenage*

- 5.71 Staff told us that relations with local solicitor firms were good, and this was confirmed by a legal representative we spoke to. There was no undue delay in solicitors attending the suite, and there was a dedicated consultation room available for solicitors to consult their clients in private.

### *Watford*

- 5.72 Custody records we reviewed confirmed whether detainees had requested a solicitor. When they declined legal representation, detainees were informed that they could request one at any point during their detention. Access to duty solicitors was managed through the CDS scheme. If a detainee required a solicitor, the CDS service was contacted and a reference number obtained; this was recorded in custody records as confirmation that a solicitor had been requested. Custody staff were satisfied with this system and said that solicitors attended promptly.
- 5.73 The case records we reviewed of five out of the six immigration detainees held at the time of the inspection showed that, despite three of the detainees requesting a solicitor and staff contacting the CDS service, no legal representative had attended, and in one case custody staff were contacted by a solicitor refusing to attend the custody suite for 'just an immigration interview'. Custody staff said that they were reliant on the CDS service and had little control over their willingness to attend. The remaining two detainees had not wanted legal representation.
- 5.74 There were three interview rooms, located on the first floor, to which there was reasonable access, and one consultation room, which was located in the same area as the custody desk, providing good visibility to custody staff. Custody records and our observations indicated that juveniles were not interviewed unless a relative, guardian or appropriate adult was present.

## **Expectation**

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- 5.75 Detainees are not interviewed by police officers while under the influence of alcohol or drugs, or if medically unfit unless in circumstances provided for under PACE.

## **Findings**

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### *Hatfield*

- 5.76 All detainees were asked if they had consumed any alcohol or drugs. We observed detainees who had been under the influence of alcohol being given time to sleep off its effects, and records we reviewed showed that custody sergeants acted on the advice given by medical staff about whether detainees were fit for interview. DEOs recorded when it was appropriate for detainees to be interviewed, and the custody sergeant was accountable for ensuring that this was adhered to by officers.

### *Hoddesdon*

- 5.77 Examination of custody records revealed that detainees brought into the custody suite under the influence of alcohol or drugs were frequently detained for several hours to allow them to recover before interview. There was no evidence of detainees being interviewed while under the influence of alcohol or drugs or while medically unfit.

*Stevenage*

- 5.78 Examination of custody records revealed that detainees brought into the custody suite under the influence of alcohol or drugs were frequently detained for several hours to allow them to recover before interview. There was no evidence of detainees being interviewed while under the influence of alcohol or drugs or while medically unfit.

*Watford*

- 5.79 All detainees were asked if they had consumed any alcohol or drugs. We observed detainees who had been under the influence of alcohol being given time to sleep off its effects, and records we reviewed showed that custody sergeants acted on the advice given by the medical staff about whether detainees were fit for interview. DEOs recorded when it was appropriate for detainees to be interviewed, and the custody sergeant was accountable for ensuring that this was adhered to by officers.

**Expectation**

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- 5.80 Suitable legal advice is available for both police detainees and immigration detainees.

**Findings**

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*Hatfield*

- 5.81 Solicitors were provided through the CDS scheme to all detainees who requested one and records revealed no significant delays for detainees in accessing legal advice, either over the telephone or in person. We were told that, if required, an immigration solicitor would be accessed through the same scheme, but staff were unsure if these solicitors were specialists in immigration matters. We were unable to review the records of any immigration detainees to assess the availability of legal advice for such individuals.

*Hoddesdon*

- 5.82 Legal advice was readily available to detainees, although no specific support was available to immigration detainees, who would be allocated a duty solicitor.

*Stevenage*

- 5.83 Legal advice was readily available to detainees although no specific support was available to immigration detainees, who would be allocated a duty solicitor.

*Watford*

- 5.84 Solicitors were provided through the CDS scheme to all detainees who requested one, and records revealed no significant delays for detainees in accessing legal advice, either over the telephone or in person. We were told that, if required, an immigration solicitor would be accessed through the same scheme, although they did not always attend (see paragraph 5.73).

## **Expectation**

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- 5.85 Detainees are not subject to inhuman or degrading treatment in the context of being interviewed, or in the denial of any services they need. They are allowed a period of eight hours continuous break from interviewing in a 24-hour period.

## **Findings**

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### *Hatfield*

- 5.86 Detainees were provided with at least an eight-hour continuous break from interviewing in a 24-hour period. Interview rooms were appropriate and sound proofed. Solicitors we spoke to did not express any concerns about their clients being poorly treated.

### *Hoddesdon*

- 5.87 There was no evidence of any inhumane or degrading treatment or of services being denied. However, staff told us that it would be rare to interview those arrested at night until the following morning. Although in many cases this would be appropriate – for example, if a detainee was under the influence of alcohol or if more investigative work was required – this could result in detainees being detained unnecessarily until the morning.

### *Stevenage*

- 5.88 There was no evidence of any inhumane or degrading treatment or of services being denied. However, staff told us that it would be rare to interview those arrested at night until the following morning. Although in many cases this would be appropriate – for example, if a detainee was under the influence of alcohol or if more investigative work was required – this could result in detainees being detained unnecessarily until the morning. It should be noted that the limited sample size examined did not reveal any examples of this.

### *Watford*

- 5.89 Detainees were provided with at least an eight-hour continuous break from interviewing in a 24-hour period. Interview rooms were appropriate and sound proofed. Solicitors we spoke to did not express any concerns about their clients being poorly treated.

## **Expectation**

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- 5.90 Detainees are not handcuffed in secure areas unless there is a risk of violence to other detainees or staff.

## **Findings**

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### *Hatfield*

- 5.91 All custody records we looked at confirmed whether detainees had been brought into the custody suite handcuffed. In most of the records we looked at, detainees were handcuffed at the front and these were removed once in the holding area of the custody suite. All detainees,

including juveniles, were restrained according to the risk they posed. During the inspection, detainees in the custody suite were not handcuffed or otherwise restrained.

*Hoddesdon*

- 5.92 No violent detainees were observed during the inspection, but staff told us that there had been occasions when violent detainees had been placed in cells wearing handcuffs. These restraints would be removed as soon as practicable.

*Stevenage*

- 5.93 No violent detainees were observed during the inspection, but staff told us that there had been occasions when violent detainees had been placed in cells wearing handcuffs. Records indicated that these restraints had been removed as soon as practicable. During the inspection, we observed that restraints were not used routinely.

*Watford*

- 5.94 All custody records we looked at confirmed whether detainees had been brought into the custody suite handcuffed. In most of the records we looked at, detainees were handcuffed at the front and these were removed once in the holding area of the custody suite. All detainees, including juveniles, were restrained according to the risk they posed. During the inspection, detainees in the custody suite were not handcuffed or otherwise restrained.

**Expectation**

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- 5.95 Those charged are produced at court promptly either in person or via video link.

**Findings**

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*Hatfield*

- 5.96 GSL was the main escort contractor and managed the court cells. Once detainees had been charged in the police custody suite, they were moved to the court cells when space became available. GSL staff checked through the paperwork with DEOs and signed to take responsibility for detainees. There were 10 court cells, which had only been open since October 2008, and there were still some teething problems regarding the movement of detainees to the court cells. Detainees from surrounding police stations were prioritised for location in the court cells. We were told by an inspector that custody staff relied on GSL to notify them when their cells were vacant and that the transfer of detainees from the custody suite to the court cells was being monitored, as there had been instances when this had not taken place at the earliest opportunity. During the inspection, there were no issues regarding the production of detainees at court; all detainees who were due to attend Hatfield Magistrates' Court were transferred by 10am and those attending other courts were transferred earlier.

*Hoddesdon*

- 5.97 GSL was the main escort contractor, and detainees were collected and taken to court between 7.30am and 8.30am. During the inspection, one detainee was charged at 12.30pm one day and the court declined to hear the case until the following day, thus resulting in an additional night being spent in custody. The custody inspector indicated that this was a rare occurrence.

*Stevenage*

- 5.98 GSL was the main escort contractor, and detainees were collected and taken to court between 7.30am and 8.30am. Custody staff did not report any undue problems with producing charged detainees at court.

*Watford*

- 5.99 GSL was the main escort contractor, and detainees were collected and taken to court between 7.30am and 8.30am. Custody staff said that the transfer of detainees to court had improved, and that the times that GSL staff attended the custody suite were predictable and worked well. The usual cut-off time for court appearances was 11am, although this was not a rigid arrangement and if a police escort could be provided, it could usually be negotiated for detainees to attend court later than this, provided that it was before 1pm.

**Expectation**

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- 5.100 Detainees know how to complain about their care and treatment. They are not discouraged from doing so but are supported in doing so where necessary.

**Findings**

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*Hatfield*

- 5.101 Detainees were not told how to make a complaint, and the complaints process was not publicised. If detainees were in custody long enough to have their detention reviewed by an inspector, they were routinely asked if they had any complaints. Staff said that if detainees wanted to make a complaint they would be referred to the duty inspector, who would deal with it. Custody staff did not acknowledge that they could manage low-level complaints.

*Hoddesdon*

- 5.102 Complaints were received by the reviewing inspector, who explained the avenues open to detainees if they were dissatisfied with the initial response. However, the process for complaining was not explained to new detainees, and it was not publicised anywhere in the custody suite.

*Stevenage*

- 5.103 Complaints were dealt with in the first instance by the reviewing inspector, who explained the process to detainees if they wanted to take matters further. However, the process for complaining was not publicised to detainees.

*Watford*

- 5.104 Detainees were not told how to make a complaint, and the complaints process was not publicised. If detainees were in custody long enough to have their detention reviewed by an inspector, they were routinely asked if they had any complaints. Staff said that if detainees wanted to make a complaint they would be referred to the duty inspector, who would deal with it. Custody staff did not acknowledge that they could manage low-level complaints.

