Report on an unannounced inspection visit to police custody suites in

Metropolitan Police Service Borough Operational Command Units of Barnet, Brent and Harrow

by HM Inspectorate of Prisons
and HM Inspectorate of Constabulary

10–15 November 2014

Glossary of terms

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Section 1. Introduction

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

In January 2014, the Home Secretary asked HM Inspectorate of Constabulary (HMIC) to undertake a thematic inspection in 2014/15 on the welfare of vulnerable people in police custody. It was decided by HMIC and HM Inspectorate of Prisons to use the existing rolling programme of police custody inspections to facilitate the principal fieldwork. The findings from the inspection of police custody suites carried out as part of this fieldwork will inform the final thematic report, which is to be published in 2015.

Previously the Metropolitan Police Service (MPS) managed its custody suites by delegating responsibilities to the local borough operational command unity (BOCU); now the MPS intends to organise the 32 London boroughs into seven clusters. This inspection covered part of the proposed north west cluster. We were aware of this imminent change and current transitional arrangements - some staff were waiting to take up posts and duties relating to the new structure. Our previous inspections of borough custody suites revealed significant differences between them, despite being within the same senior management structure, however, the proposed single custody-specific command structure is intended to ensure consistency and that similar standards are applied across the MPS. This may also offer the opportunity for coordination and strategic planning of Pan-London services and partnerships supporting local initiatives which improve services to detainees.

There were significant gaps in the management information available across a number of the custody related performance areas, and the current performance management arrangement could not provide sufficient assurance to chief officers and managers that custody was being used proportionately and appropriately. There was no monitoring of detainees, for example, by age, ethnicity or gender. Similarly there was no information about the use of voluntary attendance, or how often accommodation for children was requested by the police, or provided by the local authority - vital information if the needless detention of children being held overnight is to be minimised.

Custody staff were courteous and polite to detainees but there were often long delays in the booking-in process, with some vulnerable people enduring long waits in vans and van dock areas.

There were considerable variances in the delivery of custody, for example, in risk assessments, handovers, observations and pre-release risk assessments. This was largely due to each local BOCU operating independently from one another. The new structure is meant to standardise practices and ensure a consistency in custody across London.

We were concerned about the lack of oversight in use of force in custody as it was only recorded on the custody record which did not allow for routine checking of incidents involving force. MPS should reassure themselves that all use of force is recorded, records are easily accessible, force used is accountable and any learning derived for the safe detention of detainees is shared among staff.

Too many detainees stayed in detention longer than necessary because of factors such as delays in acquiring an appropriate adult (AA) and a lack of focus on case progression. AA services were either limited or not available between midnight and 8am, which meant that many vulnerable adults and children had to spend the night in custody, compounding their vulnerability and distress.

Health services were generally effective. Staff training, professional updating and supervision of clinical skills were good. However, there were long delays in attendance by forensic medical examiners at the custody suites, and there were too few custody nurses. We noted some good practice around substance misuse. For example, the presence of a drug intervention project worker at Brent custody suite enabled good joint working with custody and health care staff, and resulted in early responses to detainees' substance use needs.

Custody suites were rarely used to detain people under section 136 of the Mental Health Act 1983. Custody staff could refer detainees to mental health services, and attendance post-referral was prompt. However, there were regular delays in finding bed spaces for mental health patients.

The proposed change to the MPS structure offers the opportunity to provide a consistent standard of custody services across London.

We expect our findings to be considered and an action plan to be provided in due course.

Sir Thomas P Winsor
HM Chief Inspector of Constabulary

Martin Lomas
HM Deputy Chief Inspector of Prisons

June 2015

Section 2. Background and key findings

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

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

2.3 The Metropolitan Police Service (MPS) was in the process of bringing all its custody suites under one single command, called the Met Detention Operational Command Unit (MDOCU). The implementation date was expected to be 26 January 2015. The previous practice of having local borough operational custody suites allowed many differing practices and standards to develop within the same organisation. The MDOCU was to be organised into seven clusters or areas, with the hope that this centralisation would provide consistency and reduce the estate to 30 suites across the MPS area. MPS currently operates with 32 suites and 10 overflow suites.

2.4 This inspection reflected, in part, the make-up of the new arrangements. We inspected the custody suites in the boroughs of Barnet, Brent and Harrow, which formed part of the proposed North-West area, but not Hillingdon and Heathrow, which were also to be included in this area. For ease of reference, we refer to the collection of suites as the 'North-West area', even though we did not inspect Hillingdon and Heathrow.

2.5 This inspection was undertaken to provide one report for the three different boroughs, to reflect the imminent changes.

Custody suite	Number of cells
Barnet (Colindale)	25
Brent (Wembley)	25
Harrow	13

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

Strategy

2.6 There was a clear strategy for bringing together all borough custody suites under a single command for future custody provision. However, the structures for delivery were not all in place yet and were in transition.

2.7 There were significant gaps in management information across many of the custody performance areas. Current performance management arrangements did not provide sufficient assurance to chief officers and managers that custody was being used proportionately and appropriately. There was no monitoring of detainees, for example, by age, ethnicity or gender, and there was no information about the use of voluntary attendance, or how often local authority accommodation was requested and provided for children.

2.8 Day-to-day management of the custody suites differed between boroughs, but overall responsibility was devolved to the borough operational command unit (BOCU). Under the new arrangements, a chief inspector was to become responsible for the entire cluster, ensuring consistent practices.

2.9 There were arrangements for statutory organisations, such as the local criminal justice board, to work together across the borough. However, it was not always clear that custody was included in discussions at this level.

2.10 While some local arrangements worked adequately, there was insufficient knowledge of, and links with, existing Pan-London organisations, especially those that might have been able to support and complement custody and post-custody services and promote the welfare of detainees across the whole London area.

2.11 Independent custody visitor (ICV) panels met quarterly and received briefings on the new custody plans with the chief inspector or inspector.

2.12 Training was generally good. All custody staff received induction and mandatory refresher training. Custody managers and custody support inspectors were held accountable for quality assurance, although this was not always fully achieved.

Treatment and conditions

2.13 Staff were courteous, approachable and friendly to detainees. There were sometimes long delays in the booking-in of detainees, and, with the exception of Colindale, privacy in custody suites for booking-in was very poor and potentially inhibited full disclosure of personal information that was relevant to a full risk assessment.

2.14 There were some issues about the general provisions for, and understanding of, the needs of women. Not all suites were able to provide a gender balance within teams; one in particular was an all-male team, making it difficult for women in custody to speak to a female member of custody staff. We also saw a heavily pregnant woman left on a vehicle in the docking area while people in front of her were being booked in; the arresting officers ensured that she did not wait in the queue but failed to ask the custody sergeant to prioritise her.

2.15 There was inconsistent and often poor attention to, and focus on, the needs of children in custody. We saw two girls under 16 detained for most of the day and, other than performing basic 30-minute checks, staff made little attempt to interact with them. One had been denied a drink of water because of her 'bad' behaviour. However, we also saw some good

interactions, such as in Harrow, where the custody sergeants allowed children to remain in the booking-in area with their appropriate adult (AA) pending interview.

2.16 The provision for older detainees and those with disabilities was limited. Religious diversity was understood by custody staff, and a good stock of holy books and materials was available.

2.17 On most occasions we saw prompt booking-in. However, at Harrow, we saw detainees being held in a corridor, waiting outside the custody suite or remaining in vehicles for excessively long periods of time because there was no holding room. Some were held between one and two hours, still in handcuffs.

2.18 The quality of risk assessments was highly variable. Custody sergeants conducted some thorough risk assessments and asked supplementary questions when assessing risk, although some did not explain to detainees the meaning of phrases such as 'mental health'.

