



# Report on an inspection visit to police custody suites in Surrey Police

1 – 5 February 2010

by

HM Inspectorate of Prisons and

HM Inspectorate of Constabulary

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# Contents

1. Introduction	5
2. Background and key findings	7
3. Strategy	11
4. Treatment and conditions	15
5. Individual rights	21
6. Healthcare	25
7. Summary of recommendations	31
<b>Appendices</b>	
I Inspection team	34
II Custody record analysis	35
III Summary of detainee questionnaires and interviews	38



# 1. Introduction

This report is part of a programme of inspections of police custody carried out jointly by our two inspectorates. These inspections form a key part of the joint work programme of the criminal justice inspectorates. They also contribute to the United Kingdom's response to its international obligation to ensure regular and independent inspection of all places of detention.<sup>1</sup> The inspections look at force-wide strategies, treatment and conditions, individual rights and healthcare.

Surrey has four designated custody suites - Guildford, Staines, Woking and Reigate - all of which operated 24 hours a day. A further small suite at Farnham was rarely used. All suites were visited and assessments were further informed by a survey of prisoners at HMP Highdown who had previously been held in Surrey police cells.

A clear strategic management structure was in place under an assistant chief constable, but with day-to-day management devolved to the three divisions. There was a force-wide restructuring process under way, together with a programme of refurbishment of detention facilities and plans to increase capacity. However, there was also a need to review the current staffing model and ensure appropriate rotation of detention staff. Relationships with the Police Authority were good and there was a strong independent custody visitor scheme. Partnership working was generally effective.

We were pleased to find that Surrey was developing specific use of force policies for custody. There was scope to improve the use of management information relating to custody, for example complaints, and to aid staff access to Independent Police Complaints Commission learning lessons information.

We observed generally relaxed and respectful relationships between staff and detainees, although this was not assisted by the lack of privacy at the booking-in desks, and there was a tendency for all detainees to be treated alike instead of addressing particular vulnerabilities, for example age, gender and disability. Moreover, risk assessments did not always take into account available information, including safety markers from the local intelligence system and the Police National Computer, which posed unnecessary risks to both detainees and staff.

The quality of accommodation varied, but was uniformly clean. Unfortunately, we found numerous ligature points in some suites and this required urgent remedial action, as well as improved monitoring and better training for staff to identify such risks. Farnham was intrinsically unsafe and, we welcome the force's decision to no longer use the facility. In some suites, basic hygiene needs, including toilet paper and female sanitary products, were only available on request.

The provisions of the Police and Criminal Evidence Act were adhered to, although this also meant that appropriate adults were not sought for children of 17. There was no accurate information about the number of immigration detainees held and, while good relationships with the United Kingdom Border Agency meant that few stayed unnecessarily in police custody, staff were concerned that there was a lack of appropriate legal advice available to these detainees. As we have found on too many inspections, there were serious weaknesses in the management of forensic samples, which required immediate review.

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

The quality of healthcare was mixed. Clinical governance arrangements were good, as was medicine management, and medical facilities were excellent. However, management of healthcare contracts needed to be more robust to ensure appropriate and timely attendance by healthcare providers. Mental health and substance misuse support was limited. There was a need to review policy and practice to ensure consistency across the force on the use of places of safety under the Mental Health Act.

This inspection of custody suites in Surrey has identified a generally positive picture, but with scope for improvement in certain areas. Accordingly, this report sets out a number of recommendations that we believe will assist managers and the Police Authority to improve the quality of custody provision. We expect these recommendations to be considered in the wider context of priorities and resourcing, and for an action plan to be provided in due course.

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**HM Chief Inspector of Constabulary**

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**March 2010**

## 2. Background and key findings

- 2.1 HM Inspectorates of Prisons and Constabulary have a programme of joint inspections of police custody suites, as part of the UK's international obligation to ensure regular independent inspection of places of detention. These inspections look beyond the implementation of the Police and Criminal Evidence Act 1984 (PACE) codes of practice and *Safer Detention and Handling of Persons in Police Custody* 2006 (SDHP) guide, and focus on outcomes for detainees. They are also informed by a set of *Expectations for Police Custody*<sup>2</sup> 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 Surrey Police had four main custody suites designated under PACE for the reception of detainees. These were located at Guildford (24 cells), Staines (19), Woking (15) and Reigate (12). Custody facilities at Farnham (8) had been used in 2009 to cover for the closure of Guildford, but had not been used since. The custody suites operated 24 hours a day and dealt with detainees arrested as a result of mainstream policing. This inspection was largely conducted in the designated custody suites, but Farnham was also visited. A survey of prisoners at HMP Highdown, who had formerly been detained at custody suites in the force area, was conducted by HM Inspectorate of Prisons researchers to obtain additional evidence (see Appendix III).
- 2.3 In the 12 months to the end of 2009, these cells had been used for 19,858 detainees, including 3,285 women and 1,972 juveniles.
- 2.4 Comments in this report refer to all suites unless specifically stated otherwise.

### Strategy

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- 2.5 There was a clear management structure from assistant chief constable (ACC) through the headquarters custody standards unit (CSU) to the three divisional chief inspectors who led on custody. Responsibility for the day-to-day management of custody was devolved to the three divisions. An inspector custody manager was responsible for each of the four main suites. The force was about to re-structure from three divisions to four functional work-streams, which would create a centrally managed custody function within the 'investigation' work-stream.
- 2.6 The estates strategy involved the upgrading of custody facilities and was well supported with resources by the Police Authority (PA). The force believed cell capacity was insufficient and was considering options to address the shortfall.
- 2.7 Custody suites were staffed by police sergeants and designated detention officers (DDOs), but the force was seeking to review the staffing model used. A nationally approved custody training course was delivered in house to sergeants and DDOs.
- 2.8 Daily divisional briefing meetings were held where risks related to custody could be flagged. Adverse incident reports were monitored centrally, including any significant use of force, although many staff were confused about the process. The quarterly custody development group discussed relevant issues.

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

- 2.9 Relationships with the PA, independent custody visitors (ICVs) and the local criminal justice board (LCJB) were good. Relationships with the crown prosecution service (CPS) were improving and those with HM court service were strong. The force was in the process of setting up a forum to meet with defence solicitors.
- 2.10 Dip sampling of custody records was undertaken by CSU and at divisional level by custody managers. We were told that no themes were emerging.
- 2.11 The force was developing specific use of force policies for custody, although these were not yet available. Management information needed to be improved to allow better understanding of trends and themes in custody. There was confusion about how complaints should be dealt with, although some information relating to complaints was collated and disseminated. Learning the lessons information from the independent police complaints commission (IPCC) was disseminated, but there was no central log or storage to make historical information easily accessible.

## Treatment and conditions

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- 2.12 Relationships between staff and detainees were generally relaxed and respectful and first or preferred names were mostly used. Booking in desks offered little privacy. Staff had been trained in the different types of detainees held in custody, but generally approached everyone in much the same way. A few staff had a greater understanding of how young people and women might be particularly vulnerable in custody. Access for detainees with disabilities was good at Guildford, but limited elsewhere. A range of materials was provided for detainees with different faith needs.
- 2.13 The force could not provide details of the numbers of immigration detainees held in custody or the average length of stay, but most staff said this was usually less than 24 hours. The on-site UK Border Agency (UKBA) member of staff at Woking was valued by staff, although the other suites did not receive this level of support.
- 2.14 The local intelligence system and Police National Computer (PNC) were checked for any self-harm and safety issues relating to new arrivals and sergeants used their experience and common sense when assessing levels of risk. Not all sergeants were actively involved in the risk assessment process. DDOs were aware of the importance of rousing detainees and staff were not over-reliant on closed-circuit television (CCTV) or life signs equipment. Some custody records indicated delays and inconsistencies in risk assessments reflecting all the information available. This included examples of a lack of attention to safety markers from the local intelligence system and the PNC, which ought to have alerted staff to issues such as potential self-harm and violence and have been reflected in the risk assessment. Good handovers took place at shift changes and all staff carried anti-ligature knives.
- 2.15 There were ligature points in detainee areas at all the suites. Farnham was intrinsically unsafe and the decision had been made, rightly, not to use the facility again. Health and safety checks were not carried out in line with SDHP guidance and not all staff were able to identify ligature points. Staff attended use of force training every six months, but there were deficiencies in the monitoring of use of force. Fire alarms were tested weekly and staff knew what to do in the event of a fire.
- 2.16 Suites varied greatly in age and condition, but were mostly very clean. Mattresses were not routinely wiped down after use and clean blankets were usually supplied only on request. Smoking was not allowed at any of the suites and no nicotine replacement was offered. The

use of cell call bells was explained to detainees. Showers were not routinely provided and in some suites detainees had to request toilet paper. Alternative clothing was usually a paper suit, but track suites were provided for those going to court or being released. Plimsolls and underwear were available. Exercise, visits and reading materials were rarely offered. There was a good selection of microwave meals, although limited halal and vegetarian options.