## **Expectation**

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- 5.105 There is an effective system in place for reporting and dealing with racist incidents.

## **Findings**

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### *Hatfield*

- 5.106 There was no formal system for detainees to report racist incidents. If such a complaint was made, it would be dealt with in the same manner as any other complaint (see paragraph 5.101).

### *Hoddesdon*

- 5.107 Any racist behaviour, language or writing was dealt with promptly, using the general complaints procedure outlined above (see paragraph 5.102).

### *Stevenage*

- 5.108 Any racist behaviour, language or writing was dealt with promptly, using the general complaints procedure outlined above (see paragraph 5.103).

### *Watford*

- 5.109 There was no formal system for detainees to report racist incidents. If such a complaint was made, it would be dealt with in the same manner as any other complaint (see paragraph 5.104).

## **Expectation**

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- 5.110 All custody suites hold a copy of the PACE Code of Practice C, and detainees, including immigration detainees, know they are able to consult it. Detainees or their legal representatives are able to obtain a copy of their custody record on release, or at any time within 12 months following their detention.

## **Findings**

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### *Hatfield*

- 5.111 An up-to-date PACE Code of Practice C was available, and all newly arrived detainees were told that this was available on request. We were told by police staff that detainees or their legal representatives could obtain a copy of the custody record on release, or at any time within the 12 months following detention. This information was also contained in the written notice of entitlements that was given to all detainees. We were told by police officers and legal advisers that detainees were permitted to read through their record of interview but were not obliged to sign it, and interpreting services were accessed where necessary.

### *Hoddesdon*

- 5.112 Several copies of the PACE Code of Practice C were held, and detainees were offered a copy as part of the booking-in process after detention was authorised. No detainees were seen to be released during the inspection, so it was not possible to confirm whether the right to a copy of the custody record was explained, but we were told that these records were available on request at any time during the 12 months following detention. Detainees were not provided with a transcript of their interview record, but were given a copy of the interview tape.

### *Stevenage*

- 5.113 Several copies of the PACE Code of Practice C were held, and detainees were offered a copy as part of the booking-in process after detention was authorised. No detainees were seen to be released during the inspection, so it was not possible to confirm whether the right to a copy of the custody record was explained, but we were told that these records were available on request at any time during the 12 months following detention. Detainees were not provided with a transcript of their interview record, but were given a copy of the interview tape.

### *Watford*

- 5.114 An up-to-date PACE Code of Practice C was available, and all newly arrived detainees were told this was available on request. We were told by police staff that detainees or their legal representatives could obtain a copy of the custody record on release, or at any time within the 12 months following detention. This information was also contained in the written notice of entitlements that was given to all detainees. We were told by police officers and legal advisers that detainees were permitted to read through their record of interview but were not obliged to sign it, and interpreting services were accessed where necessary.

## **Expectation**

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- 5.115 Pre-release risk management is conducted and vulnerable detainees are released safely.

## **Findings**

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### *Hatfield*

- 5.116 A pre-release detention exit plan was available for vulnerable detainees. We did not observe any exit plans being implemented, but DEOs were aware of the pre-release document and identified circumstances in which it would be used, usually for level three and level four detainees who required enhanced supervision while in custody. The document was designed to prompt the DEO to give consideration to how the detainee would travel home and whether this needed to be done by police transport. A support agency leaflet was also available, which provided useful information and contact details for a range of agencies.

### *Hoddesdon*

- 5.117 Pre-release risk management was dealt with efficiently. Vulnerable people were identified throughout their stay and a pre-release action plan was considered and, where appropriate, implemented. There were forms specifically designed for this.

### *Stevenage*

- 5.118 Pre-release risk management was dealt with efficiently. Vulnerable people were identified throughout their stay and a pre-release action plan was considered and, where appropriate, implemented. There were forms specifically designed for this.

### *Watford*

- 5.119 A pre-release detention exit plan was available for vulnerable detainees. We did not observe any exit plans being implemented, but DEOs were aware of the pre-release document and identified circumstances in which it would be used, usually for level three and level four detainees who required enhanced supervision while in custody. The document was designed to prompt the DEO to give consideration to how the detainee would travel home and whether this needed to be done by police transport. A support agency leaflet was also available, which provided useful information and contact details for a range of agencies.

## **Recommendations**

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- 5.120 All custody staff should have training in child welfare/ protection matters.
- 5.121 An effective appropriate adult scheme, including out-of-hours arrangements, should be available in all custody suites.
- 5.122 Newly arrived detainees should routinely be asked about any childcare issues resulting from their detention.
- 5.123 Newly arrived detainees should be told how to make complaints, including about a racist matter, and the complaint procedures should be displayed in all custody suites.
- 5.124 Discussions should be held with HM Court Service to ensure that cut-off points for accepting detainees are not too early and thus result in people spending too long in police custody.
- 5.125 If female detainees are not initially seen by female custodial staff, they should have access on request to a female member of staff.

## 6. Healthcare

- 6.1 A 24- hour health service was provided to detainees. Senior officers told us that the overall quality of services was good and response times were generally acceptable. The overall level of cleanliness in custody suites was unsatisfactory and the standard of clinical record keeping variable. Mental health services were variable, with two custody suites having dedicated support and the other two relying on emergency response teams. There were concerns about service differences impacting on the effective provision of mental health services. The drug support agency provided excellent support to all custody suites.

### **Expectation**

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- 6.2 The decency, privacy and dignity of detainees are respected.

### **Findings**

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- 6.3 When detainees were booked in they were asked questions about their physical and mental health, and whether they were substance users. In Stevenage, Hatfield and Watford, attempts had been made to ensure privacy by the use of screens, but at Hoddesdon the front desk was open to all other people in the custody reception area.
- 6.4 The forensic medical examiner's (FME's) rooms at all four sites provided privacy for any detainee undergoing examination. All windows were opaque and the rooms were well sound-proofed.

### **Expectation**

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- 6.5 Detainees are treated by health care professionals and drug treatment workers in a professional and caring manner that is sensitive to their situation and their diverse needs, including language needs.

### **Findings**

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- 6.6 Interviews and observation of all levels of custody staff demonstrated that detainees' health needs were dealt with in a professional and caring manner. Assessments of their health needs started with the arresting officer and continued with the detention and escort officers (DEOs) and custody sergeants. This process was documented in the custody record, and Language Line and interpreters were used for those unable to speak English. There were three female FMEs available if any female detainee requested to be seen by a female doctor. Custody assistants (CA) told us that they were sometimes asked to act as chaperones. Female drug support workers were also available to see female detainees on request.

### **Expectation**

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- 6.7 Clinical governance arrangements include the management, training and supervision and accountability of staff.

## Findings

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- 6.8 The contract for the provision of medical services to Hertfordshire police stations was between Hertfordshire Constabulary and Hertfordshire Forensic Examiners Response Network (H-FERN). The copy we saw was undated, but we were told by the operations director (OD) that the contract had been in place for three years. Contract monitoring had previously over-relied on information provided by H-FERN, but the constabulary had recognised this and had recently begun to gather its own data. Custody staff that we spoke to were satisfied with the FME service. Generally, the response times were regarded as good, but occasionally there were delays because the doctor was already working at his or her GP surgery. When this happened, another doctor was asked to attend, which could increase response times. FMEs could also be working a 24-hour shift which included time in their surgery, as well as undertaking FME duties. GPs based at the Manor House surgery had their registration details checked by the surgery, but it was not clear what checks were made, and by whom, on GPs from other surgeries. H-FERN had recently initiated monthly FME meetings. The OD, approved mental health professional (AMHP) and drug intervention programme (DIP) manager all told us that they had been involved in staff training at custody suites but had not been involved recently. All showed a willingness to participate in training custody staff to understand better the healthcare issues of detainees.

## Expectation

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- 6.9 Patients are treated by health care staff who receive ongoing training, supervision and support to maintain their professional registration and development. Staff have the appropriate knowledge and skills to meet the particular health care needs of detainees in police custody.

## Findings

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- 6.10 The FMEs included two retired GPs, a psychiatrist and an anaesthetist. One of the doctors was Mental Health Act Section 12<sup>2</sup> trained. Some were members of the Forensic Medical Society. We were told that all FMEs maintained their own continuing professional development and reaccreditation status. There was one registered nurse who covered Stevenage and Hatfield custody suites. She had experience in prison and practice nursing.
- 6.11 The role of the CA was relatively new to the force and was based around a care function. The role was to provide 'care' to detainees, in terms of physical and limited mental health support. Detainees were visited every hour and a comment made in their custody records. The CAs we met were inexperienced but eager to develop the role. We considered that this was a useful and important role in the management of detainees which the force should develop with professional guidance.

## Expectation

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- 6.12 Clinical examinations are conducted out of the sight and preferably out of the hearing of police officers. Treatment rooms provide conditions that maintain decency, privacy and

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<sup>2</sup> Section 12(2) of the Mental Health Act 1983 states that one of the medical practitioners making recommendations in respect of applications for the involuntary admission of patients to hospital under Part II of the Act should be individually approved by the Secretary of State as having 'special experience in the diagnosis or treatment of mental disorder'.