2.19 Custody staff were clear in their understanding of observation levels and we mostly saw dynamic risk assessments, with care plans reviewed appropriately in light of interactions between detainees and custody staff. We also saw some very poor risk management, with leg restraints being applied to a vulnerable person, without logic or rationale.

2.20 The quality of staff shift handovers was variable. The information handed over about the care of the detainees was mostly good but handovers were rarely conducted as a full custody team. There was a lack of focus on case progression in the handover process.

2.21 We saw some good pre-release risk assessments but in several instances risks arising during custody were disregarded at the point of release; for example, a man who had tied his shoelaces around his neck in the cell was released with 'no issues' recorded. Detainees were usually given a useful support agency information leaflet, and help with travel home was provided where necessary. However, we found recorded instances when potentially vulnerable people appeared to have been released without it being clear how they were getting home. Whether this was a practice issue or a recoding issue could not be determined.

2.22 Many detainees arrived in custody handcuffed; in most cases these were removed promptly, except in Harrow where we saw compliant detainees handcuffed for more than two hours. Use of force in custody was not recorded or analysed.

2.23 The custody suites were mostly clean and in a fair condition. A request culture prevailed, whereby detainees were expected to ask for services, such as blankets, showers, to wash their hands and to take exercise, and it was not clear if they knew that these could be provided. Meals were not always provided at recognised mealtimes and we saw detainees being taken to court after an overnight stay in custody without having had anything to eat.

Individual rights

2.24 Staff said that voluntary attendance had increased considerably over the previous 12 months; however, record keeping was poor and no details could be found to corroborate this.

2.25 Staff told us that they believed they were criminalising some people unnecessarily under the MPS's domestic violence and abuse policy. They believed the current policy did not allow for police officers to use their discretion and that sometimes they had to arrest vulnerable people and children; this made them feel 'uncomfortable', especially when other actions might have been more appropriate.

2.26 There was poor availability of secure local authority accommodation for children. Staff could recall some occasions when foster care had been available but none when secure accommodation had been found for children who were charged and refused bail. This meant that they had been detained in custody overnight.

2.27 Too many detainees remained in custody for long periods. Contributing factors included delays in the attendance of AAs and poor case progression. Between midnight and 8am, there was a limited (or no) AA service available. In many cases, this compounded the vulnerability and distress of the detainee.

2.28 Rights and entitlements were given to all detainees during booking-in. Legal advisers we spoke to reported good relationships with custody staff and an adherence to the rights and entitlements of detainees. The Police and Criminal Evidence (PACE) codes of practice were available but not readily offered; legal advisers were given copies of the custody record summary, and the full record on request.

2.29 Hendon Magistrates Court closed to detainees unreasonably early (2pm on weekdays and 10 am on Saturdays) and staff told us that this often resulted in detainees being held in police custody overnight or over the weekend.

2.30 Custody staff told us that detainees wishing to make a complaint might have it taken if the inspector was available; alternatively, and more commonly, they had to submit their complaint once they left police custody.

Health care

2.31 Overall, governance arrangements were reasonable. There was opportunity for nurses and forensic medical examiners (FMEs) to undergo professional development beyond the minimum requirements. Staff assured us nurses were appropriately trained.

2.32 Confidentiality and privacy for detainees were compromised by health professionals leaving the treatment room doors open. We were told that this was because of risks; however, this appeared to be routine practice and not subject to any risk assessment. In Barnet, we saw nurses' notebooks containing patient-sensitive data in an unlocked cupboard.

2.33 There were insufficient nurses to provide 24/7 cover, although FMEs provided 24-hour cover. We saw some long delays in response times, and in some cases detainees who asked to be seen by a health care practitioner were not seen.

2.34 There was no monitoring or oversight of FME services. Custody records showed occasions when calls for an FME had had to be repeated several times; this was worse when the FME was covering more than one area. In some cases, the delays had led to an ambulance having to be called or detainees being taken to the local accident and emergency department.

2.35 Access to drug intervention services was good. Initial follow-up appointments were well managed, there were appropriate links with out-of-area substance use services, and children and young people were referred to local specialist services. Detainees with active withdrawal symptoms were provided with symptom relief but access to opiate substitution was limited to situations where a detainee's existing prescription could be collected from their usual pharmacy.

2.36 Custody suites were rarely used to detain detainees under section 136 (s136) of the Mental Health Act 1983 (MHA). Health care professionals (HCPs) and custody staff could refer to the mental health service; the provision was appropriate and response times in normal

working hours were usually prompt, including mental health assessments. However, there were regular delays in getting bed spaces for mental health patients.

2.37 Adult detainees with mental health needs were usually referred to a new combined criminal justice court liaison and diversion service. It was too early in its implementation to make any reasonable judgements as to outcomes for detainees.

Main recommendations

2.38 As part of the change programme for the implementation of the MDOCU, the MPS should provide management information to assess the delivery of custody services.

2.39 The MPS and chief officer group should engage with their counterparts in the local authority and instigate an immediate review for the provision of local authority accommodation under section 38(6) PACE 1984 for young people. Performance data should be monitored to ensure that young people are not unnecessarily detained in police cells.

2.40 The MDOCU should collate use of force data from custody and examine it for trends in accordance with the Association of Chief Police Officers' policy and College of Policing guidance.

Section 3. Strategy

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

Strategic management

3.1 In April 2014, the Met Detention Operational Command Unit (MDOCU) was established from the previous Metropolitan Police Service (MPS) territorial policing criminal justice directorate. The purpose of this change was to set up a specific command structure to oversee and deliver custody services for the MPS force area. The implementation date for this new body to take full control of custodial services was set for 26 January 2015. The present inspection report recognised that the inspection took place during a period of transition. The MDOCU was led by a commander in territorial policing headquarters, supported by a chief superintendent and two superintendents with geographical and functional responsibility.

3.2 The 32 London boroughs and Heathrow Airport were organised into seven geographical clusters. Seven chief inspectors had been appointed to manage the transition to the new arrangements under the MDOCU. It was planned that the boroughs of Barnet, Brent and Harrow would form part of the North-West custody cluster command.

3.3 At the time of the inspection, the boroughs of Barnet, Brent and Harrow each had responsibility for the day-to-day management of their custody suites via the Borough Operational Command Unit (BOCU). The BOCU commander, a chief superintendent, was responsible for this.

3.4 MDOCU had responsibility for audit and compliance for health and safety, and the implementation of the Authorised Professional Practice – Detention and Custody, which is the College of Policing and Association of Chief Police Officers' approved operating manual for custody.

3.5 Policies were signed off at a strategic command level in the MPS, and the MDOCU provided standard operating procedures (SOPs) in each Metropolitan Police custody suite. The SOPs covered a broad spectrum of areas, including use of police custody, use of closed-circuit television (CCTV) and guidance to custody staff on the supervision of detainees. They were designed to assist BOCUs to deliver a consistent service across all of the MPS area.

3.6 The MDOCU maintained an organisational risk register for all MPS custody suites. The BOCU commander had responsibility for addressing and managing risks, including identifying actions to mitigate them.

3.7 There was one designated full-time custody suite for the borough of Barnet, located in Colindale, and one for the borough of Brent, located in Wembley. Brent also had on overflow suite at Kilburn, with 17 cells. At the time of the inspection, this suite was not in use and therefore not inspected. The borough of Harrow had one designated full-time custody suite, located at Harrow police station.

3.8 A chief inspector led the custody function, but beyond that arrangements differed slightly at borough level. Each borough had an inspector designated as a custody manager who had overall responsibility for the suite, but when the custody managers were not available these roles were performed by custody support managers, except in Harrow, where this role was undertaken by the on-call duty operational inspector.