## Individual rights

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- 2.17 Custody sergeants looked critically at the reasons for detention and aimed to ensure it lasted no longer than necessary. Detainees were not routinely offered a free telephone call, but someone was contacted on their behalf. Staff said custody was not used as a place of safety for children and young people under the Children Act (1989).
- 2.18 Professional interpreters were used during the booking in process and at other times when required, although staff at Reigate reported some significant delays in them arriving. Rights and entitlements information was available in a range of languages.
- 2.19 Detainees were not routinely asked about dependency obligations, although some staff demonstrated awareness of these issues. A pre-release risk assessment was conducted and a leaflet given out providing a useful range of contacts.
- 2.20 There was no evidence that PACE was not being adhered to. Up-to-date PACE codes of practice were available and offered to detainees. Defence solicitors were mainly positive about working relationships with staff and reinforced that staff were respectful to detainees. Some voiced complaints about delays. The appropriate adult (AA) service covered juveniles and vulnerable adults and was highly thought of by staff. Staff adhered to the PACE definition of a child when deploying AAs.
- 2.21 Court cut off times were acceptable. The way the force took, stored and tracked DNA samples needed to be improved. Detainees were not routinely told by booking in staff how to make a complaint, but prominent notices at Woking and Guildford explained how to do so, a range of IPCC leaflets was available at all suites and detainees were given written information outlining their right to make a complaint. Senior managers thought complaints were dealt with while detainees were still in custody, but many staff said this did not happen until detainees were released.

## Healthcare

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- 2.22 The quality of healthcare provision was mixed. Clinical governance was well organised for paramedics, but more limited for forensic medical examiners (FMEs) and strategic links were underdeveloped. Medical rooms and facilities were some of the best we have seen and the management of medicines was also good. Paramedics had good arrangements to manage clinical records, but the arrangements for FMEs were less robust. There was good engagement between health professionals involved in custody.
- 2.23 Primary care was mainly provided by paramedics and a delay in them arriving when called was a problem, as were delays with FMEs. This was not robustly monitored and challenged by the force. Nevertheless, custody and healthcare staff demonstrated a good level of care. There was a new provider of substance use services, but there were some gaps in provision. Services for juveniles and those with alcohol problems were limited to signposting other provision. Mental health services were valued by custody staff, but were limited in the times they were available. There was no designated cover for absence and no formal service level

agreement or specification. Staff were confused about services available for detainees under Section 136 of the Mental Health Act (1983) and lacked clarity regarding admissions criteria.

## Main recommendations

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- 2.24 Risk assessments should take into account all the relevant information available to staff, including safety markers from the local intelligence system and PNC.
- 2.25 All cells should be fit for purpose and free of ligature points and custody staff should be trained to identify potential ligature points.
- 2.26 How the force takes, stores, tracks and deals with DNA should be urgently reviewed and the review should be owned by a senior responsible officer.
- 2.27 Surrey police should have clear contractual arrangements, including relevant management information, with all health providers and there should be strategic oversight and robust management and performance monitoring of all health provider contracts.

## 3. Strategy

### Expected outcomes:

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

- 3.1 There was clear evidence of effective strategic leadership. An ACC was the lead officer for the custody portfolio and the PA was actively engaged with forward planning and development of the custody estate. The ACC said custody had been the PA's key priority over the last two years. The PA was very supportive, while appropriately challenging force custody plans. The force operated a devolved model of custody whereby custody suites and staff were managed by the three divisions. The ACC managed custody through a temporary superintendent who was in charge of criminal justice and of the CSU based at headquarters. The CSU was responsible for ensuring that custody standards were maintained consistently throughout the force.
- 3.2 Surrey Police was working to address the challenge posed by its custody estates and the limited cell capacity. Plans to streamline operational structures, increase efficiency and reduce risk included the proposed purchase of a site near Reigate with a 30 cell capacity. Capacity at Guildford had been increased and the suite had recently been refurbished. The force was also considering mothballing the Woking custody suite, although the PA was not fully reconciled to this and wanted further discussion. The PA had also rejected plans for a major development of Farnham police station and custody suite as not representing value for money and was in favour of further developing the custody facilities at Guildford. Farnham custody suite had not been used since December 2009 and it had been decided, rightly, not to use the facility again.
- 3.3 East Surrey division was responsible for Reigate custody suite, North Surrey for Staines and West Surrey for Guildford, Woking and Farnham. Each division had a chief inspector responsible for the custody suites who was a member of the senior management team (SMT). A custody manager in each division, who was an inspector, was charged with the day-to-day running of the custody suites. They reported to their divisional SMTs rather than the CSU, which limited the CSU's ability to fulfil its key role. All custody sergeants were permanently posted into custody and were well trained, but a number had performed this role for many years and were losing their general policing skills. Refresher training for staff took place at least once every 10 weeks. To its credit, the Police Authority and the force had invested heavily in DDOs, but had struggled to find any national guidance on the recommended ratio of custody sergeants to DDOs and therefore wanted to collect benchmarking data to allow them to make informed choices. The inspection team felt that the ratio of DDOs to detainees was in excess of what was needed and that the ratio of custody sergeant to detainees was too low. The force had already recognised this anomaly and there were plans to recruit additional custody sergeants if the proposed new custody suite at Reigate went ahead.
- 3.4 Surrey Police was approaching a period of substantial change, which meant a move away from the current structure of three divisions to one county-wide operational command unit. As part of the preparation for this, a review entitled Operation Armstrong had covered investigative and custodial processes as well as examining how criminal justice partnership links could be improved. From 1 April 2010, custody would come within the investigative function, which the force believed would deliver greater ownership of custody services and lead to a more consistent approach to custodial and investigative processes by staff, as well as leading to better management of risk. However, there were inherent risks in proposals to remove

experienced custody managers and to replace them with managers with little experience of custody suites.

- 3.5 A custody development group met monthly, bi-monthly or quarterly depending on the issues at hand. Issues could be escalated up the chain of command accordingly. The ACC had visited each custody suite and identified concerns such as rousing inebriated detainees and record keeping. He had instigated a series of visits to every custody suite by night duty critical incident managers (chief inspectors). The chief inspectors reported their findings back to the ACC.
- 3.6 The learning the lessons documents from the IPCC and other investigation outcomes were emailed to staff, but there was no intranet site where custody staff could search for particular issues.
- 3.7 A Bradley oversight group had been established to respond to the mental health issues highlighted in the Bradley Report (2009). The group was chaired a chief police officer and had links into the LCJB, but the force reported real ongoing difficulties in all partners engaging fully with this important area of work.
- 3.8 Relationships with the CPS had improved since the Operation Armstrong review and there were now face-to-face clinics and an appeals process that allowed early and constructive intervention when there were disagreements. A forum where defence solicitors could highlight concerns to the force was being progressed. The UKBA had a member of staff based at Woking. Relations were good and no major issues had been identified, but police staff did not believe the operation successfully reduced delays in the other two divisions. There was a sound relationship with Her Majesty's Courts Service, with good links at LCJB level. The courts often offered additional slots that became vacant late in the day, a particularly helpful and proactive approach that allowed faster access to justice, prevented detainees from being held unnecessarily and freed up police custody resources.
- 3.9 A strong ICV scheme was well supported by the PA and the force, with quarterly meetings with panel members. The ICV scheme manager ensured identified issues were addressed and information fed back to the reporting ICVs. Underlying themes were clearly identified. ICVs were highly regarded as an important independent oversight mechanism. Surrey appropriate adult volunteer scheme (SAAVS) provided a strong appropriate adult (AA) service (see section on individual rights).
- 3.10 The ACC and CSU were clear on how complaints should be dealt with, but the staff approach was inconsistent (see section on individual rights). This meant learning opportunities were potentially being missed.
- 3.11 The taking, storing, tracking and dealing with DNA needed urgent review (see section on individual rights).
- 3.12 Officers and staff recorded the use of force in detainee custody records and police officers recorded it in their evidential pocket notebooks. An adverse incident/use of force report was also submitted. However, these data were not collated or analysed to provide local or force-wide management information. The CSU was due to produce a report for staff by April 2010 giving clear guidance on use of force procedures, including the use of Tasers in custody.

## Recommendations

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- 3.13 **Surrey Police should review its current staffing model for custody.**

- 3.14 The use of force should be monitored locally and at a force-wide level.

### Housekeeping point

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- 3.15 The learning lessons documents from the IPCC should be held as a single intranet site.



## 4. Treatment and conditions

### Expected outcomes:

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

### Respect

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- 4.1 Caged vans were used if a detainee was violent or there was a risk of violence. Otherwise, detainees were usually taken to the station in police cars. Detainees raised no complaints about the vehicles or their treatment during the journey.
- 4.2 Staff were respectful to detainees and when discussing them with colleagues. They used first names where possible or addressed detainees by title. They interacted positively, giving encouragement and reassurance when necessary. Detainees we spoke to said they had been treated with respect and the solicitors confirmed that staff were generally respectful and helpful both to them and to detainees. Independent custody visitors (ICVs) we spoke to said staff treated detainees well.
- 4.3 Women were always searched and supervised by female staff and there was always a female member of staff available. Staff were aware of the risks associated with female detainees, particularly of self-harm. There were no dedicated cells for women at Staines or Guildford, but Woking and Reigate both had two cells where women detainees could be held separately to men and both had a separate shower.
- 4.4 Bibles were available and Qur'ans and prayer mats suitable for Muslims were kept at all sites. Compasses on the ceiling in many detainee areas showed the direction of Mecca. Muslim detainees could wash before prayer and microwaveable halal meals were provided, although the options were sometimes limited (see section on catering).
- 4.5 Staff said immigration detainees were usually held less than 24 hours. An immigration officer liaised closely with the Woking suite and was able to expedite the processing of immigration cases by UKBA, so people detained under immigration powers were rarely held at Woking overnight. Reigate staff said two police officers seconded to UKBA helped progress cases quickly and that liaison with UKBA was good. Staff at other suites reported the occasional longer delay in UKBA collecting immigration detainees from police custody.
- 4.6 None of the suites had hearing loops. Access for people with disabilities was reasonable at Guildford, which also had a specially adapted cell, but neither Staines nor Woking had any specific provision for detainees with disabilities. Reigate provided a ramp to the suite, which was on the first floor. Crutches were removed on location in a cell only following an individual risk assessment.
- 4.7 Staff had received general training on the needs of children as part of their initial training. Some custody sergeants tried not to detain children and demonstrated a sensitive approach. For example, one custody sergeant decided that a very drunk and abusive child who had just turned 16 should not be detained or (as the paramedic had advised) sent home, but should be sent to hospital.