**dignity. Infection control facilities are implemented. There is at least one room that is forensically clean.**

## **Findings**

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- 6.13 Overall, the general management and responsibility for FME rooms was unclear. None of the rooms were forensically clean and some were dirty. Staff were unaware of infection control issues and no one knew if any infection control audits had taken place.
- 6.14 Each of the four suites we visited provided a dedicated FME examination and consulting room. Hatfield and Stevenage custody suites were new buildings, and FME rooms were light, spacious and in good decorative order. Hoddesdon custody suite was an ageing building, and the FME room was smaller, although still light. This suite was in reasonable decorative order, but this was more difficult to maintain. It provided privacy for detainees but was situated at a distance from the custody desk. Watford custody suite was an ageing building and, again, the FME room was smaller. It was situated upstairs and far away from the custody desk; while providing privacy for the detainee, this could present logistical difficulties for the FME. There was an opaque window high up in the room which provided limited natural light. The decorative order was poor and tiles had fallen off the wall. There were blood stains on the wall near the sharps bin and around the rim of the clinical waste bin.
- 6.15 All the FME rooms were untidy, with many of the work surfaces and floors covered in a variety of items which should have been stored in cupboards and drawers. The FME room at Watford was insecure and dirty, and not suitable for its use. Cleaning schedules were only seen at Hatfield and Stevenage, but these rooms were only superficially clean. At all sites, the clinical waste bins were generally full and it was unclear who had responsibility for checking or emptying the bins between collections. There were no labels on sharps bins stating when they were assembled, by whom they were assembled or where they were situated, as required by Disposal of Waste Regulations for audit purposes.
- 6.16 We found DNA and forensic samples being inadequately stored in refrigerators and freezers. Old blood, urine, DNA and forensic samples were found at two sites, and it was unclear whether they should have been sent for analysis or stored elsewhere if still required, or disposed of in a suitable manner if no longer required as evidence.
- 6.17 At Watford, a 'samples freezer' contained some forensic samples that were undated, and others going back to February 2007, despite a notice on the front of the freezer stating 'everything over 6 months old will be destroyed'. It also contained what can only be described as a DNA filing system, which contained numerous Police and Criminal Evidence Act (PACE) and volunteer DNA samples which had not been sent off for analysis, and the forms indicated that the DNA had been taken for a range of offences including violent crimes and robbery. At Hemel Hempstead, an old DNA sample, which presumably was not required, was found in a clinical waste bag in a medical examination room. The attached paperwork identifying the offence, suspect and officer in the case was in the DNA bag. The DNA freezer contained evidential DNA samples dated November 2008 and forensic samples dated July 2008. A refrigerator contained blood samples dating back to June 2008 and forensic exhibits going back to November 2007.

## **Expectation**

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- 6.18 **All equipment (including resuscitation kit) is regularly checked and maintained and all staff (healthcare and custody staff) understand how to access and use it effectively.**

## **Findings**

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- 6.19 Each of the four sites we visited held at least one automatic defibrillator. All the defibrillators that we saw showed a green light and the expiry dates were current.
- 6.20 Staff at all four sites confirmed that a healthcare checklist has been instigated throughout the force. The list required that equipment was checked weekly and the checklists were then sent to a central point for collation. We saw first-aid boxes throughout the custody suites and within the FME examination rooms. Eye wash kits were also available in all four suites. All staff we spoke to knew where the defibrillators and first-aid kits were located, and confirmed that they had been trained in how to use them.

## **Expectation**

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- 6.21 **Detainees are able to request the services of a health care professional in and out of hours, and to continue to receive any prescribed medication for current health conditions or for drug maintenance.**

## **Findings**

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- 6.22 When detainees were booked into the custody suites they were asked about their healthcare needs, and current medication, mental and physical health needs and substance usage were all recorded. Where necessary, custody staff used the Glasgow Coma Scale to assess the consciousness of the detainees. If a detainee required a healthcare intervention, the DEO or CA contacted the appropriate healthcare professional. Contact details for all types of healthcare professional were easily available at all four custody suites.
- 6.23 If detainees were currently taking prescribed medications, this was verified by the DEOs or CAs, and the FME was informed. If appropriate, the medication was continued. CAs and DEOs told us that if, for example, a detainee requested mild pain relief for a headache, the FME would be contacted and a verbal instruction would be taken over the telephone. The medication, normally paracetamol, would then be administered by the CA or DEO, and this would be recorded in the detainee's custody record. Any other medication would require the FME to attend the custody suite. Detainees bringing in their own medication were seen by the FME, and where appropriate the medication was continued. Substance users were always seen by the FME, who would attempt to verify medication details with the providing pharmacists, GP and/or DIP teams. Methadone could be prescribed while in custody, but custody staff confirmed that only the FME could administer this drug. With the exception of controlled drugs, all medicines could be administered by the CA or DEO, provided that the FME prepared the medication and dispensed it into a correctly labelled plastic wallet. The wallet was then held securely for the detainee until the drug was administered, after which a record was made in the detainee's custody record and on the medication chart. CAs confirmed that detainees' own medications were returned to them on release.

## **Expectation**

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- 6.24 A liaison and/or diversion scheme enables mentally disordered detainees to be identified and diverted into appropriate mental health services, or referred on to prison health care services.

## **Findings**

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- 6.25 Mental health services were provided by Hertfordshire Partnership NHS Foundation Trust, which provided support in the form of an AMHP, who could be a social worker or a registered mental health nurse. If the arresting officer considered that a detainee might have mental health problems, he or she informed the suite's DEO, who contacted the mental health teams. The detainee would be assessed by an AMHP and treated appropriately, either in the police station or in a mental health unit.
- 6.26 Watford and Stevenage custody suites were served by an AMHP working Monday to Friday office hours; he visited stations daily to check for potential clients. Hatfield and Hoddesdon custody suites had no specific AMHP and had to contact the local area emergency duty team. Recruitment for an AMHP in the Hatfield and Hoddesdon areas was under way. The emergency duty teams consisted of two people on weekdays, and one at nights and weekends; however, the emergency duty team served several other functions in the local area, in addition to mental health provision, and they were often extremely busy when called out.
- 6.27 AMHPs also assessed the fitness to detain and fitness to interview, and advised whether an appropriate adult was required. AMHPs carried out criminal justice assessments in order to divert out of custody and into other establishments. In the event of the potential use of the Mental Health Act Section 136 (see paragraph 6.32) being invoked, a senior AMHP would be contacted and the detainee would be seen within the hour; if necessary, the detainee would be moved to the local secure unit and not brought into a custody suite. DEOs and CAs had been provided with limited mental health awareness training.

## **Expectation**

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- 6.28 Detainees are offered the services of a drugs or alcohol arrest referral worker where appropriate and referred on to community drugs/alcohol teams or prisons' drugs workers as appropriate.

## **Findings**

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- 6.29 DIP teams provided support to detainees in the four custody suites that we visited, from 9.30am to 7pm Monday to Friday. All DIP workers had experience in either social work or nursing. An out-of-hours service in the form of a 24-hour telephone line directed callers to a local rehabilitation centre contact. The DIP service provided help only for users of class A drugs; all other substance users were signposted to other appropriate organisations.
- 6.30 DIP workers visited custody suites twice a day and saw any referrals from custody staff. They also visited all detainees to offer support to those not wishing to disclose a drug habit to officers. If a detainee received a custodial sentence, the drug intervention record was sent to the prison counselling, assessment, referral, advice and throughcare (CARAT) team. The DIP worker would also contact the receiving prison to provide additional information, and would

then follow the client through the custodial system until release. The DIP team had established excellent relationships with local prisons, so throughcare for substance users was good. We were told that DIP workers had provided substance use training for custody staff, but that this had been stopped for some unknown reason. The needle exchange programme in custody suites was not adequate to ensure the safe use of substances.

### **Expectation**

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- 6.31 **Police custody is not used as a place of safety for section 136 assessments<sup>3</sup> except where the detainee needs to be controlled for his or her own safety or the safety of others.**

### **Findings**

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- 6.32 The force had an extant joint policy with Hertfordshire Partnership Foundation Trust and Adult Care Services for the management of 'Place of Safety Detention' under the Mental Health Act 1983 Section 136, as amended by the Mental Health Act 2007.
- 6.33 All custody staff interviewed were emphatic that the Mental Health Act Section 136 was only used as a last resort. Staff were unable to tell us when the section had last been used.

### **Expectation**

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- 6.34 **Each detainee seen by health care staff has a clinical record containing an up-to-date assessment and any care plan conforms to professional guidance from the regulatory bodies. Ethnicity of the detainee is also recorded.**

### **Findings**

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- 6.35 FMEs recorded their clinical notes in a 'doctors' notes' book, which was kept in the FME room. One copy of the notes stayed in the book and another copy remained with the FME. Some FMEs had made entries into this book but had not signed them; in other cases the name and designation of the writer was illegible. The H-FERN operations manager (OM) told us that these records were kept mainly at their surgery base, but some FMEs kept them at their own homes in secure storage, although the OM was unable to provide evidence that this was the case. CAs told us that if a detainee was seen in the custody suite by the nurse or the doctor, this was recorded in the custody record, where any instructions would also be written, and we saw evidence of this.

### **Expectation**

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- 6.36 **Any contact with a doctor or other health care professional is also recorded in the custody record, and a record made of any medication provided. The results of any clinical examination are made available to the detainee and, with detainee consent, his/her lawyer.**

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<sup>3</sup> Section 136 of the Mental Health Act enables a police officer to remove someone from a public place and take them to a place of safety e.g. 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.

## Findings

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- 6.37 CAs confirmed that if a detainee was seen by any health services professional, the visit was recorded in the custody record, where any instructions would be written. Prescriptions were also noted in the custody record. We also saw records of visits by AMHPs and DIP workers in custody records. We were unable to speak with any detainees' lawyers, but we had no reason to believe that clinical records would not be made available to them with detainees' consent.<sup>4</sup>

## Expectation

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- 6.38 Information-sharing protocols exist with all appropriate agencies to ensure efficient sharing of relevant health and social care information.