3.9 Staffing in the custody suites was generally adequate and included permanent custody sergeants who were managed by custody managers and custody support inspectors. We were told that backfill sergeants were used infrequently to cover for absences; this ensured that experienced staff were generally responsible for the welfare of detainees.

3.10 Permanent designated detention officers (DDOs) were responsible for the care and welfare of detainees and were line-managed by the custody sergeants. DDOs had received training to book in detainees under the supervision of custody sergeants.

3.11 Risks in custody were discussed at a senior level, and a MDOCU project board managed the change programme for the centralisation of custody suites. A member of the senior leadership team (SLT) in each borough chaired three daily 'pace-setter' meetings. These established the daily priorities for the borough and provided a forum for raising custody issues; however, there was inconsistent and irregular attendance by custody representatives. Custody could also be discussed by exception at the daily borough SLT meetings. There were no other formal meetings at borough management level at which custody performance and delivery were discussed and no custody user group meetings at which practitioners could discuss custody issues

3.12 There was no quality assurance process to monitor the basic aspects of custody delivery. Chief officers and senior managers were unsighted on the basic elements of performance owing to the general lack of monitoring of issues such as booking-in times, the age, gender, and ethnicity of detainees, and voluntary attendance (see main recommendation 2.38). Many staff spoke of a propensity to arrest, even though they were aware of alternative approaches such as voluntary attendance (see section on individual rights). The current arrangements did not provide sufficient assurance to chief officers and managers that custody was being used proportionately and appropriately, and it had resulted in extended stays in custody (see section on individual rights).

Housekeeping point

3.13 Custody managers and custody support inspectors should be more involved in 'pace-setter' meetings.

Partnerships

3.14 The new centralised command structure was in transition and therefore too early to determine how it will complement existing arrangements. This will be an area for some development and strategic planning to ensure outcomes for detainees are maintained and accessible in their local communities. Currently there are working protocols with local criminal justice boards, courts, NHS trusts and local authorities. There are good outcomes in relation to section 136 MHA and police cells are rarely used as a place of safety, but more can be done with local authorities to improve outcomes for children in custody.

3.15 Arrangements for health-based places of safety for people detained for reasons of mental ill health were effective (see section on mental health) but the provision of local authority accommodation for young people who had been refused bail by the police was inadequate (see section on rights relating to detention).

3.16 There was an established Independent Custody Visitor (ICV) scheme covering all three boroughs, with regular visits to the suites. ICVs said that immediate concerns were dealt with effectively and that they received feedback on outstanding issues and concerns received. ICV panels met quarterly, regularly attended by police staff, and they received briefings on the new custody plans by the chief inspector or inspector.

Recommendation

3.17 As part of the change programme for the implementation of the MDOCU, the MPS should review engagement with key partners, both across London and at local borough level, to improve partnership working directly linked to custody provision.

Learning and development

3.18 All custody sergeants and DDOs had received initial custody training before working in custody. Custody-specific refresher training had been provided, although some staff said that they had not received this. Annual mandatory refresher training, such as in personal protection and first aid, was provided for custody sergeants, and staff we spoke to had either received this training or were scheduled to attend. The proposed shift pattern for the new command would include two days for mandatory refresher training and four days for custody-specific refresher training annually.

3.19 Custody managers and custody support inspectors were expected to dip-sample 10% of custody records; however, this was not being achieved. For example, in October 2014, some inspectors had not carried out any dip-sampling. When this had been carried the process used was comprehensive and included the checking of prisoner escort record (PER) forms and CCTV recordings, and included a focus on staff handovers, although the quality of the handovers we observed was variable (see section on safety).

3.20 There were processes for dealing with adverse incidents, referred to as 'successful interventions' by the MPS. The process was based on a computer-based form, which was passed on to the custody manager and the MDOCU. The process was captured on a force-wide database, with an audit trail of actions taken and communication of lessons learned. Successful interventions analysis was presented quarterly at the MPS health and safety board. Learning from successful interventions was communicated to staff either face-to-face or via email. A weekly newsletter from the MDOCU was also used to communicate learning opportunities from successful interventions, highlight good work and inform staff on the development towards the centralisation of custody services. However, some staff said that they were unaware of the newsletter.

3.21 The Independent Police Complaints Commission (IPCC) 'learning the lessons' bulletin was put on the force intranet, and managers expected staff to visit the site regularly to update themselves. Staff we spoke to were aware of these documents but rarely accessed them.

Recommendations

3.22 As part of the change programme for the implementation of the MDOCU, the MPS should review the current quality assurance processes to make sure that there is robust management and assessment of the standards of custody provision, to ensure positive and consistent outcomes for detainees.

3.23 The custody newsletter and the Independent Police Complaints Commission `learning the lessons` bulletin should be promoted more actively.

Section 4. Treatment and conditions

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

Respect

4.1 Custody staff treated detainees respectfully and were professional, friendly and courteous in undertaking their role. Detainees were asked how they wished to be addressed.

4.2 With the exception of Colindale, where there were dividing screens between the booking-in points, the booking-in areas afforded little privacy and the general area was sometimes congested with non-custody staff. Custody sergeants made little attempt to ensure privacy and we saw some detainees actively listening to what was being disclosed by other detainees being booked in next to them. This could have inhibited full disclosure of personal information that was relevant to a full risk assessment. At Colindale, there was a booking-in desk in a private room which could have been better used for processing vulnerable detainees.

4.3 On most occasions, on arrival at the police station we saw detainees being brought before the custody sergeant within 20 minutes. However, at busy times this took longer, particularly at Harrow, where we saw two detainees waiting two hours and 20 minutes to be booked in, which was too long.

4.4 During the booking-in process, women detainees were asked if they might be pregnant or if they wanted to speak to a female officer. The latter would have been difficult to facilitate at Wembley as there was all-male custody team on duty. During the inspection, over two days at Wembley we saw no female staff member on the dayshift, late shift or night shift. At all suites, detainees being booked in were asked about any welfare or dependency issues.

4.5 At Harrow, we saw a heavily pregnant woman waiting to be booked in. She had to remain in a vehicle while she waited in a queue, for up to an hour, as there were several detainees waiting to be booked in ahead of her (see also section on safety). Although it was understandable that they did not want to make her wait in the queue, it did not occur to them to ask the custody sergeant to prioritise her. The arresting officers did not make the custody sergeants aware of her condition until she entered the suite; she was then asked if she needed to see an health care professional (HCP) which she declined.

4.6 There was a lack of focus on the needs of children in custody. Most of the children we saw in custody received scant attention from staff and were given little with which to occupy their time. MPS data showed that in the 12 months before the inspection, a total of 2,237 children[2] had been detained at the three suites.

4.7 Girls aged 18 and under were not routinely allocated to a named female member of staff. We saw two girls, aged 14 and 15, detained at Wembley overnight and for most of the next day. Other than performing basic checks every 30 minutes, staff made little attempt to

[2] Detainees aged 11–17 years.

interact with them. One had been denied a drink of water during the night, ostensibly on the grounds of her 'bad' behaviour.

4.8 Rooms or cells located close to the custody desk were available at all suites for the detention of children. The standard level of observations for children was every 30 minutes. We saw few children being booked in during the inspection, but at Harrow we saw the custody officer allowing a 13- and a 15-year-old to remain seated on a bench in the booking-in area with their AA rather than placing them in a cell pending interview. Some custody staff told us that if children had to be held in custody overnight, they would be treated no differently to adults (see also section on rights relating to detention).