- 4.8 Where available, juveniles were located in designated cells. Staff were clear that, if possible, they should avoid detaining a young person.
- 4.9 There was a general lack of privacy at the booking in desks. The desks at Guildford and Woking were also high, which potentially made it more uncomfortable for detainees to disclose confidential information or vulnerabilities.

## Safety

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- 4.10 On reception to custody, all detainees were risk assessed to ensure their own and staff safety. In some cases, this was done by the custody sergeant while a DDO completed the IT-based data inputting, but at Guildford and Reigate it was carried out by DDOs and signed off by the sergeant who was not actively involved in the process. Staff regularly checked the PNC and the local criminal intelligence system when assessing risk. However, an examination of custody records identified examples of important information not being used when assessing risk and others where there was a delay in this happening. In one case, evidence of recent self-harm was not reflected in the risk assessment of a vulnerable 17 year old detainee. (See main recommendation at paragraph 2.24.)
- 4.11 Staff were aware of risk indicators, with the intervals between in-cell observations revised in line with changing perception of risk. Cells were checked regularly between every occupation for anything left behind that might be used by another occupant to self-harm. Anti-ligature knives were carried by all staff. In most cases, cell keys were carried by the two staff dedicated to supervising the cell area, while a further set of keys was available behind the custody front desk.
- 4.12 The force had invested significantly in safety equipment for all cells including all cells having CCTV and life signs monitoring (LSM) equipment, and staff did not appear to be over reliant on these. At Guildford, where the suite had recently reopened following refurbishment, the CCTV monitors were on a back row of desks where staff did not check them at regular or frequent intervals.
- 4.13 There were clear procedures for mitigating risk by clearing the reception area and making preparations when arresting officers notified the suite of the imminent arrival of a violent prisoner. Cell locations were carefully planned, along with strategies for forcible cell placement if necessary. There was no sharing of cells and good handovers took place at shift changes.

## Use of force

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- 4.14 Staff received conflict training at least annually and were aware how to de-escalate potentially violent situations through talking to the detainee concerned. Viper restraint equipment was available and, while information on its use was not systematically collected, we established that it had been used only six times in the previous 12 months. Overall, force appeared to be rarely used.
- 4.15 Staff knew how to restrain a pregnant woman and were aware of the risks of positional asphyxia. Handcuffs were removed on entry to the suite unless there was a continuing risk of violence in an open area or in the course of cell placement if a detainee was uncooperative. A Taser had been deployed and fired at Woking to restrain a detainee who was violently self-harming. The force had reviewed this case and it was satisfied that in this case use had been proportionate and appropriate. We also viewed CCTV footage and while the Taser's deployment appeared proportionate, we remained concerned that there was neither local nor

national guidance on its deployment in custody. However, we understood that local guidance was in development. (See paragraph 3.12.)

- 4.16 There was some confusion among custody staff about when a healthcare professional would be called following the use of force, but they were clear this would happen if there were obvious injuries or if the detainee requested it.

## Physical conditions

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- 4.17 Cells at Woking were cleaned three times a day and after each use, but were gloomy and tired with a lot of graffiti. The cell used for inebriated detainees had little natural light and was particularly gloomy. At Reigate, the cells were clean and reasonably well maintained, although there was some graffiti. Staff cleared any rubbish after each use, but did not routinely clean cells. The heating was adequate, but the suite was poorly ventilated so could be stuffy and uncomfortable. At Guildford, the cells were clean and free of graffiti, but some of the older cells were poorly lit. At Staines, the cells were clean, well maintained and relatively free of graffiti. Cells at each suite contained a toilet and the 16 newer cells at Guildford had integral hand-washing facilities.
- 4.18 There was little evidence of staff following SDHP guidance and limited understanding of the necessity for daily, weekly, monthly and quarterly cell inspections. Daily and yearly inspections that were taking place were more estates based than SDHP oriented and many staff were unable to identify ligature points. This left the force, staff and detainees unnecessarily exposed to risk. We reported ligature points in many cells and the force responded promptly to remove them where possible or mitigate the risks. (See main recommendation at paragraph 2.25.) The suites were reasonably well maintained and work was carried out fairly promptly, although there could be delays of up to two weeks for parts to repair electrical equipment in cells. Fire alarms were tested weekly and most suites ran an evacuation exercise every three to six months. All suites had enough handcuffs to evacuate detainees safely.
- 4.19 All cells at Woking, Staines and Reigate had a working call bell and these were tested at the start of each shift. The purpose and use of the bells was clearly explained to detainees, who said staff responded to them fairly promptly. Staff at Guildford could talk directly to detainees using an intercom, although a number of cells were out of use because their intercom was broken.
- 4.20 None of the suites allowed smoking and none offered nicotine replacement, advice or support.

## Personal comfort and hygiene

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- 4.21 Cells at all suites contained a mattress with an integrated pillow, but blankets usually had to be requested. All cells were covered by CCTV cameras, but with toilet areas blocked out for privacy. Toilet paper was routinely provided at Staines, but had to be requested at Woking, Reigate and Guildford. Hygiene packs for women were mostly given only on request.
- 4.22 All suites had showers that offered adequate privacy. Proper towels were used at Woking, Guildford and Reigate, but detainees at Staines were given disposable paper and foam towels. Showers were not routinely offered to all detainees, but tended to be prioritised for those attending court in the morning.
- 4.23 Detainees whose clothes had been removed were usually given paper suits and disposable foam-based slippers to wear in the cell. Track suits and plimsolls were reserved for those

attending court or being released. Underwear and socks were also available. Foam suits and foam blankets were given to detainees at severe risk of self-harm.

## Catering

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- 4.24 Food was offered at mealtimes. Families and friends were sometimes allowed to bring food in unopened packets. There was a reasonable range of frozen microwave meals, although halal and vegetarian options were limited. Muffins and breakfast cereals were also provided and hot and cold drinks were freely available during the inspection. However, custody records indicated that some detainees held for longer periods had not been offered a meal. In our survey, 65% of detainees, against a comparator of 80%, said they had been given something to eat and 63%, against a comparator of 83%, said they had been offered something to drink.

## Activities

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- 4.25 Woking, Guildford and Staines had small exercise yards, but Reigate did not. Exercise was mostly provided on request if staff were not too busy. The only items offered to occupy detainees were books in poor condition and in English. These were not routinely offered.
- 4.26 Adult detainees at Woking, Guildford and Staines were not allowed visits, while children could see their parents or other relatives in interview rooms or solicitors' rooms. Some adult detainees at Reigate had been allowed a visit when the sergeant believed this would greatly improve their well being.

## Recommendations

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- 4.27 Booking-in desks should be an appropriate height and the reception area should allow adequate privacy for the interviewing of new arrivals.
- 4.28 Subject to individual needs assessment, nicotine replacement aids should be available to detainees.
- 4.29 The daily, weekly and monthly health and safety, maintenance and cleanliness checks should be reviewed and formalised across the custody estate and the results reviewed by managers. Staff should be provided with appropriate training to allow them to carry out these checks.
- 4.30 All graffiti should be regularly removed.
- 4.31 Blankets and toilet paper should be provided routinely.
- 4.32 Women detainees should routinely be offered hygiene packs.
- 4.33 Where exercise yards are available, detainees held overnight or for long periods of time should be offered outdoor exercise.
- 4.34 Detainees remaining in custody for more than 24 hours should be allowed visits.

## Housekeeping points

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- 4.35 All call bells/intercoms should be connected and working.
- 4.36 Proper towels should be available at Staines.
- 4.37 A wider range of reading materials should be actively offered to detainees.



## 5. Individual rights

### Expected outcomes:

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

### Rights relating to detention

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- 5.1 Custody sergeants were robust in ensuring that detention was used only when appropriate. Staff at Reigate were particularly robust in resisting UKBA requests for overnight detention under immigration powers. Custody sergeants took the facts of the case, the detainee's background and the community impact into account when deciding if detention was appropriate and gave examples where they had refused it. Staff said custody was not, and would not be, used as a formal place of safety for children and young people under section 46 of the Children Act 1989.
- 5.2 Detainees were asked if they wanted someone informed that they were being detained, but free telephone calls were not offered unless custody staff deemed detainees to be particularly vulnerable. Detainees were not specifically asked about any dependency obligations so the system relied on them raising any care concerns. However, if any did come to light, action was taken to resolve them if required. At Reigate, the custody sergeant went to great lengths to ensure the safety of two young children at the end of the school day when a couple who had been detained were held incommunicado for the sake of the investigation.
- 5.3 A professional interpreting service was used to communicate with detainees who spoke little or no English, with face-to-face interpreters used for police interviews and solicitor consultations. There were no facilities for telephone interpreting in the solicitor consultation rooms. Staff at Reigate said they often waited a long time for interpreters to arrive and that this caused significant problems. Woking had information about accessing legal help available in 11 languages, and the words of the standard caution were available in 38 languages at all suites. Translated leaflets were available to detainees explaining their rights, but there were no easy read format leaflets for those with learning difficulties.
- 5.4 Appropriate pre-release risk assessments were carried out for all detainees and recorded on the custody records. Staff were aware of their duty of care to detainees and that it extended to the 24 hours after release. Detainees being released were asked if they would like their details passed to a suitable agency that may be able to offer support and assistance.