## Findings

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- 6.39 We were unable to confirm the existence of information-sharing protocols between any health providers and the Constabulary. However, we observed good working relationships between community healthcare workers, including drugs and mental health professionals. Custody staff were mindful of the need to respect medical confidentiality, and any detainee using external health facilities, such as accident and emergency departments, had treatment outcomes recorded in their custody records.

## Expectation

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- 6.40 All medications on site are stored safely and securely, and disposed of safely if not consumed. There is safe pharmaceutical stock management and use.

## Findings

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- 6.41 The overall management of medicines in some custody suites was poor and the potential for the misuse of medicines was of concern. FMEs were responsible for the management of all medicines held in custody suites, and one of them was responsible for the ordering, storage and disposal of stock medicine in the custody suites. Keys to medicine cupboards were available to all staff working in the custody suite. There was no audit of medicines used and no records of remaining stock. The volume of medication at some sites was particularly concerning. Although buying in bulk is clearly more cost effective, the large amounts of medication held unchecked in these custody suites was unacceptable and posed an unnecessary risk. For example, Hoddesdon custody suite held over 2,000 dihydrocodeine tablets. In addition, large pots of diazepam tablets were open, with no record of how many tablets were left and no record of whom they had been administered to. Stevenage custody suite had one pot labelled 'Diazepam 10mgs in 500 tablets'. However, it had been overfilled with tablets decanted from another pot, with no expiry date on the pot. There were no records of how many tablets (of any type) were held on site and no audit trail of their usage or disposal. We also found metformin tablets that had expired in August 2008.

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<sup>4</sup> Only individuals who need access to patient-identifiable information should have access to it. Action should be taken to ensure that those handling patient-identifiable information – both clinical and non-clinical staff – are aware of their responsibilities and obligations to respect patient confidentiality.

## Recommendations

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- 6.42 The forensic medical examiner (FME) contract with H-FERN should be reviewed, to include: assurance from H-FERN that FMEs on call for a 24-hour period maintain their professional competencies throughout that period; confirmation that clinical records are stored safely and securely at all times in its custody suites and in the possession of FMEs; a policy relating to the sharing of information between health professionals; and evidence of annual checks of professional registration, professional appraisals and maintenance of their professional development.
- 6.43 The management of medicines held in custody suites should be reviewed to ensure that appropriate quantities of medicines are held. Advice should be sought from a qualified pharmacist for the introduction of a proper medicine management system, to include: the safe custody of medicines; the appropriate recording of medicines administered; regular stock checks and balances; and disposal of out-of-date medicines.
- 6.44 A professional health-related cleaning company should be introduced to ensure that FME rooms across the force meet infection control guidelines and maintain high levels of cleanliness in clinical areas. Custody staff and FMEs should ensure that the FME room is clean and tidy after every usage.
- 6.45 The force should urgently review how it takes, stores, tracks and submits all DNA and forensic samples taken from detainees, volunteers and victims. The review should identify gaps in policies, training, storage facilities and destruction audit trails. The review should have a senior officer responsible for the delivery of an action plan which addresses the issues.
- 6.46 A programme of regular mental health and substance use updates should be introduced for all staff involved in the primary management of detainees.
- 6.47 The services of the local health provider should be commissioned to undertake an infection control audit of its custody suites to ensure that infection control measures are in place and inspected regularly.
- 6.48 FMEs should always sign entries made into clinical records. The name and designation of the writer should be legible.
- 6.49 The constabulary should work with its mental health partners to ensure that the quality of mental health provision is consistently good across all police custody suites.
- 6.50 All custody reception areas should provide privacy for detainees being interviewed about their medical history.
- 6.51 The role of the custody assistant (CA) should be developed, and CAs should be given basic training in care skills similar to that of the role of NHS healthcare assistants.
- 6.52 Mental health awareness training for detention and escort officers and CAs should be initiated and updated at least annually.
- 6.53 The needle exchange programme should be reintroduced under the guidance of the drug support teams.

- 6.54 All necessary repairs to FME rooms should be made.
- 6.55 Clinical waste bins should be in working order and conform to waste regulations.

### Good practice

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- 6.56 *The drug support teams collaborated with local prisons to ensure that substance users received good support throughout their time in custody.*
- 6.57 *Custody assistants supported the well-being of detainees.*



# 7. Summary of recommendations

## Recommendations

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### Strategy

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- 7.1 The provision of custody services at Watford should be overhauled at the earliest opportunity to ensure the consistent application of corporate standards. (3.23)
- 7.2 An ongoing regime of refresher training should be implemented which addresses core skills and knowledge. This should be centrally managed on behalf of BCUs. (3.24)
- 7.3 The risk posed by ligature points should be understood by staff, and detainees supervised according to risk while in custody. (3.25)
- 7.4 BCU policies which offer local guidance should be validated to ensure that they do not conflict with force policies. (3.26)
- 7.5 Specific policies in relation to the treatment female detainees and young people under 18 years of age should be introduced. (3.27)
- 7.6 The roles of custody sergeant and detention escort officer should be dedicated for a reasonable length of time and staff specially selected for the role based on motivation and suitability. (3.28)

### Treatment and conditions

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- 7.7 A clear protocol for transferring detainees from police to court cells should be agreed with the escort contractor and adhered to in all custody suites, maximising the use of both sets of cells. (4.93)
- 7.8 All custody suites should be refurbished and deep cleaned where necessary, with regular cell fabric checks, and removal of graffiti and any ligature points. (4.94)
- 7.9 Seating should be provided in all cells. (4.95)
- 7.10 Toilets in all custody suites should be adequately screened and blocked out on closed-circuit television (CCTV) screens. (4.96)
- 7.11 Detainees should be offered showers and exercise at regular intervals when held for more than 24 hours. All custody suites should provide an adequate number of showers. (4.97)
- 7.12 All cells should have en-suite hand washing facilities, and towels and soap should be provided when risk assessments allow. (4.98)
- 7.13 All custody suites should have exercise areas cleaned at least daily. (4.99)

- 7.14 Detainees should be offered regular meals. More substantial meals, with a higher nutritional value, should be available for detainees held more than 24 hours. The policy regarding food being sent in should be clarified for all staff. (4.100)
- 7.15 Underwear should be available when detainees require changes of clothing. (4.101)
- 7.16 A greater range of reading materials, particularly books, should be available and offered to detainees as a matter of course. (4.102)
- 7.17 Female cells should never be located at a distance from the main cell area. (4.103)
- 7.18 Visits should be facilitated in all custody suites, and visitors only strip searched when intelligence and risk indicate that this is necessary. (4.104)
- 7.19 The booking-in area in all custody suites should offer sufficient privacy. (4.105)
- 7.20 Specified observation levels for detainees should always be adhered to, and observations should be carried out in person and not through CCTV systems. (4.106)
- 7.21 Staff in all custody suites should routinely explain to new detainees that in-cell CCTV monitoring will take place. (4.107)
- 7.22 All staff should be issued with and carry anti-ligature knives. (4.108)
- 7.23 Staff in all custody suites should attend refresher suicide and self-harm training, at least every three years. (4.109)
- 7.24 Staff in all custody suites should routinely explain to new detainees how the cell call bell system operates. (4.110)
- 7.25 Staff in all custody suites should undergo fire safety training, fire evacuation arrangements should be on display and there should be regular fire drills. (4.111)
- 7.26 Staff in all custody suites should not use personal mobile telephones while on duty other than in exceptional circumstances. (4.112)

## Individual rights

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- 7.27 All custody staff should have training in child welfare/ protection matters. (5.120)
- 7.28 An effective appropriate adult scheme, including out-of-hours arrangements, should be available in all custody suites. (5.121)
- 7.29 Newly arrived detainees should routinely be asked about any childcare issues resulting from their detention. (5.122)
- 7.30 Newly arrived detainees should be told how to make complaints, including about a racist matter, and the complaint procedures should be displayed in all custody suites. (5.123)
- 7.31 Discussions should be held with HM Court Service to ensure that cut-off points for accepting detainees are not too early and thus result in people spending too long in police custody. (5.124)

- 7.32 If female detainees are not initially seen by female custodial staff, they should have access on request to a female member of staff. (5.125)

## Healthcare

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- 7.33 The forensic medical examiner (FME) contract with H-FERN should be reviewed, to include: assurance from H-FERN that FMEs on call for a 24-hour period maintain their professional competencies throughout that period; confirmation that clinical records are stored safely and securely at all times in its custody suites and in the possession of FMEs; a policy relating to the sharing of information between health professionals; and evidence of annual checks of professional registration, professional appraisals and maintenance of their professional development. (6.42)
- 7.34 The management of medicines held in custody suites should be reviewed to ensure that appropriate quantities of medicines are held. Advice should be sought from a qualified pharmacist for the introduction of a proper medicine management system, to include: the safe custody of medicines; the appropriate recording of medicines administered; regular stock checks and balances; and disposal of-out-of date medicines. (6.43)
- 7.35 A professional health-related cleaning company should be introduced to ensure that FME rooms across the force meet infection control guidelines and maintain high levels of cleanliness in clinical areas. Custody staff and FMEs should ensure that the FME room is clean and tidy after every usage. (6.44)
- 7.36 The force should urgently review how it takes, stores, tracks and submits all DNA and forensic samples taken from detainees, volunteers and victims. The review should identify gaps in policies, training, storage facilities and destruction audit trails. The review should have a senior officer responsible for the delivery of an action plan which addresses the issues. (6.45)
- 7.37 A programme of regular mental health and substance use updates should be introduced for all staff involved in the primary management of detainees. (6.46)
- 7.38 The services of the local health provider should be commissioned to undertake an infection control audit of its custody suites to ensure that infection control measures are in place and inspected regularly. (6.47)
- 7.39 FMEs should always sign entries made into clinical records. The name and designation of the writer should be legible. (6.48)
- 7.40 The constabulary should work with its mental health partners to ensure that the quality of mental health provision is consistently good across all police custody suites. (6.49)
- 7.41 All custody reception areas should provide privacy for detainees being interviewed about their medical history. (6.50)
- 7.42 The role of the custody assistant (CA) should be developed, and CAs should be given basic training in care skills similar to that of the role of NHS healthcare assistants. (6.51)
- 7.43 Mental health awareness training for detention and escort officers and CAs should be initiated and updated at least annually. (6.52)