4.9 The provision for older detainees and those with disabilities was poor overall. There was no specific provision for such detainees at Wembley. At Colindale, one cell was designated 'DDA [Disability Discrimination Act] compliant' but, although it had lowered cell call bells, the bed plinth was low, making it unsuitable for someone with impaired mobility. There were no thick mattresses available. Staff indicated that detainees who found the bed plinths too low owing to age or infirmity would be issued with two mattresses or, if held at Harrow, moved to another section of the custody suite which had higher bed plinths. All suites had hearing loops installed at the booking-in desks.

4.10 Religious diversity was understood by all custody staff but custody sergeants did not routinely ask detainees about any religious observance on booking-in. Suites had good stocks of holy books for the main religions, and prayer mats, although these were not always stored appropriately. At Wembley and Harrow, the direction of Mecca was indicated on cell ceilings but at Colindale staff had to rely on someone having a smartphone compass for determining this. In our custody record analysis (CRA), we found that one detainee had been allowed to wash before prayer, and that another had requested and received a prayer mat.

4.11 Staff had a good awareness of conducting searches which respected a detainee's culture, religion and gender, and how to search transgender detainees appropriately.

Recommendations

4.12 Booking-in areas should allow enough privacy to enable effective communication between staff and detainees.

4.13 There should be clear local policies and procedures to meet the specific needs of female detainees, children and those with disabilities.

4.14 The MDOCU should ensure that all female detainees are made aware that they can speak to a female member of staff, and as far as possible ensure that there is a mixed staffing group to look after the welfare of female detainees, including allocating a named female member of staff to girls under the age of 18.

4.15 Detainees should not be denied basic requirements for punitive reasons.

Housekeeping point

4.16 Staff should ask detainees if they wish to undertake any religious observance, and items for religious observance should be stored appropriately.

Safety

4.17 At Harrow, we saw detainees waiting in a corridor, standing outside the custody suite or remaining in vehicles for excessively long periods waiting to be booked in, partly owing to the custody suite not having a holding room. We saw three detainees arriving together who had to stand outside the custody suite for between just over one hour and two hours and 20 minutes waiting to be booked in. Later that day, at the afternoon staff handover, there were four detainees queuing to be booked in, all of whom remained in handcuffs throughout (see also section on use of force).

4.18 Risk assessments were variable across the custody suites. Some custody sergeants conducted thorough risk assessments, using the questions set out in the National Strategy for Police Information Systems (NSPIS) computerised custody system. Most asked supplementary questions when assessing risk and were friendly and empathetic with detainees. However, a few approached the risk assessment process in a more mechanistic manner and failed to explain to detainees the meaning and significance of phrases such as 'mental health'. We saw the police national computer (PNC) being checked for warning markers before risk assessments were completed but in our CRA there was often no reference to checks being made on the PNC for these.

4.19 Risk management was also highly variable. Some care plans were reviewed appropriately in light of interactions between detainees and custody staff. We saw most intoxicated detainees being subject to rousing checks and appropriately cared for. The 4-Rs mnemonic (an aide memoir for the rousing procedure set out in Annex H to Code C in PACE[3]) was available in the custody suites; custody staff understood the importance of obtaining a response and our CRA found that good detail was given in the custody record about detainees' responses to it.

4.20 However, we also saw some risk management that was unsatisfactory; for example, two highly intoxicated teenage girls at Wembley (see also section on respect) were not made subject to rousing checks overnight and custody staff could offer no rationale for that decision.

4.21 At Colindale, we viewed the CCTV recording of staff's response to a detainee who had tied his shoelaces into a ligature which he had then wrapped around his neck. Staff had attended his cell and tried to reason with him briefly. However, after a short time they had resorted to applying leg restraints, even though he had been compliant by that time. Custody staff claimed that it had been the only way to stop him banging his head, even though the recording had not shown him doing this or suggested that he might subsequently do so. He had then been placed on constant observations. The rationale for the use of leg restraints seemed to lack logic and proportionality (see also section on use of force).

4.22 In our CRA, we found that an intoxicated detainee with a history of self-harm while in custody had initially been placed on 30-minute rousal checks. He had tried to self-harm within a short period by tying his boxer shorts around his neck and, appropriately, had then been placed on close proximity constant observations. However, he had also been kept naked for some time and it was not clear why this had been deemed necessary, especially as he was being watched so closely.

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[3] 4Rs – Rousability, Response to questions, Response to commands, Remember to take into account the possibility of other illnesses/conditions.

4.23 Our CRA revealed that observation levels were mostly met. We observed the constant supervision of a detainee and noted that the police constable gaoler conducting it was fully aware of the detainee's demeanour and history, and had been properly instructed to complete a custody record continuation sheet with details of all interactions with the detainee.

4.24 The booking-in areas and custody corridors were all monitored by CCTV, but not all cells were. Detainees who presented additional risks were, where possible, placed in CCTV-monitored cells. Staff carried anti-ligature knives and additional ones were attached to the cell keys.

4.25 Custody sergeants allowed arresting officers to place detainees in cells, and often to take them to and return them from interview. This was a practice that carried risks as officers were not custody trained, did not always explain to detainees the workings of the cell, such as the use of the call bell, and were less likely to pass on information relevant to the care of the detainee to the custody staff.

4.26 The quality of staff shift handovers was inconsistent, with some being poor. We rarely saw handovers being conducted as a team. In some cases, the DDOs and custody sergeants had separate handovers, grouped around a computer terminal at opposite ends of the booking-in desks. We also occasionally saw handovers being conducted while other colleagues were booking in detainees. The information handed over about the care of the detainees was good but little information was given about the progress of investigations (see section on individual rights). Not all custody sergeants visited detainees in the cells after the handover.

4.27 We saw some good pre-release risk assessments (PRRAs), involving a discussion between the custody sergeant and detainee, and signposting to support agencies. In some instances, risks identified at booking-in were referred to in the PRRA, whereas new risks arising during custody were disregarded at the point of release, which was potentially unsafe. This included the detainee on constant observation at Colindale described above (paragraph 4.21), who had been released with 'no issues' recorded, even though he had tied his shoelaces around his neck. Many detainees were given a useful support agency information leaflet that included helplines for sex offenders and perpetrators of domestic violence and abuse. This was available in the most common 19 foreign languages spoken across London. There were also additional specialist leaflets for ex-forces personnel and those with alcohol dependency.

4.28 Most detainees were asked how they planned to get home and we were told that, if necessary and appropriate, police officers took them. However, in our CRA we found instances when potentially vulnerable detainees had been released without it being clear how they would get home; it was not clear if this had not been asked or not recorded.

Recommendations

4.29 Custody managers should ensure that detainees do not wait outside the custody suites in vans or van dock areas because of long booking-in times.

4.30 All custody staff should be involved in the same shift handover and, wherever possible, this should be away from the booking-in area and recorded; sergeants should inform detainees about the change of shift.

4.31 Risk assessments should respond to the continued welfare of the detainee. Any restraint or seizure of clothing in mitigating risk should be subject to appropriate authorisation and a clear account of the rationale and risk.

4.32 Pre-release risk planning should be meaningful, based on interaction between custody staff and the detainee, and take into account risks arising during custody.

4.33 Custody sergeants should explain to detainees the meaning and significance of terms that are open to interpretation, such as 'mental health'.

Use of force

4.34 All staff had been trained in approved safety techniques and received annual refresher training. We saw some staff using good de-escalation techniques.

4.35 Many detainees arrived in custody handcuffed. These were mostly removed before booking-in started; however, in most cases this was only after the arresting officer had checked with the custody sergeant, and this sometimes took a long time – for example, up to two hours 20 minutes for one compliant detainee at Harrow (see section on safety). It was clear from talking to some arresting officers that they believed they had to obtain the custody sergeant's permission to remove handcuffs, which was not the case. We also saw detainees being booked in and searched while still in handcuffs, which was unreasonable.