### Rights relating to PACE

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- 5.5 PACE was adhered to and the codes of practice were readily available. There was no evidence that detainees were interviewed while under the influence of drugs or alcohol. A defence solicitor, appropriate adults and detainees we spoke to said interviews had been conducted in a reasonable and respectful way.
- 5.6 Detainees were routinely asked if they would like to consult a defence solicitor and the duty solicitor scheme worked well. Defence solicitors were mainly positive about working relationships with custody staff, but raised some complaints about delays. One solicitor at Guildford said they had been kept waiting for up to three hours to get into the suite, while

another solicitor at Reigate said he was sometimes delayed by an hour with no waiting area or place where visiting professionals could prepare. Staff said immigration detainees did not have access to specialist immigration advice and the Legal Services Commission's immigration advice line, available through the duty solicitor scheme, was not used.

- 5.7 Juveniles were not interviewed unless accompanied by an appropriate adult (AA), although Surrey Police adhered to the PACE definition of a child instead of the Children Act (1989) definition, which meant those aged 17 were not provided with an AA unless otherwise deemed vulnerable<sup>3</sup>. Staff would in the first instance look to family members to be an AA. When this was not possible or appropriate, SAAVS provided an effective AA service for vulnerable adults and minors. Custody staff AAs said the scheme worked very well.
- 5.8 Some DNA samples were submitted to the national DNA database only if the suspect was charged with an offence. Some were submitted to property stores as property exhibits rather than forensic samples and property officers said officers in cases did not always tell them what to do with them. In some cases, PNC records did not show that a sample had ever been taken, while others recorded the DNA as 'missing' or 'destroyed' because it had never been submitted. Surrey's failure to submit some samples had a negative impact on the effective operation of the national DNA database and therefore potentially on the identification of suspects. (See main recommendation at paragraph 2.26.)
- 5.9 There were no video link facilities, but court cut-off times were acceptable and no problems with prompt arrival at court were reported.
- 5.10 Detainees and legal representatives at some suites could make a written request to look at a copy of the custody records. Some custody sergeants required a detainee's written consent before letting a legal representative see medical records, while others said they would simply remove the medical form and convictions information. Staff said requests for complete custody records were handled centrally under Freedom of Information Act (2000) procedures.

## Rights relating to treatment

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- 5.11 Detainees were not specifically told they could make a complaint, but prominent notices beside the booking in desks at Woking and Guildford outlined the procedure and detainees at all the suites were given written information about their right to complain. All suites also had a range of IPCC leaflets available. Not all staff were aware of the procedures for taking a complaint and some told detainees to complain at the front desk on their release. This left anyone taken straight to court or sent directly to prison with little opportunity to have their complaint heard, investigated or recorded.

## Recommendations

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- 5.12 Custody staff should ensure that detainee dependency obligations are routinely identified and, where possible, addressed.
- 5.13 Detainees requiring immigration advice should be referred to the Legal Services Commission's immigration advice line.

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<sup>3</sup> Although this met the current requirements of PACE, in all other UK law and international treaty obligations, 17 year olds are treated as juveniles. The UK government has committed to bringing PACE into line as soon as a legislative slot is available.

- 5.14 Detainees aged 17 years should be provided with an appropriate adult.
- 5.15 Staff should be made aware of the correct process for handling complaints and these should be taken while the detainee is still in custody.

### Good practice

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- 5.16 *Managers actively and robustly liaised with the UK Border Agency to avoid overnight stays by immigration detainees unless absolutely necessary.*



## 6. Healthcare

### Expected outcomes:

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

### Clinical governance

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- 6.1 Several agencies provided health services to Surrey Police. First line primary care services were available 24 hours a day through South East Coast Ambulance Trust (SECAmb) paramedics, with vehicles provided by Surrey police as part of the contract, and FMEs when required. Secondary level mental health services were provided by Surrey and Borders Mental Health Partnership NHS Trust (SaBPT) community forensic team, and drug workers by the charitable organisation Crime Reduction Initiative (CRI). CRI had held the contract since August 2009, although some staff had worked for the previous provider.
- 6.2 A Surrey multi-agency information sharing protocol set out the principles for sharing personal or confidential information based on good practice and legal and national standards. It had been agreed between a variety of agencies to reduce the risk to vulnerable individuals and to underpin effective partnership working. It was reviewed biennially, with Surrey County Council as the lead agency.
- 6.3 There was a lack of strategic focus on health, although a working group was being set up to look at oversight and commissioning arrangements. Groups where the police and partner agencies could take oversight and set strategic intent for the paramedic service had been established, but the oversight group had not met for a year. Performance and compliance with the SECAmb contract was not robustly monitored and there was a lack of awareness of strategic direction for other health and drug services development. (See main recommendation at paragraph 2.27.)
- 6.4 The paramedics had excellent clinical governance arrangements with regard to the management, training and accountability of staff. Arrangements for other staff groups were less robust. Two FMEs were on call at any one time, although one or both could also be providing services to their own GP practice, which was inappropriate. They were also on call for 24 hours at a time, which could potentially compromise their clinical judgement. The FMEs met quarterly as a group and had received some training, but there were no formal appraisal systems of their work. The forensic community mental health team was part of a wider mental health trust, but provided a service to detainees only between 9am and 4pm on weekdays. There were no formal arrangements for absence cover and no out-of-hours provision. Drug workers were trained and supervised by CRI.
- 6.5 Interactions between health and drug treatment workers and detainees were limited but respectful, and clinical records were written professionally. Custody staff said a female member of staff could chaperone a male health professional if required. There were no female FMEs. Interviews with detainees who did not speak English took place by telephone using a professional interpreting service.
- 6.6 Each site had a dedicated clinical room laid out for medical in-confidence encounters and assessments. All had been recently refurbished and each had an anti-barricade hinged door, an en-suite toilet and minimal ligature points. There was very good practice in infection control

audit and evident subsequent actions taken to redress identified non-compliance. A complete review of infection control measures had taken place in 2007 before the refurbishment, with microbiological swabbing of a range of areas throughout the custody suites. The results had been used to formulate a cleaning contract for all custody suites and this was evidently adhered to. The exercise had recently been repeated and the results were being compared. All the sharps bins were signed and dated on first use, surfaces were clear, stocks were low and in date and all the furniture was wipe-clean. DDOs were also responsible for checking the room for cleanliness and stock levels at the beginning of each shift. There was a contract for the removal of clinical waste.

- 6.7 Medications were stored in a safe, to which only the paramedics had the code. Stocks held were limited and all medications were subject to audit and stock control every time they were used. Most paramedics were trained to use patient group directions for the administration of paracetamol, ibuprofen, diazepam [5mg] and dihydrocodeine. FMEs carried their own stock of medications, but these were not always in lockable containers and there appeared to be no stock control of these. Any medication brought in by a detainee or left for them by an FME was locked in the top of the same safe, to which custody staff had access, or with the detainee's other property. Discarded medicines were removed and destroyed by police drugs officers in line with local policy.
- 6.8 Each custody suite had an emergency bag of essential medical equipment, including an automated external defibrillator. These were stored at the custody desk and checked daily, and a named DDO was responsible for ordering new stock as required. The bags were heavy and difficult for staff to carry to the scene of an emergency. All custody staff underwent first aid and resuscitation training, including the use of a defibrillator and the administration of oxygen. After their initial training, they had six-monthly reviews and a full retraining course every three years. Custody staff we spoke to said the training gave them confidence to use the equipment.

## Patient care

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- 6.9 In our survey, only 16% of detainees, against a comparator of 36%, said they had been asked on arrival if they wanted to see a health professional and we observed during the inspection that staff were not routinely doing this.
- 6.10 There were delays in health professionals attending custody. Paramedics had an agreed response time of seeing detainees within 100 minutes, with some specific cases, such as blood tests for drink driving offences, within 30 minutes. There were no similar targets for FMEs. In our survey of custody records, 10 detainees had required the services of a health professional and the longest wait had been over three hours. During the inspection, a paramedic was requested in the late afternoon for a detainee who was diabetic, had cardiac problems and took numerous medications. Only one paramedic was apparently available, despite the contract stating there would be two, and the detainee was not seen until over five hours later. In another case where an FME was called, staff were told he would be at least 90 minutes and he later telephoned to say he was due at his GP surgery for a clinic and had arranged for another FME to attend. The detainee was eventually seen over three hours after the original request.
- 6.11 Detainees who arrived in custody with their own medication were allowed to continue to receive it as long as the paramedic confirmed it was correctly labelled and in date. In most cases, the paramedic consulted the FME by telephone regarding administration. If a detainee was taking Methadone, every effort was made to obtain it from their home or dispensing pharmacy. FMEs who prescribed medications to be taken later left these in a small labelled

plastic bag in the medications safe, but if the paramedic determined that more medications were required at a later date, he arranged for a paramedic visit so that the medication could be administered. Some detainees were allowed to keep a limited range of personal medications, such as respiratory inhalers or GTN spray, in their possession following risk assessment.