- 7.44 The needle exchange programme should be reintroduced under the guidance of the drug support teams. (6.53)
- 7.45 All necessary repairs to FME rooms should be made. (6.54)
- 7.46 Clinical waste bins should be in working order and conform to waste regulations. (6.55)

## Good practice

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### Healthcare

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- 7.47 The drug support teams collaborated with local prisons to ensure that substance users received good support throughout their time in custody. (6.56)
- 7.48 Custody assistants supported the well-being of detainees. (6.57)

## Appendix I : Inspection team

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Sara Snell	HMIP team leader
Vinnett Percy	HMIP inspector
Karen Dillon	HMIP inspector
Andrew Rooke	HMIP inspector
Sean Sullivan	HMIP inspector
Bridget McEvilly	HMIP healthcare inspector
Julia Salmon	CQC inspector
Paddy Craig	HMIC inspector
Gary Boughen	HMIC inspector

## Appendix II : Custody record analysis

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### Background

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As part of the inspection of Hertfordshire police cells, a sample of the custody records of detainees held on 7, 10 and 13 January 2009 were analysed. A total sample of 37 records were analysed from across the Hertfordshire area:

Custody suite	Number of records analysed
Watford	7
Hemel Hempstead	6
Hoddesdon	10
Hatfield	8
Stevenage	6
TOTAL	37

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

### Demographic information

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- Six (16%) of the detainees were female and 31 were male.
- None were immigration detainees.
- The average age of detainees was 30 years, ranging from 16 to 60 years. Only one person under the age of 17 was included in the sample.
- Thirty-two detainees were white European, and five were from a black and minority ethnic background.
- Seventeen (46%) detainees had been held overnight, including those who had arrived during the night and were not released until the morning. Three (8%) had been held for more than 24 hours.

### Removal of clothing

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One detainee had had their trousers taken as evidence and had been given issue trousers to replace them. Three detainees had had their clothing removed and been put in blue safety suits for the following reasons:

- Watford: the detainee suffered from claustrophobia and had a history of self-harm.
- Hemel Hempstead: the detainee was intoxicated on arrival and had recently self-harmed. Although a risk assessment was conducted, due to the detainee's state, his father was also taken through the medical checks when telephoned to inform him of his son's arrest. The detainee was reassessed when sober and his clothes returned once his risk had dropped to low.
- Hatfield: the female detainee was intoxicated on arrival and upset. She had self-harmed a couple of weeks previously. Despite this, her record stated that she had been assessed as low risk.

## **Appropriate adults**

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No detainees had required an appropriate adult during interview. The one detainee in our sample under the age of 17 had not been interviewed during his time in custody, as he was there for breach of bail.

## **Services**

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- All detainees had been asked whether they wanted someone informed of their arrest. Thirteen (35%) detainees had made a free telephone call, but this often relied on detainees having to request to make a call. One detainee had been refused a call, but had been given reasons for this.
- Nineteen (51%) detainees had spoken to either their solicitor or a duty solicitor. The other 18 had signed to say that they did not want a solicitor. For those who declined a solicitor, they were reminded that this was an ongoing right and that they could request one at a later point, and there were examples of this having been done.
- Interpreters had been used for three detainees who did not have English as their first language, to ensure that they understood why they were being arrested and what their rights were.
- No detainees had shared a cell while in custody.
- No detainees had received injuries while in custody.
- Six detainees had been seen by the forensic medical examiner (FME).
- Thirteen (35%) detainees had eaten at least one meal while in custody. Ten (27%) declined the offer of food. Of the 14 (38%) records that did not mention the offer or taking of food, detainees had been held for an average of six hours, ranging from one hour to 12 hours. Hot drinks and water were regularly offered.
- Two detainees had received a 'wash' and another detainee was recorded as having been offered the chance to wash. These three detainees were held in custody for 12 hours, 20 hours and six hours, respectively. None of the three detainees who had been held for over 24 hours were recorded as having had a shower or having been offered the chance to have one.
- Only one detainee had received outside exercise. There was no record of the other detainees having been offered it.
- Two detainees had been provided with reading material, one had been offered reading material and one person had had reading material brought in for them. There was no note in any other records of reading material having been offered.

## **Additional issues of note**

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- Watford: a detainee had arrived into custody intoxicated. He was found attempting to shock himself using the light and so was moved to a cell with closed-circuit television. Later, his blanket had to be removed, as he was attempting to make strips from it. From the custody record, he did not appear to have been put into a safety suit.
- Hoddesdon: the custody record for the only detainee under the age of 17 (aged 16) in our sample showed that he had received extra attention owing to his young age. He was the only person in our sample to have received outside exercise, and he had also been provided with reading and writing materials. His care worker had been contacted and his parents informed. He was held for 39 hours and ate four meals within that time.
- Hoddesdon: one detainee had been assessed as low risk, despite having self-harmed the night before being taken into custody.

- Hoddesdon: a pregnant female detainee was held in custody for 37 hours. During this time, she ate no food, although she was offered food at meal times and food was also brought in for her, which she also refused. She was seen by the FME.
- Hatfield: a 17-year-old detainee had requested a telephone call at 1.50am but had been told that staff were busy. The next comment at 2am stated that the detainee was lying in bed. There was no mention that a call was actually given, although the detainee was not released until 12.21pm. He also requested food, but, again, there was no record of him having received a meal.
- Hatfield: one detainee was placed on constant observation, as he had stated that he was claustrophobic and would self-harm if his cell door was shut. The detainee was seen by the FME, who confirmed the continuation of constant observation.
- Hemel Hempstead: one detainee had been lent religious items and had been able to wash before prayers.
- Detainees who arrived into custody intoxicated were put on regular observations, during which they were roused and spoken to.

### **Overall state of the records**

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The intimation sheets contained in the custody records were not always fully completed.

# Appendix III : Detainee survey

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## Detainee survey methodology

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A voluntary, confidential and anonymous survey of the detainee population, who were present in a police station in Hertfordshire, was carried out during this inspection. The results of this survey formed part of the evidence base for the inspection.

The survey was conducted on 26 and 27 January 2009 on all available detainees: those willing, available and fit for interview. Police stations where surveying took place were: Watford, Hemel Hempstead, Hatfield, Hoddesdon and Stevenage. In total, 16 interviews were conducted.

## Methodology

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Every interview was conducted with each detainee individually. This gave an opportunity to explain the independence of the Inspectorate and the purpose of the questionnaire, as well as to answer questions confidentially. All completed questionnaires remained confidential – only members of the Inspectorate saw them.

Respondents were not asked to put their names on the survey, but as their names were obvious and known on selection, there was an opportunity for verification and follow-up of issues at the police station via inspection of their custody record.

# Police Custody Survey

## Section 1: About You

<b>Q1</b>	<b>What police station are you currently being held at?</b> 3 Watford; 3 Hemel Hempstead; 5 Hatfield; 3 Hoddesdon; 2 Stevenage	
<b>Q2</b>	<b>What type of detainee are you?</b>	
	Police detainee .....	16
	Prison lock-out (i.e. you were in custody in a prison before coming here).....	0
	Immigration detainee .....	0
	I don't know .....	0
<b>Q3</b>	<b>How old are you?</b>	
	16 years or younger.....	1
	17-21 years .....	5
	22-29 years .....	1
	30-39 years .....	6
	40-49 years.....	1
	50-59 years.....	2
	60 years or older.....	0
<b>Q4</b>	<b>Are you:</b>	
	Male.....	14
	Female .....	2
	Transgender/Transexual .....	0
<b>Q5</b>	<b>What is your ethnic origin?</b>	
	White - British .....	12
	White - Irish .....	1
	White - Other .....	0
	Black or Black British - Caribbean .....	0
	Black or Black British - African .....	2
	Black or Black British - Other.....	0
	Asian or Asian British - Indian .....	0
	Asian or Asian British - Pakistani.....	0
	Asian or Asian British - Bangladeshi.....	0
	Asian or Asian British - Other .....	0
	Mixed Race - White and Black Caribbean .....	0
	Mixed Race - White and Black African .....	0
	Mixed Race - White and Asian .....	0
	Mixed Race - Other .....	0
	Chinese .....	0
	Other ethnic group.....	0
<b>Q6</b>	<b>Are you a foreign national (i.e. you do not hold a British passport, or you are not eligible for one)?</b>	
	Yes.....	5
	No.....	10
<b>Q7</b>	<b>What, if any, would you classify as your religious group?</b>	
	None .....	7
	Church of England.....	5
	Catholic .....	1
	Protestant.....	0
	Other Christian denomination.....	1
	Buddhist .....	0
	Hindu.....	0
	Jewish .....	0
	Muslim.....	0
	Sikh .....	0

<b>Q8</b>	<b>How would you describe your sexual orientation?</b>	
	<i>Straight / Heterosexual</i> .....	13
	<i>Gay / Lesbian / Homosexual</i> .....	0
	<i>Bisexual</i> .....	0
<b>Q9</b>	<b>Do you consider yourself to have a disability?</b>	
	<i>Yes</i> .....	6
	<i>No</i> .....	10
	<i>Don't know</i> .....	0
<b>Q10</b>	<b>Have you ever been held in police custody before?</b>	
	<i>Yes</i> .....	14
	<i>No</i> .....	2