4.36 Leg restraints were available and used, but there was no policy or governance process which indicated to staff when and on whom they should be used (see also section on safety and recommendation 4.31).

4.37 Staff told us that detainees who were subject to the use of force or who wanted to see an HCP would see one afterwards. However, a detainee at Colindale who had been placed in leg restraints had asked to see an HCP but no such arrangement had been made.

4.38 Use of force in custody was noted only in the custody record or the officers' notebooks, and there was no monitoring or analysis of data (see main recommendation 2.40).

Recommendation

4.39 Detainees should be handcuffed only if it is necessary, justified and proportionate.

Physical conditions

4.40 The custody suites were clean and in a fair condition, although the interview and consultation rooms at Wembley were dirty and in a poor state of decoration. There was a large amount of graffiti on the wooden benches and door jambs at Harrow but elsewhere there was minimal graffiti. Some cells at Colindale were cold (see also section on detainee care).

4.41 Cells were checked between occupancies and this was recorded formally. Staff and ICV reports indicated that routine maintenance repairs were conducted promptly. All cells had a call bell and we saw DDOs responding promptly to them. Most detainees we spoke to said that the use of the call bell had been explained to them.

4.42 Staff were knowledgeable about fire evacuation procedures and told us that there had been fire drills in the recent past, although there were no records to corroborate this. All suites had a fire evacuation box containing sufficient handcuffs for each cell and other items that would be useful in an emergency evacuation.

Recommendations

4.43 Interview and consultation rooms should be clean and fit for purpose.

4.44 Cells should be adequately heated and ventilated.

4.45 The use of the call bell should be explained to all detainees.

Housekeeping point

4.46 Emergency practice evacuations should take place regularly and be recorded.

Detainee care

4.47 At the time of the inspection, there were good stocks of clean blankets available but staff told us that they sometimes ran out of them. It was clear that blankets were not routinely offered to detainees who were held overnight; for example, at Wembley, we spoke to four detainees at 7am and none of them had a blanket, and only one of them said that they had been offered one. At Colindale, some cells were far too cold (see recommendation 4.44). DDOs generally gave blankets only on request, and one detainee told us that he had not known that he could ask for one.

4.48 All cells contained a mattress and a pillow but staff did not routinely wipe them down between uses. All cells had toilets but in many cases detainees had to ask for toilet paper as it was not routinely available in the cells. The view of the toilet area was obscured on CCTV images of the cells but detainees were not told about this.

4.49 Hand-washing facilities were not available in cells, but were located in the cell corridors. All suites had clean showers, providing a good level of privacy. These were offered only if a detainee requested it and there were enough staff on duty to facilitate it.

4.50 We spoke to a detainee who had been detained overnight who claimed that he had asked several times to be able to wash his hands or take a shower but, despite assurances that his request would be met, it had not been. Cotton towels were available at all suites and good stocks of toothbrushes, toothpaste, shampoo, soap and combs were also available.

4.51 Feminine hygiene packs were available but not proactively offered. Our CRA revealed that only three out of the seven detainees in our sample who had been transferred to court had been given access to washing facilities. The remaining four had been held for between 17 and just over 38 hours.

4.52 Detainees whose clothes were removed for evidential or safety reasons were offered paper overalls and plimsolls. Replacement underwear was also available. Detainees were offered jogging trousers, T-shirts or sweatshirts, available in a variety of sizes, for court appearances.

4.53 The food provided consisted of microwave meals and all suites were stocked for a range of dietary needs. At Colindale, some were out of date, and both there and at Wembley the microwave ovens were dirty. The meals were of a low calorific value but staff provided more than one if necessary. Meals were not always provided at recognised mealtimes, and we saw detainees being taken to court after an overnight stay in custody without having had anything to eat. Staff told us that in exceptional circumstances they would accept food for detainees from family or friends, and this was confirmed in one record in the CRA.

4.54 At Colindale, ICV records noted concerns that staff had sometimes been too busy to offer showers and provide meals at reasonable intervals. At Wembley, there were no drinking cups available.

4.55 All suites had reading materials, including some in languages other than English. However, we rarely saw books and magazines given out and, with the exception of Harrow, there was little that was suitable for young people. In our CRA, we came across an occasion when a detainee had requested reading materials but had been refused them, with no reason specified.

4.56 We were told that social visits could be facilitated for detainees who were held for longer periods, but rarely were. The exercise yards at Colindale and Wembley had multiple ligature points and detainees were not allowed in them unsupervised, making it less likely for them to be used. Harrow did not have an exercise yard at all. Only three detainees in our CRA sample had received outside exercise during their detention, and we did not see anyone using the exercise yards throughout the inspection.

Recommendations

4.57 Adequate supplies of essential items such as blankets and drinking cups should be maintained at all times and should always be offered to detainees.

4.58 Detainees held overnight and those who require it should be offered a shower.

4.59 Whenever possible, detainees held for longer periods should be offered outside exercise and visits.

Housekeeping points

4.60 Mattresses and pillows should be routinely wiped down between uses.

4.61 A small supply of toilet paper should be available in every cell, subject to a risk assessment.

4.62 Detainees should be informed that they are not under observation on closed-circuit television while using the toilet.

4.63 Female detainees should be routinely offered hygiene packs.

4.64 Wherever possible, meals should be provided at recognised mealtimes, or at other times if needed.

4.65 A range of reading materials should be available and routinely offered, including books and magazines suitable for children and for detainees whose first language is not English.

Section 5. Individual rights

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

Rights relating to detention

5.1 Custody officers said that it was rare that they would refuse detention once an officer had explained the reasons for arrest to them, but we saw this occur. We also saw police officers seeking advice from custody officers before undertaking planned arrests. Staff told us that they had been made aware of code G of PACE, which emphasises the importance of ensuring that an arrest is necessary. They also told us that voluntary attendance of suspects at police stations (known as Caution +3), as opposed to be being arrested, had increased considerably over the previous 12 months; however, record keeping was poor and it was difficult to corroborate that this was the case (see also paragraph 3.12).

5.2 Custody and operational staff consistently told us that they could not use discretion in dealing with domestic violence and abuse incidents. They said that they were directed to take 'positive action', which they believed meant arrest, in all domestic violence and abuse cases. They told us that they felt 'uncomfortable' when this resulted in the arrest of children and vulnerable adults, when other actions may have been more appropriate.

5.3 Too many detainees remained in custody for long periods owing to delays in health care practitioner (HCP) and Appropriate Adult (AA) attendance, and custody sergeants not ensuring that investigations were progressed promptly. A detainee was kept in custody for 12 hours overnight, having been arrested for possession of a small amount of a Class B drug. Staff told us that this was because there was no one working on the case progression unit that night. The detainee was released with a caution once the morning shift picked up the case. In another case, a 17-year-old arrested and detained at 4.40pm for being in possession of cannabis was not dealt with until the arrival of a night shift case progression officer at 10pm, even though an AA had been available soon after the time of arrest. The detainee was released at 11.55pm. Case progression was not shared with custody staff, which meant that staff were not always able to inform detainees about their case when they asked them about this.

5.4 The average time of detention within the three boroughs in the previous 12 months ranged from 12 hours 15 minutes at Harrow, to 13 hours 33 minutes at Wembley. In our CRA, 77% of detainees in the sample had been detained for more than six hours.

5.5 At Colindale, we saw a written direction from BOCU managers to officers that the use of police bail in investigations should be a last resort, that they should aim to secure evidence while the detainee is in custody, and encouraging officers to use the full 24 hours allowed under PACE to investigate an offence and to seek a further extension where appropriate. We were told that this was an attempt to reduce the number of people answering police bail. While this was positive, we were concerned that this approach might have resulted in people being kept in custody for longer than necessary (albeit for no longer than 24 hours) and cases not being progressed as quickly as possible within this timeframe.