- 6.12 Each detainee seen by a health professional had a clinical record containing an up-to-date assessment. All health professionals used a variety of triplicate/self-carbonated forms for assessments. Paramedics also used a SECAMB audit form, one copy of which was kept in the custody record while another two copies were kept by the paramedic and returned to SECAMB for storage. If necessary, the paramedic could have one copy for their professional portfolio. The FMEs had a slightly different system where one copy of the record served as their invoice for payment and they kept one copy. We were not reassured that all FMEs stored the clinical records in line with the Data Protection Act and Caldicott guidelines. The mental health team kept hard copy records, which were stored in locked filing cabinets at their office base in Chertsey. They also had access to custody records.
- 6.13 If an officer was injured by a detainee and subsequently seen by the FME, a copy of the officer's clinical record was stored in that detainee's custody file. This was poor practice as it meant officers' clinical records were not held securely and were potentially available to detainees who requested a copy of their records.

## Substance use

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- 6.14 CRI drug workers visited all custody suites daily. Each worked slightly differently, but essentially took referrals from custody staff and some carried out 'cell sweeps' to see if anyone wanted to talk to them. The drug workers provided throughcare to adult detainees for up to 12 weeks or signposted them to other services. Some custody staff allowed drug workers to see detainees in their cells, while others insisted they use an interview room, which could make it difficult to complete interviews when no rooms were available. Juveniles and detainees with alcohol issues were merely signposted to relevant services.
- 6.15 Custody staff valued the drug workers' services and the training they provided, but the service was available only on weekdays during office hours. Following the recent change in provider, custody staff had been instructed not to refer any more detainees to the out-of-hours provider, but had not been informed what other services were in place. This had caused some confusion. In our survey of custody records, 12 detainees (40% of the sample) had arrived in custody intoxicated and none had been offered the services of a drug or alcohol worker.
- 6.16 Intravenous drug users were not offered clean needles or syringes on release, although there had been a previous pilot service. Staff at Staines custody suite knew of a local needle exchange service if required.

## Mental health

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- 6.17 SaBPT forensic services provided mental health practitioners to each of the four custody suites on weekdays from 9am to 4pm. They also carried a caseload in the community and provided a service to the local courts. There was no service level agreement or formal contract and the force did not performance manage the arrangements. The mental health service worked to an in-house target to acknowledge the receipt of a referral within one hour and to assess the referred detainee within two hours, but this information was not shared with the force. SaBPT did not routinely provide absence cover for annual leave or sickness. However, it did provide mental health awareness training for DDOs. The service received referrals from DDOs,

paramedics and FMEs. Little management information was held and our request for details of custody assessments for the previous three months was not met. Mental health staff said there had been about one telephone referral a week over the previous 12 months.

- 6.18 Following assessment, the practitioner could give advice to DDOs, offer further support or refer the detainee for further mental health services inputs. In the case of juveniles, this included referral to child and adolescent mental health services. The team had links with the mental health in-reach team at HMP Highdown. Custody staff valued the mental health service, but it was available only on weekdays during office hours. Outside office hours, the local emergency team had to be called, but most staff said the response was not satisfactory.
- 6.19 Mental health staff undertook joint assessments with either the paramedics or drug workers when appropriate, but said engagement with FMEs was less common.
- 6.20 The Section 135/136<sup>4</sup> policy required review. There was some confusion among SaBPT and Surrey police staff over where the S136 suites were located. Access to some of the suites appeared variable and it could take several hours to get a detainee into a S136 assessment suite. The custody inspector at Reigate had tried to engage with staff at the local S136 suite and had introduced a local engagement monitoring form to exchange positive and negative feedback from both police and mental health staff. This initiative was reported to be showing dividends, but had not been replicated in the other two divisions.
- 6.21 Staff at Reigate also regularly used a S136 suite in neighbouring Sussex and apparently preferred this as they said staff at the Sussex unit were inviting and kept them informed of progress when assessing the detainee. In Surrey, by contrast, they and detainees were kept waiting outside all the units, sometimes for over an hour, while collateral information was sought and arrangements were made to open the S136 suite. Staff also said SaBPT sometimes refused to accept a detainee who smelt of alcohol, even though the police did not deem them to be incapacitated. This meant the detainee had to be taken to a custody suite and returned to the S136 suite later, which was unacceptable.

## Recommendations

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- 6.22 Female detainees should be able to see a female health professional on request.
- 6.23 FMEs should be contracted solely to FME duties when working for Surrey police force and their hours of work should be such as not to compromise their clinical judgment.
- 6.24 There should be cover for absence and out of hours for both the forensic mental health team and substance use workers to meet the needs of detainees.
- 6.25 All detainees should be asked on arrival if they want to see a health professional.
- 6.26 Substance use services should be provided for juvenile detainees and those with alcohol issues.
- 6.27 Out-of-hours drug service provision should be clarified.
- 6.28 Drugs workers should offer clean needles and relevant equipment to injecting drug users who are being released into the community.

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<sup>4</sup> Section 135 and 136 of the Mental Health Act 1983

- 6.29 Arrangements for the admission of detainees to S136 mental health suites should be reviewed so that all staff are aware of the policy and work to meet the needs of detainees expeditiously.

### Housekeeping points

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- 6.30 Medications carried by FMEs should be stored safely and securely and subject to stock control.
- 6.31 All clinical records should be held in line with the Data Protection Act and Caldicott guidelines.
- 6.32 Emergency bags should be made lighter so that they can be easily transported when required.
- 6.33 Clinical records of police officers injured in the line of duty should not be stored with detainees' custody records.

### Good practice

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- 6.34 *The results of the complete review of infection control measures throughout the custody suites in 2007, with microbiological swabbing of a variety of areas, had been used to formulate a cleaning contract for all the custody suites and the levels of cleanliness not only in the clinical rooms but elsewhere in the suites were among the best we have seen.*
- 6.35 *The specification of the clinical rooms was to a high standard that other forces would do well to emulate.*
- 6.36 *The first aid, defibrillation and oxygen administration training and updates for all custody staff were commendable.*
- 6.37 *The fact that following risk assessment, detainees could keep salbutamol or GTN sprays in their possession showed a mature attitude to the needs of detainees.*



# 7. Summary of recommendations

## Main recommendations

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- 7.1 Risk assessments should take into account all the relevant information available to staff, including safety markers from the local intelligence system and PNC. (2.24)
- 7.2 All cells should be fit for purpose and free of ligature points and custody staff should be trained to identify potential ligature points. (2.25)
- 7.3 How the force takes, stores, tracks and deals with DNA should be urgently reviewed and the review should be owned by a senior responsible officer. (2.26)
- 7.4 Surrey police should have clear contractual arrangements, including relevant management information, with all health providers and there should be strategic oversight and robust management and performance monitoring of all health provider contracts. (2.27)

## Strategy

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- 7.5 Surrey Police should review its current staffing model for custody. (3.13)
- 7.6 The use of force should be monitored locally and at a force-wide level. (3.14)

## Treatment and conditions

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- 7.7 Booking-in desks should be an appropriate height and the reception area should allow adequate privacy for the interviewing of new arrivals. (4.27)
- 7.8 Subject to individual needs assessment, nicotine replacement aids should be available to detainees. (4.28)
- 7.9 The daily, weekly and monthly health and safety, maintenance and cleanliness checks should be reviewed and formalised across the custody estate and the results reviewed by managers. Staff should be provided with appropriate training to allow them to carry out these checks. (4.29)
- 7.10 All graffiti should be regularly removed. (4.30)
- 7.11 Blankets and toilet paper should be provided routinely. (4.31)
- 7.12 Women detainees should routinely be offered hygiene packs. (4.32)
- 7.13 Where exercise yards are available, detainees held overnight or for long periods of time should be offered outdoor exercise. (4.33)
- 7.14 Detainees remaining in custody for more than 24 hours should be allowed visits. (4.34)

## Individual rights

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- 7.15 Custody staff should ensure that detainee dependency obligations are routinely identified and, where possible, addressed. (5.12)
- 7.16 Detainees requiring immigration advice should be referred to the Legal Services Commission's immigration advice line. (5.13)
- 7.17 Detainees aged 17 years should be provided with an appropriate adult. (5.14)
- 7.18 Staff should be made aware of the correct process for handling complaints and these should be taken while the detainee is still in custody. (5.15)

## Healthcare

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- 7.19 Female detainees should be able to see a female health professional on request. (6.22)
- 7.20 FMEs should be contracted solely to FME duties when working for Surrey police force and their hours of work should be such as not to compromise their clinical judgment. (6.23)
- 7.21 There should be cover for absence and out of hours for both the forensic mental health team and substance use workers to meet the needs of detainees. (6.24)
- 7.22 All detainees should be asked on arrival if they want to see a health professional. (6.25)
- 7.23 Substance use services should be provided for juvenile detainees and those with alcohol issues. (6.26)
- 7.24 Out-of-hours drug service provision should be clarified. (6.27)
- 7.25 Drugs workers should offer clean needles and relevant equipment to injecting drug users who are being released into the community. (6.28)
- 7.26 Arrangements for the admission of detainees to S136 mental health suites should be reviewed so that all staff are aware of the policy and work to meet the needs of detainees expeditiously. (6.29)

## Housekeeping points

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### Strategy

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- 7.27 The learning lessons documents from the IPCC should be held as a single intranet site. (3.15)

### Treatment and conditions

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- 7.28 All call bells/intercoms should be connected and working. (4.35)
- 7.29 Proper towels should be available at Staines. (4.36)

- 7.30 A wider range of reading materials should be actively offered to detainees. (4.37)