## Section 2: Your experience of this custody suite

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

<b>Q11</b>	<b>How long have you been held at this police station?</b>	
	<i>1 hour or less</i> .....	0
	<i>More than 1 hour, but less than 6 hours</i> .....	6
	<i>More than 6 hours, but less than 12 hours</i> .....	5
	<i>More than 12 hours, but less than 24 hours</i> .....	5
	<i>More than 24 hours, but less than 48 hours (2 days)</i> .....	0
	<i>More than 48 hours (2 days), but less than 72 hours (3 days)</i> .....	0
	<i>72 hours (3 days) or more</i> .....	0
<b>Q12</b>	<b>Were you given information about your arrest and your entitlements when you arrived here?</b>	
	<i>Yes</i> .....	15
	<i>No</i> .....	1
	<i>Don't know/Can't remember</i> .....	0
<b>Q13</b>	<b>Have you been told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')?</b>	
	<i>Yes</i> .....	14
	<i>No</i> .....	1
	<i>I don't know what this is/I don't remember</i> .....	1
<b>Q14</b>	<b>If your clothes have been taken away, have you been offered different clothing to wear?</b>	
	<b><i>My clothes were not taken</i></b> .....	12
	<i>I was offered a tracksuit to wear</i> .....	0
	<i>I was offered an evidence suit to wear</i> .....	4
	<i>I was offered a blanket</i> .....	0
<b>Q15</b>	<b>Can you use a toilet when you need to?</b>	
	<i>Yes</i> .....	16
	<i>No</i> .....	0
	<i>Don't Know</i> .....	0
<b>Q16</b>	<b>If you have used the toilet here, were these things provided?</b>	
	Yes	No
	<i>Toilet paper</i> .....	4
	10	
<b>Q17</b>	<b>Have you shared a cell at this police station?</b>	
	<i>Yes</i> .....	0
	<i>No</i> .....	16

<b>Q18</b>	<b>How would you rate the condition of your cell:</b>			
		<i>Good</i>	<i>Neither</i>	<i>Bad</i>
	Cleanliness	7	7	1
	Ventilation / Air Quality	4	6	5
	Temperature	2	1	12
	Lighting	10	3	2
<b>Q19</b>	<b>Was there any graffiti in your cell when you arrived?</b>			
	Yes .....			6
	No.....			10
<b>Q20</b>	<b>Did staff explain to you the correct use of the cell bell?</b>			
	Yes .....			4
	No.....			12
<b>Q21</b>	<b>Have you been held overnight?</b>			
	Yes .....			9
	No.....			7
<b>Q22</b>	<b>If you have been held overnight, which items of clean bedding you were given?</b>			
	<b>Not held overnight</b> .....			7
	<i>Pillow</i> .....			8
	<i>Blanket</i> .....			9
	<i>Nothing</i> .....			0
<b>Q23</b>	<b>Have you been offered a shower at this police station since being here?</b>			
	Yes .....			0
	No.....			16
<b>Q24</b>	<b>Have you been offered any period of outside exercise whilst here?</b>			
	Yes .....			1
	No.....			15
<b>Q25</b>	<b>Have you been offered anything to:</b>			
		<i>Yes</i>		<i>No</i>
	Eat?	12		4
	Drink?	16		0
<b>Q26</b>	<b>Was the food/drink you received suitable for your dietary requirements?</b>			
	<b>I have not had any food or drink</b> .....			2
	Yes .....			8
	No.....			3
<b>Q27</b>	<b>If you smoke, have you been offered anything to help you cope with the smoking ban here?</b>			
	<b>I do not smoke</b> .....			1
	<i>I have been allowed to smoke</i> .....			1
	<i>I have not been offered anything to cope with not smoking</i> .....			14
	<i>I have been offered nicotine gum</i> .....			0
	<i>I have been offered nicotine patches</i> .....			0
	<i>I have been offered nicotine lozenges</i> .....			0
<b>Q28</b>	<b>Have you been offered anything to read?</b>			
	Yes .....			2
	No.....			14
<b>Q29</b>	<b>Has someone been informed of your arrest?</b>			
	Yes .....			8
	No.....			0

	<i>I don't know</i> .....	2		
	<i>I didn't want to inform anyone</i> .....	6		
<b>Q30</b>	<b>Were you offered a free telephone call?</b>			
	Yes .....	7		
	No .....	9		
<b>Q31</b>	<b>If you were denied a free phone call, was a reason for this offered?</b>			
	<b><i>My phone call was not denied</i></b> .....	7		
	Yes .....	0		
	No .....	1		
<b>Q32</b>	<b>Do you have any concerns about the following, whilst you are in police custody:</b>			
		Yes	No	
	Who is taking care of your children	0	15	
	Contacting your partner, relative or friend	3	12	
	Contacting your employer	0	15	
	Where you are going once released	3	12	
<b>Q33</b>	<b>Have you been interviewed by police officials about your case yet?</b>			
	Yes .....	5		
	No .....	11		
<b>Q34</b>	<b>Were any of the following people present when you were interviewed?</b>			
		Yes	No	Not needed
	Solicitor	0	3	1
	Appropriate Adult	0	2	2
	Interpreter	0	1	3
<b>Q35</b>	<b>How long did you have to wait (or how long have you been waiting) for your solicitor?</b>			
	<b><i>I have not requested a solicitor</i></b> .....	10		
	<i>2 hours or less</i> .....	3		
	<i>Over 2 hours but less than 4 hours</i> .....	2		
	<i>4 hours or more</i> .....	1		
<b>Q36</b>	<b>Have you been officially charged?</b>			
	Yes .....	0		
	No .....	16		
	<i>Don't Know</i> .....	0		
<b>Q37</b>	<b>How long have you been in custody <u>after</u> being charged?</b>			
	<b><i>I have not been charged yet</i></b> .....	16		
	<i>1 hour or less</i> .....	0		
	<i>More than 1 hour, but less than 6 hours</i> .....	0		
	<i>More than 6 hours, but less than 12 hours</i> .....	0		
	<i>12 hours or more</i> .....	0		

## **Section 3: Safety**

<b>Q39</b>	<b>Do you feel safe here?</b>	
	Yes .....	13
	No .....	3
<b>Q40</b>	<b>Has another detainee or a member of staff victimised (insulted or assaulted) you here?</b>	
	Yes .....	2
	No .....	14

<b>Q41</b>	<b>If you have felt victimised, what did the incident involve? (Please tick all that apply)</b>	
	<i>I have not been victimised</i> .....	14
	<i>Insulting remarks (about you, your family or friends)</i> .....	2
	<i>Physical abuse (being hit, kicked or assaulted)</i> .....	1
	<i>Sexual abuse</i> .....	0
	<i>Your race or ethnic origin</i> .....	0
	<i>Drugs</i> .....	0
	<i>Please describe:</i>	
	<i>Because of your crime</i> .....	0
	<i>Because of your sexuality</i> .....	0
	<i>Because you have a disability</i> .....	0
	<i>Because of your religion/religious beliefs</i> .....	0
	<i>Because you are from a different part of the country than others</i> .....	0
<b>Q42</b>	<b>Have you been handcuffed or restrained whilst in this police custody suite?</b>	
	Yes.....	1
	No.....	15
<b>Q43</b>	<b>Have you been injured whilst in police custody, in a way that you feel was not your fault?</b>	
	Yes.....	0
	No.....	16
<b>Q44</b>	<b>Have you been told how to make a complaint about your treatment here, if you need to?</b>	
	Yes.....	4
	No.....	12

## Section 4: Healthcare

<b>Q46</b>	<b>Are you currently on any medication?</b>		
	Yes.....	8	
	No.....	8	
<b>Q47</b>	<b>Have you been able to continue taking your medication whilst here?</b>		
	<i>Not currently taking medication</i> .....	8	
	Yes.....	6	
	No.....	2	
<b>Q48</b>	<b>Did someone explain your entitlements to see a healthcare professional, if you need to?</b>		
	Yes.....	12	
	No.....	3	
	<i>Don't know</i> .....	0	
<b>Q49</b>	<b>Have you been seen by the following healthcare professionals during your time here?</b>		
		Yes	No
	Doctor	7	9
	Nurse	0	16
	Paramedic	0	16
	Psychiatrist	2	14
<b>Q50</b>	<b>Are you able to see a healthcare professional of your own gender?</b>		
	Yes.....	1	
	No.....	0	
	<i>Don't know</i> .....	8	
<b>Q51</b>	<b>Do you have any drug or alcohol problems?</b>		
	Yes.....	3	
	No.....	13	
<b>Q52</b>	<b>Have you seen, or been offered the chance to see a drug or alcohol support worker?</b>		
	<i>I don't have any drug/alcohol problems</i> .....	13	
	Yes.....	0	
	No.....	3	

<b>Q53</b>	<b>Have you been offered relief or medication for your immediate symptoms?</b>						
	<i>I don't have any drug/alcohol problems</i> .....						13
	Yes .....						1
	No.....						1
<b>Q54</b>	<b>Please rate the quality of your healthcare whilst in police custody:</b>						
		<b>I have not been seen by health-care</b>	<i>Very Good</i>	<i>Good</i>	<i>Neither</i>	<i>Bad</i>	<i>Very Bad</i>
	Quality of Healthcare	8	1	3	1	2	1
<b>Q55</b>	<b>Do you have any specific <u>physical</u> healthcare needs?</b>						
	No.....						10
	Yes .....						6
<b>Q56</b>	<b>Do you have any specific <u>mental</u> healthcare needs?</b>						
	No.....						12
	Yes .....						4

## Appendix IV : Prisoner survey

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### Prisoner survey methodology

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

### Choosing the sample size

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The survey was conducted on 13 and 14 January 2009. A list of potential prisoners, who had been through Hertfordshire police stations, was created, listing those who had come from the Magistrates Courts of Stevenage, St Albans, Hemel Hempstead, Cheshunt, Hatfield, Watford and Hertford from 12 December 2008 to 14 January 2009. In HMP Bedford, prisoners with home boroughs in Hertfordshire, who had come into the prison within the time limit, were also identified.