5.6 Arrangements for the provision of local authority accommodation for children who had been refused bail by the police were poor. Data provided by the force stated that, in the previous 12 months, there had been 130 occasions where local authority accommodation for children

had been required. However, there was no record of whether it had been provided or of how many children had been detained overnight.

5.7 Staff told us that non-secure accommodation with foster carers had been made available on a few occasions but could not recall any instance where secure local authority accommodation had been provided. In our CRA, we found a case of a 16-year-old boy who had been held in custody overnight at Wembley pending appearance at court the following day. There was nothing recorded in the custody log to suggest that the local authority had been contacted to provide alternative accommodation for him (see also section on strategy and main recommendation 2.39).

5.8 In the previous 12 months, 364 people had been detained in the suites for immigration purposes. Staff told us that these detainees sometimes spent long periods, of between 24 hours and two to three days, waiting for transfer to an immigration removal centre. However, records showed that the average detention time for these detainees was between 16 and 21 hours, which was better than we have seen elsewhere.

5.9 All detainees under the age of 18 and vulnerable adults were interviewed in the presence of an AA. Staff told us that they tried to find relatives to act as AAs in the first instance. Local authority schemes were available between 8am and midnight, both for children and vulnerable adults. Outside these times, there was no or limited availability of AAs. This meant that vulnerable adults and children could spend longer in custody, thereby compounding both their vulnerability and distress. There was no information about the timeliness of AAs or whether this impacted on prolonged detention for vulnerable people.

5.10 According to our CRA, information about the AA was rarely recorded. This meant that there was no record of how many people had their detention unnecessarily extended when the AA failed to attend. The average time elapsed between a child entering the suite and the arrival of an AA was four hours 34 minutes, but in two cases this had been more than 10 hours. For example, a 16-year-old boy in Wembley had been admitted to custody at 5.15pm. The custody log entry an hour later showed that there would be no further action until his rights had been explained in the presence of an AA. The boy's mother did not live close by and his father was not at home. The rights had been read in the AA's presence at noon the following day.

5.11 Custody staff assured us that, to their knowledge, the custody suite had not been used as a place of safety for children under section 46 of the Children Act 1989.[4]

5.12 Professional telephone interpreting facilities were mainly good, as was the video-link to enable interpreters to participate in interviews more efficiently.

Recommendations

5.13 Met Detention should ensure that staff are proactive in progressing investigations so that the total time spent by detainees in police detention is appropriate and no longer than necessary.

5.14 Appropriate adults (AAs) should be available 24 hours a day to support children and vulnerable adults in custody, and the response times and details of AAs

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

should clearly be recorded on custody records, for monitoring purposes and to maintain or improve performance outcomes.

Rights relating to PACE

5.15 All suites displayed posters reminding detainees of their rights to legal representation, and this was reinforced by all custody officers. Those who refused this offer were asked their reasons and reminded that they could change their mind at any time. In our CRA, all detainees had been offered legal advice and 60% had accepted it; those who had not been able to understand their rights had been told them again when sober or in the presence of an AA.

5.16 Legal advisers were given copies of the custody record summary, and the full record on request. Those we spoke to reported good relationships with custody staff and an adherence to the rights and entitlements of detainees. However, at Harrow and Wembley it was not possible for a detainee to speak to a solicitor on the telephone in private.

5.17 During the booking-in process, all detainees were told that someone could be informed of their whereabouts. In our CRA, 13 (22%) detainees had wanted someone to be told of their arrest but in only five cases did the record clearly demonstrate that the nominated people had been contacted.

5.18 Detainees were given a notice of their rights and entitlements, which was available in many different languages and in an easy-read format, although not all custody staff knew of the latter format. The rights and entitlements leaflet was written in a very small font that was virtually unreadable. The PACE codes of practice were readily available but custody staff were not proactive in offering detainees an opportunity to read them.

5.19 There were sufficient interview and consultation rooms at Colindale and Wembley but at Wembley they were in a poor state (see section on physical conditions). At Harrow, there was just one room, and at busy times we saw queues to use it, potentially increasing the time in detention for detainees.

5.20 The PACE reviews we observed were thorough and timely. In our CRA, 44 detainees had required a PACE review, all of which had been conducted on time. However, only a third of reviews had been conducted face to face with the detainee. The rest had been conducted on the telephone or while the detainee was in interview or asleep, and we found no evidence that these detainees had been informed that the review had taken place or reminded of their rights and entitlements after they woke up.

5.21 Hendon Magistrates Court closed to new detainees unreasonably early, at 2pm on weekdays and 10am on Saturdays. During the inspection, we did not see people kept in police detention for this reason. However, staff told us that early court cut-off times sometimes resulted in detainees being held in police custody overnight or over the weekend, which was unacceptable.

5.22 The management of DNA was good, and samples were collected frequently from the suite.

Recommendations

5.23 **Detainees should always be able to speak to their legal representative privately on the telephone.**

5.24 At Harrow, there should be enough suitable accommodation for solicitors to confer with their clients promptly and privately.

5.25 Senior police managers should engage with HM Courts and Tribunal Service to ensure that early court cut-off times do not result in unnecessarily long stays in custody.

Housekeeping points

5.26 All the information in the rights and entitlements leaflet should be written in a font size that is easily readable.

5.27 Staff should ensure that detainees are always informed, on waking, if a review of their detention has taken place while they were asleep.

Rights relating to treatment

5.28 Information on how to make a complaint was included in the rights and entitlements leaflet but this was in extremely small print and could easily have been missed. There was no other visible information about the complaints process. Custody staff told us that detainees' complaints would be taken if an inspector was available, especially if it was of a serious nature; alternatively, and more commonly, they had to submit their complaint once they left police custody.

Recommendation

5.29 Complaints should be taken while detainees are still in custody.

Section 6. Health care

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

Governance

6.1 Overall governance arrangements were reasonable. Health services were provided by the MPS. NHS England had recently commissioned a health needs assessment in preparation for the inception of NHS commissioning of health services, scheduled for 2015/16.

6.2 A chief inspector had overall responsibility for MPS forensic health services, and borough custody managers were responsible for operational delivery. Professional leadership was shared between a medical director and the director of nursing.

6.3 There was regular oversight of current professional registration and basic training requirements, but appraisal and revalidation were the responsibility of individuals, with MPS requiring documentary evidence. One forensic medical examiner (FME) told us that he linked with his local clinical commissioning group for appraisal and revalidation, and another said that she sought informal supervision from a professional colleague, which was good professional practice.

6.4 Custody nurse practitioners (CNPs) received a three-week induction and two update days per year, which included intermediate life support training (ILS); FMEs said that they sourced their own training, including ILS training. There was limited scope for individual continuing professional development.

6.5 CNPs were embedded within the suites at Barnet and Brent, supported by on-call FMEs. There were insufficient nurses to provide 24/7 cover, and during the inspection there was no nurse in either suite. Harrow was supported by FMEs only. Recruitment and retention of nursing staff remained a challenge. Two nurse managers provided day-to-day management and senior clinical support to all CNPs, at all suites, mainly by telephone.

6.6 Custody staff and FMEs described good working relationships between police staff and clinical staff. There were dual handsets for professional telephone interpreting in all the suite treatment rooms.

6.7 The overall environment in the suite treatment rooms was clean, although the floor at the Wembley suite was grubby. Cleaning arrangements were variable. Storage cupboards were clean and tidy, and work surfaces clean. Forensic sampling kits were all in date.

6.8 In the consultation rooms paper towels were not routinely used to cover examination couches after visits, and there were no mobile screens to ensure the dignity of patients. Hand washing arrangements were compromised at Barnet by short arm taps - longer arm taps should be used to avoid the potential for contamination. Regular checklists were not evident and there was no evidence that infection control audits were completed.