### **Healthcare**

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- 7.31 Medications carried by FMEs should be stored safely and securely and subject to stock control. (6.30)
- 7.32 All clinical records should be held in line with the Data Protection Act and Caldicott guidelines. (6.31)
- 7.33 Emergency bags should be made lighter so that they can be easily transported when required. (6.32)
- 7.34 Clinical records of police officers injured in the line of duty should not be stored with detainees' custody records. (6.33)

### **Good practice**

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#### **Individual rights**

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- 7.35 Managers actively and robustly liaised with the UK Border Agency to avoid overnight stays by immigration detainees unless absolutely necessary. (5.16)

### **Healthcare**

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- 7.36 The results of the complete review of infection control measures throughout the custody suites in 2007, with microbiological swabbing of a variety of areas, had been used to formulate a cleaning contract for all the custody suites and the levels of cleanliness not only in the clinical rooms but elsewhere in the suites were among the best we have seen. (6.34)
- 7.37 The specification of the clinical rooms was to a high standard that other forces would do well to emulate. (6.35)
- 7.38 The first aid, defibrillation and oxygen administration training and updates for all custody staff were commendable. (6.36)
- 7.39 The fact that following risk assessment, detainees could keep salbutamol or GTN sprays in their possession showed a mature attitude to the needs of detainees. (6.37)

## Appendix I: Inspection team

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Nigel Newcomen	HMIP Deputy Chief inspector
Sean Sullivan	HMIP team leader
Anita Saigal	HMIP inspector
Martin Kettle	HMIP inspector
Colin Carroll	HMIP inspector
Paddy Craig	HMIC inspector
Fiona Shearlaw	HMIC inspector
Nick Budden	HMIC inspector
Elizabeth Tysoe	HMIP healthcare inspector
Paul Tarbuck	HMIP healthcare inspector
Huw Jenkins	Care Quality Commission inspector
Adam Altoft	HMIP researcher
Sherrelle Parke	HMIP researcher

## Appendix II: Custody record analysis

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### Background

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As part of the inspection of Surrey police custody cells, a sample of the custody records of detainees held between 13 and 16 December 2010 was analysed. Custody records were held electronically on CIS. A total sample of 30 records was analysed from across Surrey:

Custody suite	Number of records analysed
Woking	8
Reigate	8
Staines	7
Farnham	4
Guildford	3
Total	30

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

### Demographic information

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- Five (17%) of the detainees were female and 25 (83%) were male.
- Five people (17%) under the age of 17 were included in the sample.
- Three (10%) detainees were from a black and minority ethnic background. Twenty-five (83%) detainees were White British and two (6%) were White Other.
- Sixteen (53%) detainees had been held overnight, including those who had arrived during the night and were not released until the morning. Two (7%) had been held for more than 24 hours. Ten (33%) detainees had been held for less than six hours.
- Risk assessments showed that nine (30%) detainees had previously self-harmed.
- Seven (23%) detainees had disclosed mental health problems.
- Four (13%) detainees disclosed learning difficulties.
- Ten (33%) detainees were in police custody for the first time.
- On leaving custody, three detainees (10%) went to court, 25 (83%) returned home, one returned to prison and one was taken to hospital after being sectioned.

### Removal of clothing

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Four detainees had some clothing removed from them; one was aged 14. One detainee, who was held under Section 136, had his clothing removed and was left in only his underwear for over nine hours before being given a tracksuit. Two detainees were immediately provided with paper clothing as a replacement for their removed clothing and one detainee waited six minutes for alternative clothing.

### Young people

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- All of the five young people in the sample were interviewed. All had an appropriate adult with them during interview; for four of these young people, the appropriate adult was a parent.

- Three of the five young people in our sample spent over six hours in custody. One young person aged 14 spent nine hours in custody and was not offered a meal during this time. He was not offered the opportunity to make a telephone call due to a 'delay of entitlements'. This was his first time in custody.
- None of the young people was offered an opportunity to shower or exercise or any reading material. Two of the five young people were given the opportunity to make a telephone call.

## **Interpreters**

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One (3%) detainee in the sample could not understand English and required an interpreter. An interpreter was requested and attended and was present during the interview with the detainee. However, the detainee signed to say that he had received his rights and entitlements before the arrival of the interpreter.

## **Inspector reviews**

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Inspector reviews were held in line with requirements.

## **Services**

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- Nineteen (63%) detainees were not offered a telephone call during their time in custody. This included one detainee who was held for 33 hours and another held for 23 hours. Three detainees requested a telephone call and one of those was refused the call. One detainee, held at Reigate, was given the opportunity to make four telephone calls during the 40 hours he spent in custody there and parties concerned for the detainee were kept updated of his welfare during his time in custody.
- All detainees had been asked if they wanted a solicitor. Fifteen (50%) detainees had spoken to/seen either their solicitor or a duty solicitor.
- No detainees shared a cell while in custody.
- Ten (33%) detainees required the attention of a healthcare professional (HCP). The longest wait was over three hours where the HCP was called early in the morning. Of the 10, custody records showed that only seven had to wait less than an hour to see the HCP.
- Twelve (40%) detainees had arrived in custody intoxicated. No detainee in our sample met with either a drugs or alcohol worker during their time in custody.
- Fourteen (47%) detainees had eaten at least one meal while in custody. One detainee was provided with a halal meal. Three (10%) detainees did not eat a meal, but had been offered food and refused. Thirteen (43%) detainees had not received a single meal nor were they recorded as having refused a meal; two of these were held for nine hours.
- No detainees were given exercise or offered a shower.
- One (3%) detainee, at Woking, had been given reading material.

## **Additional points of note**

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- The Polish embassy was informed of the arrest of one detainee, but nothing in the detention log indicated that she was made aware of this.
- One detainee, held under Section 136, was twice placed in a restraint suit during his time in custody. On the second occasion, the detainee was left in the restraint suit for six hours, despite the detention log noting that he had calmed down.
- The risk assessment for one detainee stated that he had recently been sectioned, had ongoing mental health issues and had self-harmed earlier that day (of such severity that

he was taken to hospital before arriving in custody). It was not considered that an appropriate adult was necessary for this detainee.

- The paramedic initial assessment for one detainee stated that he had no history of self-harm, despite the initial risk assessment showing that he had taken an overdose six years previously.
- One detainee, a 17 year old female, told staff that she had a mental health worker. The circumstances of arrest documentation stated that she had been banging her head against a window, had swallowed some paracetamol and said she was 'going to die'. She was taken to hospital as a precaution before arriving in custody. On the initial risk assessment, the arresting/escorting officer was asked if they were aware of anything that may affect the detainee's care, safety or security and the response was: 'no, not aware of anything'. The detainee was recorded as 'medium risk'. An appropriate adult was not considered necessary.
- The risk assessment for one detainee indicated that he had not recently been drinking alcohol. This was despite the initial detention log stating that he was 'under the influence of alcohol' and the inspector's review, five hours after the detainee arrived in custody, stating that he was 'being allowed to rest and sober up'.
- One elderly detainee, at Reigate, was held in custody for 40 hours. He was offered two meals during this time, but was not offered any outdoor exercise or the opportunity to have a shower. He was taken straight to court from the custody suite.
- The appropriate adult for one young person, his father, was present when he was given his rights and entitlements, but was later removed from custody as he became aggressive with custody staff and was acting inappropriately. However, he was later allowed back into custody and was present when the young person was interviewed.

## Appendix III: Summary of detainee questionnaires and interviews

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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 Surrey, was carried out for this inspection. The results of this survey formed part of the evidence-base for the inspection.

### **Choosing the sample size**

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The survey was conducted on 19 January 2010. A list of potential respondents to have passed through Woking, Guildford, Reigate, Farnham and Staines police stations was created, listing all those who had arrived from Guildford, Woking, Kingston upon Thames, Croydon or Staines Magistrates court within the past month.

### **Selecting the sample**

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In total, 70 respondents were approached. Fifty reported either being held in police stations outside Surrey or were not in the establishment at the time. On the day, the questionnaire was offered to 20 respondents. There were no refusals, no questionnaires were returned blank and there were no non-returns. All those sampled had been in custody within the last two months.

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

### **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:

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

### **Response rates**

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In total, 20 (100%) respondents completed and returned their questionnaires.

## **Comparisons**

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

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

The current survey responses were analysed against comparator figures for all prisoners surveyed in other police areas. This comparator is based on all responses from prisoner surveys carried out in 20 police areas since April 2008.

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

## **Summary**

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

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

Percentages shown in the summary may differ by 1% or 2% from that shown in the comparison data as the comparator data has been weighted for comparison purposes.