### Selecting the sample

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In HMP Bedford, nine prisoners were identified from the courts list and three from the boroughs list. All were approached but only two fitted the criteria, with 10 reporting being held in police stations outside of Hertfordshire, or outside of our one-month time period. In HMP Woodhill, 57 prisoners were identified and all were approached. Twenty-three prisoners reported being held in police stations outside of Hertfordshire, or outside of our one-month time period.

Therefore, the questionnaire was given to two prisoners at HMP Bedford and 34 prisoners at HMP Woodhill. There were no refusals.

Completion of the questionnaire was voluntary. If a prisoner had literacy problems they were offered a joint interview by the research team and HMIC. No prisoners required an interview.

### Methodology

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

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

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

Respondents were not asked to put their names on their questionnaire, but were told that if they put their names on the questionnaire it might aid inspection, as their responses could be verified.

## **Response rates**

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In total, 35 respondents completed and returned their questionnaires, two from HMP Bedford and 33 from HMP Woodhill. The response rate was 97%. One respondent returned a blank survey.

## **Comparisons**

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The following details the results from the survey. Data from each establishment were 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 following analyses have been conducted:

- The current survey responses against comparator figures for all detainees surveyed as part of the police custody inspections.

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

# Police Custody Survey

## Section 1: About You

<b>Q2</b>	<b>What police station were you last held at?</b> Hatfield – 15 (43%), Watford – 2 (6%), Hoddesdon – 3 (9%), Hemel Hempstead – 3 (9%), Stevenage – 12 (34%).	
<b>Q3</b>	<b>What type of detainee were you?</b>	
	Police detainee .....	88%
	Prison lock-out (i.e. you were in custody in a prison before coming here).....	3%
	Immigration detainee .....	0%
	I don't know .....	9%
<b>Q4</b>	<b>How old are you?</b>	
	16 years or younger..... 3%	40-49 years..... 12%
	17-21 years ..... 18%	50-59 years..... 0%
	22-29 years ..... 41%	60 years or older..... 0%
	30-39 years ..... 26%	
<b>Q5</b>	<b>Are you:</b>	
	Male.....	100%
	Female .....	0%
	Transgender/Transexual .....	0%
<b>Q6</b>	<b>What is your ethnic origin?</b>	
	White - British .....	74%
	White - Irish .....	3%
	White - Other .....	3%
	Black or Black British - Caribbean .....	12%
	Black or Black British - African .....	3%
	Black or Black British - Other.....	0%
	Asian or Asian British - Indian .....	0%
	Asian or Asian British - Pakistani.....	0%
	Asian or Asian British - Bangladeshi.....	0%
	Asian or Asian British - Other .....	3%
	Mixed Race - White and Black Caribbean.....	3%
	Mixed Race - White and Black African .....	0%
	Mixed Race - White and Asian .....	0%
	Mixed Race - Other .....	0%
	Chinese .....	0%
	Other ethnic group.....	0%
	Please specify:	
<b>Q7</b>	<b>Are you a foreign national (i.e. you do not hold a British passport, or you are not eligible for one)?</b>	
	Yes.....	3%
	No.....	97%
<b>Q8</b>	<b>What, if any, would you classify as your religious group?</b>	
	None .....	34%
	Church of England.....	26%
	Catholic .....	17%
	Protestant.....	0%
	Other Christian denomination.....	9%
	Buddhist .....	0%
	Hindu.....	0%
	Jewish .....	0%
	Muslim.....	14%

Sikh ..... 0%  
 Any other religion, please specify .....

**Q9 How would you describe your sexual orientation?**  
 Straight / Heterosexual ..... 100%  
 Gay / Lesbian / Homosexual ..... 0%  
 Bisexual..... 0%  
 Other (please specify):

**Q10 Do you consider yourself to have a disability?**  
 Yes ..... 6%  
 No..... 91%  
 Don't know..... 3%

**Q11 Have you ever been held in police custody before?**  
 Yes ..... 100%  
 No..... 0%

## Section 2: Your experience of this custody suite

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

**Q12 How long were you held at the police station?**  
 1 hour or less..... 0%  
 More than 1 hour, but less than 6 hours..... 6%  
 More than 6 hours, but less than 12 hours ..... 6%  
 More than 12 hours, but less than 24 hours ..... 41%  
 More than 24 hours, but less than 48 hours (2 days) ..... 24%  
 More than 48 hours (2 days), but less than 72 hours (3 days) ..... 9%  
 72 hours (3 days) or more ..... 15%

**Q13 Were you given information about your arrest and your entitlements when you arrived there?**  
 Yes ..... 76%  
 No..... 21%  
 Don't know/Can't remember ..... 3%

**Q14 Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')?**  
 Yes ..... 71%  
 No..... 29%  
 I don't know what this is/I don't remember..... 0%

**Q15 If your clothes were taken away, were you offered different clothing to wear?**  
**My clothes were not taken**..... 50%  
 I was offered a tracksuit to wear..... 6%  
 I was offered an evidence suit to wear ..... 21%  
 I was offered a blanket ..... 24%

**Q16 Could you use a toilet when you needed to?**  
 Yes ..... 94%  
 No..... 6%  
 Don't Know ..... 0%

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

	Yes	No
Toilet paper	65%	35%

<b>Q18</b>	<b>Did you share a cell at the police station?</b>			
	Yes .....			0%
	No .....			100%
<b>Q19</b>	<b>How would you rate the condition of your cell:</b>	<i>Good</i>	<i>Neither</i>	<i>Bad</i>
	Cleanliness	35%	35%	29%
	Ventilation / Air Quality	18%	30%	52%
	Temperature	18%	30%	52%
	Lighting	50%	22%	28%
<b>Q20</b>	<b>Was there any graffiti in your cell when you arrived?</b>			
	Yes .....			45%
	No .....			55%
<b>Q21</b>	<b>Did staff explain to you the correct use of the cell bell?</b>			
	Yes .....			29%
	No .....			71%
<b>Q22</b>	<b>Were you held overnight?</b>			
	Yes .....			86%
	No .....			14%
<b>Q23</b>	<b>If you were held overnight, which items of clean bedding were you given?</b>			
	<b><i>Not held overnight</i></b> .....			11%
	<i>Pillow</i> .....			24%
	<i>Blanket</i> .....			59%
	<i>Nothing</i> .....			7%
<b>Q24</b>	<b>Were you offered a shower at the police station?</b>			
	Yes .....			15%
	No .....			85%
<b>Q25</b>	<b>Were you offered any period of outside exercise whilst there?</b>			
	Yes .....			3%
	No .....			97%
<b>Q26</b>	<b>Were you offered anything to:</b>	<i>Yes</i>	<i>No</i>	
	Eat?	88%	12%	
	Drink?	88%	13%	
<b>Q27</b>	<b>Was the food/drink you received suitable for your dietary requirements?</b>			
	<b><i>I did not have any food or drink</i></b> .....			11%
	Yes .....			34%
	No .....			54%
<b>Q28</b>	<b>If you smoke, were you offered anything to help you cope with the smoking ban there?</b>			
	<b><i>I do not smoke</i></b> .....			18%
	<i>I was allowed to smoke</i> .....			9%
	<i>I was not offered anything to cope with not smoking</i> .....			73%
	<i>I was offered nicotine gum</i> .....			0%
	<i>I was offered nicotine patches</i> .....			0%
	<i>I was offered nicotine lozenges</i> .....			0%
<b>Q29</b>	<b>Were you offered anything to read?</b>			
	Yes .....			21%
	No .....			79%

<b>Q30</b>	<b>Was someone informed of your arrest?</b>			
	Yes .....			54%
	No.....			34%
	<i>I don't know</i> .....			6%
	<i>I didn't want to inform anyone</i> .....			6%
<b>Q31</b>	<b>Were you offered a free telephone call?</b>			
	Yes .....			46%
	No.....			54%
<b>Q32</b>	<b>If you were denied a free phone call, was a reason for this offered?</b>			
	<i>My phone call was not denied</i> .....			61%
	Yes.....			6%
	No.....			32%
<b>Q33</b>	<b>Did you have any concerns about the following, whilst you were in police custody:</b>			
		Yes	No	
	Who was taking care of your children	4%	96%	
	Contacting your partner, relative or friend	57%	43%	
	Contacting your employer	19%	81%	
	Where you were going once released	41%	59%	
<b>Q34</b>	<b>Were you interviewed by police officials about your case?</b>			
	Yes.....	80%		
	No.....	20%	If No, go to Q35	
<b>Q35</b>	<b>Were any of the following people present when you were interviewed?</b>			
		Yes	No	Not needed
	Solicitor	57%	36%	7%
	Appropriate Adult	7%	40%	53%
	Interpreter	0%	47%	53%
<b>Q36</b>	<b>How long did you have to wait for your solicitor?</b>			
	<i>I did not requested a solicitor</i> .....			27%
	2 hours or less.....			10%
	Over 2 hours but less than 4 hours.....			10%
	4 hours or more .....			53%
<b>Q37</b>	<b>Were you officially charged?</b>			
	Yes.....			83%
	No.....			17%
	<i>Don't Know</i> .....			0%
<b>Q38</b>	<b>How long were you in police custody <u>after</u> being charged?</b>			
	<i>I have not been charged yet</i> .....			17%
	1 hour or less.....			6%
	More than 1 hour, but less than 6 hours.....			11%
	More than 6 hours, but less than 12 hours .....			17%
	12 hours or more .....			49%