6.9 There were suitable, in-date sharps containers and clinical waste bins. Designated solid clinical waste disposal containers were present in all suites and custody staff told us that they used these to dispose of unused and unwanted detainee medications (except controlled drugs).

6.10 FMEs prescribed appropriately, including symptomatic relief, and nurses provided a range of medicines using patient group directions (PGDs; these enable nurses to supply and administer prescription-only medicine). CNPs received initial training during their induction and signed authorities were retained centrally and by the individual nurses. Detainees with active withdrawal symptoms were provided with symptom relief but there was no access to opiate substitution, except when custody staff could collect existing opiate substitution prescriptions for detainees. Detainees were not given nicotine replacement therapy. A quarterly medicines management committee reviewed and updated PGDs.

6.11 Storage of medicines at Brent and Harrow was in locked cupboards in the treatment room; at Barnet, the medicines cupboard was sited behind the custody desk, with monitoring by CCTV. The arrangements and audit trail for accessing the cupboard keys were not sufficiently robust at Barnet and Brent. Records of administration of scheduled controlled drugs were reasonable at all suites but a running balance was not always recorded, which meant that it was impossible to know the correct stock balance at any time. There were medicine refrigerators in all suites. At Barnet, some of the drugs were out of date. There was no evidence of refrigerator temperature checks.

6.12 Paper body maps and forensic sampling forms were stored in filing cabinets in the treatment rooms; however, the cabinet at the Brent suite was not locked and at Barnet we saw nurses' notebooks containing patient-sensitive data in an unlocked cupboard. There was a senior member of MPS staff with Caldicott Guardian responsibility (responsibility for ensuring the safeguarding of confidential patient data).

6.13 Key policies and guidance documents were held on the forensic health services intranet on National Strategy for Police Information Systems (NSPIS), and all clinical professionals had access to them. The policy for safeguarding adults and children was up to date, with an expectation that clinical staff would escalate any concern within the MPS but also report to the local safeguarding board.

6.14 The system for reporting clinical incidents had a positive emphasis on learning but there was little information recorded on any resolution or action in respect of the error or near miss.

6.15 Recently issued resuscitation kits were in all suites and were suitable, except for a lack of some child-appropriate items (for example, Guedel airways and defibrillator pads). There was no oxygen present, other than a cylinder stored in a cupboard at Barnet, although there was a PGD for this. The kits were sealed and dated, and sent for replacement after use.

Recommendations

6.16 There should be compliance with NHS-equivalent cleaning standards and infection control arrangements.

6.17 For detainees with a confirmed opiate substitution prescription, there should be access to appropriate opiate substitution therapy.

6.18 Patient confidentiality should be preserved at all times, including consultations and records, except when the requirements of the criminal justice system preclude this and it is clearly explained to detainees and/or there is a quantified, assessed risk.

6.19 Resuscitation kits should contain Guedal airways and defibrillator pads of the appropriate size for use in children.

Housekeeping points

6.20 Training opportunities for health care professionals (HCPs) should be expanded to ensure that they are able to meet service needs and continuing professional development requirements.

6.21 Medicines storage and recording should comply with national guidance and include running stock balances, refrigerator temperature checks and a suitable audit trail for the controlled drug medication cupboard keys.

6.22 Policies should mirror NHS standards and professional requirements.

Patient care

6.23 Detainees were routinely asked whether they wanted to see an HCP but some detainees who requested this were not seen before release. When custody staff identified a need to see an HCP, this always took place.

6.24 There was no local oversight of FME response times or of delays in response to calls. Custody records showed occasions when a call for an FME had to be repeated several times, with some long delays overnight, and custody staff told us that delays could be especially long when FMEs were covering more than one area. Staff told us that delays often resulted in the use of the ambulance service and local accident and emergency departments.

6.25 We saw a detainee waiting approximately six and a half hours before being seen, even though the FME on the earlier shift had been made aware of the need. There was no handover between FMEs and some of the delays related to the shift changeover period. There were no nurses on duty in any of the suites during the inspection.

6.26 Care by FMEs was clinically appropriate and respectful but we noted one detainee with limited English for whom professional interpreting services were not used. We saw sensitive and proactive care given in a case of domestic violence, which resulted in disclosure and signposting to relevant services. Consultations were conducted with the treatment door open. We were told that this was because of risks; however, it appeared to be routine practice and not subject to any risk assessment. Consent to information sharing was not sought from detainees but one FME routinely informed detainees that records were not confidential.

6.27 We saw a good handover between FMEs and custody staff, but custody staff told us that FMEs sometimes left without providing a verbal handover, which meant that custody sergeants then had to telephone for further information.

6.28 Nurses and doctors were able to access NSPIS in the treatment rooms. Clinical recording on this system was generally relevant and provided custody staff with 'need-to-know' information, although this sometimes lacked sufficient explanation of the implications of clinical indicators; for example, a detainee's very low blood pressure measurement was recorded, without explaining its relevance to custody staff. FMEs also recorded in their personal notebooks, which they retained, and nurses used the Comprehensive Health Assessment Program (CHAP; the confidential clinical template on NSPIS), although we were not able to see this in use.

6.29 Custody staff made reasonable efforts to obtain prescribed medication from detainees' homes and, subject to the FME's approval, would collect prescribed opiate substitutes from local pharmacies. Detainees' medicines were attached to the custody clipboard and kept

behind the custody desk. DDOs then provided detainees with the first dose of medicines, with FMEs seeing detainees again if a further dose was required.

6.30 There was little evidence of health promotion literature in the suites.

Recommendations

6.31 HCP response times should be improved by increasing nurse capacity and limiting the areas that the FME has to cover; there should be routine monitoring of response times, including oversight of repeated calls and any non-responses. The use of ambulance services and attendance at accident and emergency departments should be appropriate.

6.32 Professional interpreting services should be used when a detainee has limited command of English.

6.33 Clear verbal and written information pertaining to detainees' care and well-being should be properly shared between HCPs and custody staff.

6.34 There should be a single health record that is accessible to all health care and related professionals, including drug intervention programme (DIP) workers, to ensure that there is one unified view of the detainee's wider health needs.

Housekeeping point

6.35 Health promotion literature should be available.

Substance misuse

6.36 Westminster Drug Project provided 14-hour cover (7am to 9pm) from Monday to Friday across the three suites and was part of a criminal justice pathway which included the local courts. At Barnet and Harrow suites, DIP workers were not located on site but made at least two visits to them, first thing in the morning and again in the late afternoon. At the Brent suite, the DIP worker was based at the custody suite. There was good joint working with custody and health care staff, which resulted in early responses to detainees' substance use needs, although they had little contact with the FME. DIP workers told us that custody staff usually alerted them to detainees with specific substance use needs.

6.37 Detainees arrested for 'trigger' offences were tested and seen by a substance use worker before going to court. They were seen promptly and were often able to have their first mandatory appointment before release. For those being released during the night and at weekends, custody staff made appointments with local services, using a single point of contact directory.

6.38 DIP workers could provide signposting information to children and young people, and advised custody staff and AAs on referrals to local specialist services.

6.39 DIP workers recorded on their own paper records and made verbal handovers to custody staff which were then transcribed onto NSPIS. A mental health screening tool was part of the assessment and there was access to a dual diagnosis (the co-existence of mental health and substance misuse problems) service in the community. DIP workers could refer directly to mental health services.

6.40 DIP workers had trained DDOs in substance misuse issues.

6.41 There were effective post-release links with community substance misuse services, prescribers and local needle exchange services.