## Police custody survey

### Section 1: About you

Q2	<b>What police station were you last held at?</b> Reigate – 1; Woking – 9; Guildford – 10		
Q3	<b>What type of detainee were you?</b>		
	<i>Police detainee</i> .....	17	(85%)
	<i>Prison lock-out (i.e. you were in custody in a prison before coming here)</i> .....	0	(0%)
	<i>Immigration detainee</i> .....	0	(0%)
	<i>I don't know</i> .....	3	(15%)
Q4	<b>How old are you?</b>		
	<i>16 years or younger</i> .....	0	(0%)
	<i>17-21 years</i> .....	5	(25%)
	<i>22-29 years</i> .....	7	(35%)
	<i>30-39 years</i> .....	3	(15%)
	<i>40-49 years</i> .....	4	(20%)
	<i>50-59 years</i> .....	1	(5%)
	<i>60 years or older</i> .....	0	(0%)
Q5	<b>Are you:</b>		
	<i>Male?</i> .....	19	(95%)
	<i>Female?</i> .....	0	(0%)
	<i>Transgender/transsexual?</i> .....	1	(5%)
Q6	<b>What is your ethnic origin?</b>		
	<i>White - British</i> .....	16	(80%)
	<i>White - Irish</i> .....	0	(0%)
	<i>White - other</i> .....	1	(5%)
	<i>Black or black British - Caribbean</i> .....	0	(0%)
	<i>Black or black British - African</i> .....	0	(0%)
	<i>Black or black British - other</i> .....	0	(0%)
	<i>Asian or Asian British - Indian</i> .....	0	(0%)
	<i>Asian or Asian British - Pakistani</i> .....	2	(10%)
	<i>Asian or Asian British - Bangladeshi</i> .....	0	(0%)
	<i>Asian or Asian British - other</i> .....	0	(0%)
	<i>Mixed heritage - white and black Caribbean</i> .....	0	(0%)
	<i>Mixed heritage - white and black African</i> .....	0	(0%)
	<i>Mixed heritage - white and Asian</i> .....	0	(0%)
	<i>Mixed heritage - other</i> .....	0	(0%)
	<i>Chinese</i> .....	0	(0%)
	<i>Other ethnic group</i> .....	1	(5%)
	<i>Please specify:</i>	1	(100%)
Q7	<b>Are you a foreign national (i.e. you do not hold a British passport, or you are not eligible for one)?</b>		
	<i>Yes</i> .....	1	(6%)
	<i>No</i> .....	17	(94%)
Q8	<b>What, if any, would you classify as your religious group?</b>		
	<i>None</i> .....	9	(47%)

	<i>Church of England</i> .....	6 (32%)
	<i>Catholic</i> .....	2 (11%)
	<i>Protestant</i> .....	0 (0%)
	<i>Other Christian denomination</i> .....	0 (0%)
	<i>Buddhist</i> .....	0 (0%)
	<i>Hindu</i> .....	0 (0%)
	<i>Jewish</i> .....	0 (0%)
	<i>Muslim</i> .....	2 (11%)
	<i>Sikh</i> .....	0 (0%)
	<i>Any other religion, please specify</i> .....	1 (100%)
<b>Q9</b>	<b>How would you describe your sexual orientation?</b>	
	<i>Straight/heterosexual</i> .....	18 (90%)
	<i>Gay/lesbian/homosexual</i> .....	1 (5%)
	<i>Bisexual</i> .....	1 (5%)
	<i>Other (please specify):</i> .....	0 (0%)
<b>Q10</b>	<b>Do you consider yourself to have a disability?</b>	
	<i>Yes</i> .....	5 (25%)
	<i>No</i> .....	15 (75%)
	<i>Don't know</i> .....	0 (0%)
<b>Q11</b>	<b>Have you ever been held in police custody before?</b>	
	<i>Yes</i> .....	16 (80%)
	<i>No</i> .....	4 (20%)

## Section 2: Your experience of this custody suite

<b>Q12</b>	<b>How long were you held at the police station?</b>	
	<i>1 hour or less</i> .....	0 (0%)
	<i>More than 1 hour, but less than 6 hours</i> .....	2 (10%)
	<i>More than 6 hours, but less than 12 hours</i> .....	2 (10%)
	<i>More than 12 hours, but less than 24 hours</i> .....	3 (15%)
	<i>More than 24 hours, but less than 48 hours (2 days)</i> .....	7 (35%)
	<i>More than 48 hours (2 days), but less than 72 hours (3 days)</i> .....	5 (25%)
	<i>72 hours (3 days) or more</i> .....	1 (5%)
<b>Q13</b>	<b>Were you given information about your arrest and your entitlements when you arrived there?</b>	
	<i>Yes</i> .....	16 (84%)
	<i>No</i> .....	2 (11%)
	<i>Don't know/Can't remember</i> .....	1 (5%)
<b>Q14</b>	<b>Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')?</b>	
	<i>Yes</i> .....	11 (55%)
	<i>No</i> .....	8 (40%)
	<i>I don't know what this is/I don't remember</i> .....	1 (5%)
<b>Q15</b>	<b>If your clothes were taken away, were you offered different clothing to wear?</b>	
	<i>My clothes were not taken</i> .....	13 (65%)
	<i>I was offered a tracksuit to wear</i> .....	2 (10%)
	<i>I was offered an evidence suit to wear</i> .....	4 (20%)
	<i>I was offered a blanket</i> .....	1 (5%)

Q16	Could you use a toilet when you needed to?			
	Yes.....			19 (95%)
	No.....			1 (5%)
	Don't know.....			0 (0%)
Q17	If you have used the toilet there, were these things provided?			
		<i>Yes</i>	<i>No</i>	
	Toilet paper	11 (58%)	8 (42%)	
	Sanitary protection	0 (0%)	10 (100%)	
	Other (please specify):	1 (100%)		
Q18	Did you share a cell at the police station?			
	Yes.....			0 (0%)
	No.....			20 (100%)
Q19	How would you rate the condition of your cell:			
		<i>Good</i>	<i>Neither</i>	<i>Bad</i>
	Cleanliness	7 (39%)	7 (39%)	4 (22%)
	Ventilation/air quality	5 (29%)	5 (29%)	7 (41%)
	Temperature	3 (19%)	2 (13%)	11 (69%)
	Lighting	5 (29%)	5 (29%)	7 (41%)
Q20	Was there any graffiti in your cell when you arrived?			
	Yes.....			11 (58%)
	No.....			8 (42%)
Q21	Did staff explain to you the correct use of the cell bell?			
	Yes.....			6 (32%)
	No.....			13 (68%)
Q22	Were you held overnight?			
	Yes.....			16 (84%)
	No.....			3 (16%)
Q23	If you were held overnight, which items of clean bedding were you given?			
	<i>Not held overnight</i> .....			3 (15%)
	<i>Pillow</i> .....			1 (5%)
	<i>Blanket</i> .....			9 (45%)
	<i>Nothing</i> .....			7 (35%)
Q24	Were you offered a shower at the police station?			
	Yes.....			2 (11%)
	No.....			17 (89%)
Q25	Were you offered any period of outside exercise while there?			
	Yes.....			0 (0%)
	No.....			19 (100%)
Q26	Were you offered anything to:			
		<i>Yes</i>	<i>No</i>	
	Eat?	13 (65%)	7 (35%)	
	Drink?	12 (63%)	7 (37%)	

Q27	Was the food/drink you received suitable for your dietary requirements?		
	<i>I did not have any food or drink</i> .....	4 (20%)	
	<i>Yes</i> .....	9 (45%)	
	<i>No</i> .....	7 (35%)	
Q28	If you smoke, were you offered anything to help you cope with the smoking ban there?		
	<i>I do not smoke</i> .....	3 (16%)	
	<i>I was allowed to smoke</i> .....	1 (5%)	
	<i>I was not offered anything to cope with not smoking</i> .....	15 (79%)	
	<i>I was offered nicotine gum</i> .....	0 (0%)	
	<i>I was offered nicotine patches</i> .....	0 (0%)	
	<i>I was offered nicotine lozenges</i> .....	0 (0%)	
Q29	Were you offered anything to read?		
	<i>Yes</i> .....	3 (15%)	
	<i>No</i> .....	17 (85%)	
Q30	Was someone informed of your arrest?		
	<i>Yes</i> .....	8 (40%)	
	<i>No</i> .....	7 (35%)	
	<i>I don't know</i> .....	1 (5%)	
	<i>I didn't want to inform anyone</i> .....	4 (20%)	
Q31	Were you offered a free telephone call?		
	<i>Yes</i> .....	7 (37%)	
	<i>No</i> .....	12 (63%)	
Q32	If you were denied a free phone call, was a reason for this offered?		
	<i>My phone call was not denied</i> .....	7 (37%)	
	<i>Yes</i> .....	2 (11%)	
	<i>No</i> .....	10 (53%)	
Q33	Did you have any concerns about the following, while you were in police custody?		
		<i>Yes</i>	<i>No</i>
	Who was taking care of your children	0 (0%)	17 (100%)
	Contacting your partner, relative or friend	7 (41%)	10 (59%)
	Contacting your employer	2 (13%)	14 (88%)
	Where you were going once released	4 (24%)	13 (76%)
Q34	Were you interviewed by police officials about your case?		
	<i>Yes</i> .....	17 (85%)	
	<i>No</i> .....	3 (15%)	If No, go to Q36
Q35	Were any of the following people present when you were interviewed?		
		<i>Yes</i>	<i>No</i>
	Solicitor	13 (76%)	3 (18%)
	Appropriate adult	0 (0%)	6 (50%)
	Interpreter	0 (0%)	5 (42%)
			<i>Not needed</i>
			1 (6%)
			6 (50%)
			7 (58%)
Q36	How long did you have to wait for your solicitor?		
	<i>I did not requested a solicitor</i> .....	7 (35%)	
	<i>2 hours or less</i> .....	3 (15%)	
	<i>Over 2 hours but less than 4 hours</i> .....	2 (10%)	
	<i>4 hours or more</i> .....	8 (40%)	

Q37	Were you officially charged?		
	Yes.....	18 (90%)	
	No.....	2 (10%)	
	Don't know.....	0 (0%)	
Q38	How long were you in police custody <u>after</u> being charged?		
	<i>I have not been charged yet</i> .....	2 (10%)	
	<i>1 hour or less</i> .....	3 (15%)	
	<i>More than 1 hour, but less than 6 hours</i> .....	1 (5%)	
	<i>More than 6 hours, but less than 12 hours</i> .....	4 (20%)	
	<i>12 hours or more</i> .....	10 (50%)	