### **Section 3: Safety**

<b>Q40</b>	<b>Did you feel safe there?</b>		
	Yes .....		71%
	No.....		29%
<b>Q41</b>	<b>Had another detainee or a member of staff victimised (insulted or assaulted) you there?</b>		
	Yes.....	41%	
	No.....	59%	

<b>Q42</b>	<b>If you have felt victimised, what did the incident involve? (Please tick all that apply)</b>		
	<i>I have not been victimised</i> .....	40%	<i>Because of your crime</i> ..... 14%
	<i>Insulting remarks (about you, your family or friends)</i> .....	22%	<i>Because of your sexuality</i> ..... 0%
	<i>Physical abuse (being hit, kicked or assaulted)</i> ..	4%	<i>Because you have a disability</i> ..... 0%
	<i>Sexual abuse</i> .....	0%	<i>Because of your religion/religious beliefs</i> ..... 2%
	<i>Your race or ethnic origin</i> .....	0%	<i>Because you are from a different part of the country than others</i> ..... 4%
	<i>Drugs</i> .....	14%	
	<i>Please describe:</i>		

<b>Q43</b>	<b>Were you handcuffed or restrained whilst in the police custody suite?</b>	
	Yes.....	51%
	No.....	49%

<b>Q44</b>	<b>Were you injured whilst in police custody, in a way that you feel was not your fault?</b>	
	Yes.....	29%
	No.....	71%

<b>Q45</b>	<b>Were you told how to make a complaint about your treatment here, if you needed to?</b>	
	Yes.....	15%
	No.....	85%

## Section 4: Healthcare

<b>Q47</b>	<b>When you were in police custody were you on any medication?</b>	
	Yes.....	42%
	No.....	58%

<b>Q48</b>	<b>Were you able to continue taking your medication whilst there?</b>	
	<b>Not taking medication</b> .....	58%
	Yes.....	21%
	No.....	21%

<b>Q49</b>	<b>Did someone explain your entitlements to see a healthcare professional, if you needed to?</b>	
	Yes.....	35%
	No.....	56%
	<i>Don't know</i> .....	9%

<b>Q50</b>	<b>Were you seen by the following healthcare professionals during your time there?</b>		
		Yes	No
	Doctor	50%	50%
	Nurse	17%	83%
	Paramedic	0%	100%
	Psychiatrist	5%	95%

<b>Q51</b>	<b>Were you able to see a healthcare professional of your own gender?</b>	
	Yes.....	24%
	No.....	38%
	<i>Don't know</i> .....	38%

<b>Q52</b>	<b>Did you have any drug or alcohol problems?</b>	
	Yes.....	58%
	No.....	42%

<b>Q53</b>	<b>Did you see, or were offered the chance to see a drug or alcohol support worker?</b>	
	<i>I didn't have any drug/alcohol problems</i> .....	44%

Yes..... 13%  
 No..... 44%

**Q54** **Were you offered relief or medication for your immediate symptoms?**  
*I didn't have any drug/alcohol problems*..... 42%  
 Yes..... 30%  
 No..... 27%

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

	I was not seen by health -care	Very Good	Good	Neither	Bad	Very Bad
Quality of Healthcare	47%	3%	13%	22%	16%	0%

**Q56** **Did you have any specific physical healthcare needs?**  
 No..... 67%  
 Yes..... 33%  
 Please specify:

**Q57** **Did you have any specific mental healthcare needs?**  
 No..... 88%  
 Yes..... 12%  
 Please specify:

**Thank you for your time.**



## Prisoner Survey Responses for Hertfordshire Police 2009

**Prisoner Survey Responses** (Missing data has been excluded for each question) Please note: Where there are apparently large differences, which are not indicated as statistically significant, this is likely to be due to chance.

### Key to tables

		Hertfordshire	Police custody comparator
	Any percent highlighted in green is significantly better		
	Any percent highlighted in blue is significantly worse		
	Any percent highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
<b>Number of completed questionnaires returned</b>		35	218
<b>SECTION 1: General Information</b>			
2	Are you a Police detainee?	87%	84%
3	Are you under 21 years of age?	20%	8%
4	Are you Transgender/Transsexual?	0%	2%
5	Are you from a minority ethnic group? (including all those who did not tick White British, White Irish or White other categories)	20%	37%
6	Are you a foreign national?	2%	17%
7	Are you Muslim?	14%	11%
8	Are you homosexual/gay or bisexual?	0%	3%
9	Do you consider yourself to have a disability?	6%	19%
10	Have you been in police custody before?	100%	87%
<b>SECTION 2: Your experience of this custody suite</b>			
For the most recent journey you have made either to or from court or between prisons:			
11	Were you held at the police station for over 24hours?	47%	66%
12	Were you given information about your arrest and entitlements when you arrived?	77%	73%
13	Were you told about PACE?	71%	57%
For those who had their clothes taken away:			
14	Were you given a tracksuit to wear?	13%	40%
15	Could you use a toilet when you needed to?	94%	87%
16	If you did use the toilet, was toilet paper provided?	65%	52%
17	Did you share a cell at the station?	0%	4%
18	Would you rate the condition of your cell, as 'good' for:		
18a	Cleanliness?	35%	25%
18b	Ventilation/air quality?	19%	17%
18c	Temperature?	19%	12%
18d	Lighting?	50%	43%
19	Was there any graffiti in your cell when you arrived?	45%	59%
20	Did staff explain the correct use of the cell bell?	29%	21%
21	Were you held overnight?	86%	90%
22	If you were held overnight, were you given no clean items of bedding?	8%	37%

**Key to tables**

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	Any percent highlighted in green is significantly better		
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	Percentages which are not highlighted show there is no significant difference		
23	Were you offered a shower?	15%	8%
24	Were you offered a period of outside exercise?	2%	6%
25a	Were you offered anything to eat?	88%	75%
25b	Were you offered anything to drink?	87%	79%
26	Was the food/drink you received suitable for your dietary requirements?	39%	39%
27	For those who smoke: were you offered <b>nothing</b> to help you cope with the ban there?	72%	78%
28	Were you offered anything to read?	20%	14%
29	Was someone informed of your arrest?	54%	41%
30	Were you offered a free telephone call?	46%	49%
For those who were denied a free call			
31	Was a reason given?	18%	24%
32	Did you have any concerns about:		
32a	Who was taking care of your children?	3%	23%
32b	Contacting your partner, relative or friend?	56%	59%
32c	Contacting your employer?	19%	25%
32d	Where you were going once released?	42%	36%
34	If you were interviewed were the following people present:		
34a	Solicitor	58%	75%
34b	Appropriate adult	5%	6%
34c	Interpreter	0%	7%
For those who requested a solicitor:			
35	Did you wait over 4 hours for your solicitor?	72%	67%
For those who were charged:			
37	Were you held over an hour in custody after being charged?	93%	93%

**Key to tables**

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	Any percent highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
<b>SECTION 3: Safety</b>			
<b>39</b>	Did you feel unsafe?	29%	44%
<b>40</b>	Has another detainee or a member of staff victimised you?	41%	43%
<b>41</b>	If you have felt victimised, what did the incident involve?		
<b>41a</b>	Insulting remarks (about you, your family or friends)	33%	27%
<b>41b</b>	Physical abuse (being hit, kicked or assaulted)	6%	19%
<b>41c</b>	Sexual abuse	0%	3%
<b>41d</b>	Your race or ethnic origin	0%	8%
<b>41e</b>	Drugs	20%	17%
<b>41f</b>	Because of your crime	20%	21%
<b>41g</b>	Because of your sexuality	0%	0%
<b>41h</b>	Because you have a disability	0%	4%
<b>41i</b>	Because of your religion/religious beliefs	2%	4%
<b>41j</b>	Because you are from a different part of the country than others	6%	4%
<b>42</b>	Were you handcuffed or restrained whilst in the police custody suite?	52%	49%
<b>43</b>	Were you injured whilst in police custody, in a way that you feel is not your fault?	29%	30%
<b>44</b>	Were you told how to make a complaint about your treatment?	15%	15%

**Key to tables**

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	Any percent highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
<b>SECTION 4: Healthcare</b>			
<b>46</b>	Were you on any medication?	43%	49%
For those who were on medication:			
<b>47</b>	Were you able to continue taking your medication?	50%	35%
<b>48</b>	Did someone explain your entitlement to see a healthcare professional, if you needed to?	35%	36%
<b>49</b>	Were you seen by the following healthcare professionals during your time in police custody:		
<b>49a</b>	Doctor	50%	54%
<b>49b</b>	Nurse	18%	18%
<b>49c</b>	Paramedic	0%	3%
<b>49d</b>	Psychiatrist	3%	4%
<b>50</b>	Were you able to see a healthcare professional of your own gender?	24%	28%
<b>51</b>	Did you have any drug or alcohol problems?	57%	61%
For those who had drug or alcohol problems:			
<b>52</b>	Did you see, or were offered the chance to see a drug or alcohol support worker?	23%	41%
<b>53</b>	Were you offered relief medication for your immediate symptoms?	52%	29%
For those who had been seen by Healthcare:			
<b>54</b>	Would you rate the quality as good/very good?	29%	24%
<b>55</b>	Do you have any specific physical healthcare needs?	34%	37%
<b>56</b>	Do you have any specific mental healthcare needs?	13%	26%