### Section 3: Safety

Q40	Did you feel safe there?		
	Yes.....	15 (75%)	
	No.....	5 (25%)	
Q41	Had another detainee or a member of staff victimised (insulted or assaulted) you there?		
	Yes.....	8 (40%)	
	No.....	12 (60%)	
Q42	If you have felt victimised, what did the incident involve? (Please tick all that apply to you.)		
	<i>I have not been victimised</i> .....	12 (48%)	<i>Because of your crime</i> ..... 4 (16%)
	<i>Insulting remarks (about you, your family or friends)</i> .....	3 (12%)	<i>Because of your sexuality</i> ..... 0 (0%)
	<i>Physical abuse (being hit, kicked or assaulted)</i> .....	2 (8%)	<i>Because you have a disability</i> ..... 0 (0%)
	<i>Sexual abuse</i> .....	1 (4%)	<i>Because of your religion/religious beliefs</i> ..... 0 (0%)
	<i>Your race or ethnic origin</i> .....	1 (4%)	<i>Because you are from a different part of the country than others</i> ..... 0 (0%)
	<i>Drugs</i> .....	2 (8%)	
	<i>Please describe:</i>		3 (100%)
Q43	Were you handcuffed or restrained whilst in the police custody suite?		
	Yes.....	9 (45%)	
	No.....	11 (55%)	
Q44	Were you injured whilst in police custody, in a way that you feel was not your fault?		
	Yes.....	3 (15%)	
	No.....	17 (85%)	
Q45	Were you told how to make a complaint about your treatment here if you needed to?		
	Yes.....	4 (21%)	
	No.....	15 (79%)	

### Section 4: Healthcare

Q47	When you were in police custody were you on any medication?		
	Yes.....	7 (35%)	
	No.....	13 (65%)	

Q48	Were you able to continue taking your medication while there?						
	<i>Not taking medication</i> .....					13 (65%)	
	<i>Yes</i> .....					1 (5%)	
	<i>No</i> .....					6 (30%)	
Q49	Did someone explain your entitlements to see a healthcare professional if you needed to?						
	<i>Yes</i> .....					3 (15%)	
	<i>No</i> .....					16 (80%)	
	<i>Don't know</i> .....					1 (5%)	
Q50	Were you seen by the following healthcare professionals during your time there?						
		<i>Yes</i>			<i>No</i>		
	Doctor	5 (26%)			14 (74%)		
	Nurse	0 (0%)			16 (100%)		
	Paramedic	4 (22%)			14 (78%)		
	Psychiatrist	2 (13%)			14 (88%)		
Q51	Were you able to see a healthcare professional of your own gender?						
	<i>Yes</i> .....					4 (21%)	
	<i>No</i> .....					9 (47%)	
	<i>Don't know</i> .....					6 (32%)	
Q52	Did you have any drug or alcohol problems?						
	<i>Yes</i> .....					8 (40%)	
	<i>No</i> .....					12 (60%)	
Q53	Did you see, or were offered the chance to see a drug or alcohol support worker?						
	<i>I didn't have any drug/alcohol problems</i> .....					12 (60%)	
	<i>Yes</i> .....					3 (15%)	
	<i>No</i> .....					5 (25%)	
Q54	Were you offered relief or medication for your immediate symptoms?						
	<i>I didn't have any drug/alcohol problems</i> .....					12 (60%)	
	<i>Yes</i> .....					2 (10%)	
	<i>No</i> .....					6 (30%)	
Q55	Please rate the quality of your healthcare while in police custody:						
		I was not seen by healthcare	<i>Very good</i>	<i>Good</i>	<i>Neither</i>	<i>Bad</i>	<i>Very bad</i>
	Quality of healthcare	13 (65%)	0 (0%)	1 (5%)	3 (15%)	0 (0%)	3 (15%)
Q56	Did you have any specific <u>physical</u> healthcare needs?						
	<i>No</i> .....					16 (84%)	
	<i>Yes</i> .....					3 (16%)	
	<i>Please specify:</i>					3 (100%)	
Q57	Did you have any specific <u>mental</u> healthcare needs?						
	<i>No</i> .....					16 (84%)	
	<i>Yes</i> .....					3 (16%)	
	<i>Please specify:</i>					2 (100%)	



## Prisoner survey responses for Surrey Police 2010

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

### Key to tables

		Surrey Police	Police custody comparator
	Any percent highlighted in green is significantly better.		
	Any percent highlighted in blue is significantly worse.		
	Any percent highlighted in orange shows a significant difference in prisoners' background details.		
	Percentages which are not highlighted show there is no significant difference.		
<b>Number of completed questionnaires returned</b>		20	683
<b>SECTION 1: General information</b>			
2	Are you a police detainee?	84%	88%
3	Are you under 21 years of age?	26%	9%
4	Are you transgender/transsexual?	6%	1%
5	Are you from a minority ethnic group (including all those who did not tick white British, white Irish or white other categories)?	16%	34%
6	Are you a foreign national?	7%	14%
7	Are you Muslim?	10%	11%
8	Are you homosexual/gay or bisexual?	10%	1%
9	Do you consider yourself to have a disability?	26%	19%
10	Have you been in police custody before?	80%	92%
<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 24 hours?	65%	64%
12	Were you given information about your arrest and entitlements when you arrived?	83%	74%
13	Were you told about PACE?	55%	54%
14	If your clothes were taken away, were you given a tracksuit to wear?	28%	43%
15	Could you use a toilet when you needed to?	94%	90%
16	If you did use the toilet, was toilet paper provided?	58%	53%
17	Did you share a cell at the station?	0%	3%
18	Would you rate the condition of your cell, as 'good' for:		
18a	Cleanliness?	39%	31%
18b	Ventilation/air quality?	30%	20%
18c	Temperature?	20%	14%
18d	Lighting?	30%	44%
19	Was there any graffiti in your cell when you arrived?	58%	57%
20	Did staff explain the correct use of the cell bell?	31%	22%
21	Were you held overnight?	83%	91%
22	If you were held overnight, were you given <b>no</b> clean items of bedding?	38%	29%
23	Were you offered a shower?	10%	10%
24	Were you offered a period of outside exercise?	0%	7%
25a	Were you offered anything to eat?	65%	80%
25b	Were you offered anything to drink?	63%	83%
26	Was the food/drink you received suitable for your dietary requirements?	56%	43%
27	For those who smoke: were you offered <b>nothing</b> to help you cope with the ban there?	79%	79%
28	Were you offered anything to read?	16%	14%
29	Was someone informed of your arrest?	40%	43%
30	Were you offered a free telephone call?	38%	51%

**Key to tables**

	Any percent highlighted in green is significantly better.	Surrey Police	Police custody comparator
	Any percent highlighted in blue is significantly worse.		
	Any percent highlighted in orange shows a significant difference in prisoners' background details.		
	Percentages which are not highlighted show there is no significant difference.		
31	If you were denied a free call, was a reason given?	17%	15%
32	Did you have any concerns about:		
32a	Who was taking care of your children?	0%	15%
32b	Contacting your partner, relative or friend?	42%	53%
32c	Contacting your employer?	13%	20%
32d	Where you were going once released?	23%	33%
34	If you were interviewed were the following people present:		
34a	Solicitor	77%	74%
34b	Appropriate adult	0%	7%
34c	Interpreter	0%	7%
35	Did you wait over four hours for your solicitor?	61%	64%
37	Were you held 12 hours or more in custody after being charged?	56%	63%
<b>SECTION 3: Safety</b>			
39	Did you feel unsafe?	26%	38%
40	Has another detainee or a member of staff victimised you?	40%	43%
41	If you have felt victimised, what did the incident involve?		
41a	Insulting remarks (about you, your family or friends)	16%	24%
41b	Physical abuse (being hit, kicked or assaulted)	10%	14%
41c	Sexual abuse	6%	2%
41d	Your race or ethnic origin	6%	6%
41e	Drugs	10%	17%
41f	Because of your crime	20%	19%
41g	Because of your sexuality	0%	1%
41h	Because you have a disability	0%	3%
41i	Because of your religion/religious beliefs	0%	4%
41j	Because you are from a different part of the country than others	0%	5%
42	Were you handcuffed or restrained whilst in the police custody suite?	45%	46%
43	Were you injured whilst in police custody, in a way that you feel is not your fault?	16%	26%
44	Were you told how to make a complaint about your treatment?	21%	14%
<b>SECTION 4: Healthcare</b>			
46	Were you on any medication?	35%	46%
47	For those who were on medication: were you able to continue taking your medication?	17%	39%
48	Did someone explain your entitlement to see a healthcare professional if you needed to?	16%	36%
49	Were you seen by the following healthcare professionals during your time in police custody?		
49a	Doctor	27%	50%
49b	Nurse	0%	19%
49c	Paramedic	22%	3%
49d	Psychiatrist	13%	3%
50	Were you able to see a healthcare professional of your own gender?	21%	28%
51	Did you have any drug or alcohol problems?	40%	57%
For those who had drug or alcohol problems:			
52	Did you see, or were offered the chance to see a drug or alcohol support worker?	38%	42%
53	Were you offered relief medication for your immediate symptoms?	25%	35%
54	For those who had been seen by healthcare, would you rate the quality as good/very good?	17%	31%
55	Do you have any specific physical healthcare needs?	17%	35%
56	Do you have any specific mental healthcare needs?	17%	25%