Recommendation

6.42 All workers should be able to record directly onto the National Strategy for Police Information Systems (NSPIS) to ensure the integrity and accuracy of shared information.

Good practice

6.43 *The presence of a DIP worker at the Brent custody suite enabled good joint working with custody and health care staff, and resulted in early responses to detainees' substance use needs.*

Mental health

6.44 Custody suites were rarely used to detain detainees under s136 of the MHA.[5] HCPs and custody staff could refer to the mental health service. The provision was appropriate and response times during normal working hours were usually prompt, including mental health assessments. However, there had been notable delays in getting mental health assessments out of hours, and the responsible mental health services considered the custody suite as a 'place of safety'. Out-of-area detainees requiring MHA assessments were assessed and a bed sought in their area of residence. There were regular delays in getting bed spaces for mental health patients.

6.45 Adult detainees with mental health needs were usually referred to a newly developed local criminal justice court liaison and diversion service, provided by Central and North West London NHS Foundation Trust, Barnet, Enfield and Haringey Mental Health NHS Trust and a community third-sector partner, 'Together' (for people with mental health issues). The service operated from Monday to Friday during normal working hours. It had started a month before the inspection and there were early indications that it was providing an early and supportive response to detainees with mental health problems. Out of hours, staff contacted the local emergency duty team in the respective boroughs.

6.46 Community psychiatric nurses (CPNs) were employed by two different health trusts and recorded on their own separate clinical systems; the CPNs would then provide relevant information to custody staff for them to transcribe onto NSPIS as this was the only way to ensure information was recorded on to the custody record (see recommendation 6.42).

6.47 Arrangements for the provision of health-based places of safety for persons detained under s136 were effective, and only two people had been detained in the previous year. However, there were no data available on the extent of the use of this legislation by police officers in the MPS.

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[5] Section 136 of the Mental Health Act 1983 enables a police officer to remove someone from a public place and take them to a place of safety – for example, a police station. It also states clearly that the purpose of being taken to the place of safety is to enable the person to be examined by a doctor and interviewed by an approved social worker, and for the making of any necessary arrangements for treatment or care.

6.48 We were told that children and young people were referred directly to local child and adolescent mental health services but the pathway was unclear, with no easy access to this information in the custody suites.

Recommendation

6.49 There should be a clear and well-advertised pathway into child and adolescent mental health services that all custody staff and HCPs can access.

Section 7. Summary of recommendations and housekeeping points

Main recommendations

7.1 As part of the change programme for the implementation of the MDOCU, the MPS should develop a performance management framework which provides management information to assess the delivery of custody services. (2.38)

7.2 The MPS and chief officer group should engage with their counterparts in the local authority and instigate an immediate review for the provision of local authority accommodation under section 38(6) PACE 1984 for young people. Performance data should be monitored to ensure that young people are not unnecessarily detained in police cells. (2.39)

7.3 The MDOCU should collate use of force data from custody and examine it for trends in accordance with the Association of Chief Police Officers' policy and College of Policing guidance. (2.40)

Recommendations

Strategy

7.4 As part of the change programme for the implementation of the MDOCU, the MPS should review engagement with key partners, both across London and at local borough level, to improve partnership working directly linked to custody provision. (3.17)

7.5 As part of the change programme for the implementation of the MDOCU, the MPS should review the current quality assurance processes to make sure that there is robust management and assessment of the standards of custody provision, to ensure positive and consistent outcomes for detainees. (3.22)

7.6 The custody newsletter and the Independent Police Complaints Commission `learning the lessons` bulletin should be promoted more actively. (3.23)

Treatment and conditions

7.7 Booking-in areas should allow enough privacy to enable effective communication between staff and detainees. (4.12)

7.8 There should be clear local policies and procedures to meet the specific needs of female detainees, children and those with disabilities. (4.13)

7.9 The MDOCU should ensure that all female detainees are made aware that they can speak to a female member of staff, and as far as possible ensure that there is a mixed staffing group to look after the welfare of female detainees, including allocating a named female member of staff to girls under the age of 18. (4.14)

7.10 Detainees should not be denied basic requirements for punitive reasons. (4.15)

7.11 Custody managers should ensure that detainees do not wait outside the custody suites in vans or van dock areas because of long booking-in times. (4.29)

7.12 All custody staff should be involved in the same shift handover and, wherever possible, this should be away from the booking-in area and recorded; sergeants should inform detainees about the change of shift. (4.30)

7.13 Risk assessments should respond to the continued welfare of the detainee. Any restraint or seizure of clothing in mitigating risk should be subject to appropriate authorisation and a clear account of the rationale and risk. (4.31)

7.14 Pre-release risk planning should be meaningful, based on interaction between custody staff and the detainee, and take into account risks arising during custody. (4.32)

7.15 Custody sergeants should explain to detainees the meaning and significance of terms that are open to interpretation, such as 'mental health'. (4.33)

7.16 Detainees should be handcuffed only if it is necessary, justified and proportionate. (4.39)

7.17 Interview and consultation rooms should be clean and fit for purpose. (4.43)

7.18 Cells should be adequately heated and ventilated. (4.44)

7.19 The use of the call bell should be explained to all detainees. (4.45)

7.20 Adequate supplies of essential items such as blankets and drinking cups should be maintained at all times and should always be offered to detainees. (4.57)

7.21 Detainees held overnight and those who require it should be offered a shower. (4.58)

7.22 Whenever possible, detainees held for longer periods should be offered outside exercise and visits. (4.59)

Individual rights

7.23 Met Detention should ensure that staff are proactive in progressing investigations so that the total time spent by detainees in police detention is appropriate and no longer than necessary. (5.13)

7.24 Appropriate adults (AAs) should be available 24 hours a day to support children and vulnerable adults in custody, and the response times and details of AAs should clearly be recorded on custody records, for monitoring purposes and to maintain or improve performance outcomes. (5.14)

7.25 Detainees should always be able to speak to their legal representative privately on the telephone. (5.23)

7.26 At Harrow, there should be enough suitable accommodation for solicitors to confer with their clients promptly and privately. (5.24)

7.27 Senior police managers should engage with HM Courts and Tribunal Service to ensure that early court cut-off times do not result in unnecessarily long stays in custody. (5.25)

7.28 Complaints should be taken while detainees are still in custody. (5.29)

Health care

7.29 There should be compliance with NHS-equivalent cleaning standards and infection control arrangements. (6.16)

7.30 For detainees with a confirmed opiate substitution prescription, there should be access to appropriate opiate substitution therapy. (6.17)

7.31 Patient confidentiality should be preserved at all times, including consultations and records, except when the requirements of the criminal justice system preclude this and it is clearly explained to detainees and/or there is a quantified, assessed risk. (6.18)

7.32 Resuscitation kits should contain Guedal airways and defibrillator pads of the appropriate size for use in children. (6.19)

7.33 HCP response times should be improved by increasing nurse capacity and limiting the areas that the FME has to cover; there should be routine monitoring of response times, including oversight of repeated calls and any non-responses. The use of ambulance services and attendance at accident and emergency departments should be appropriate. (6.31)

7.34 Professional interpreting services should be used when a detainee has limited command of English. (6.32)

7.35 Clear verbal and written information pertaining to detainees' care and well-being should be properly shared between HCPs and custody staff. (6.33)

7.36 There should be a single health record that is accessible to all health care and related professionals, including drug intervention programme (DIP) workers, to ensure that there is one unified view of the detainee's wider health needs. (6.34)

7.37 All workers should be able to record directly onto the National Strategy for Police Information Systems (NSPIS) to ensure the integrity and accuracy of shared information. (6.42)

7.38 There should be a clear and well-advertised pathway into child and adolescent mental health services that all custody staff and HCPs can access. (6.49)

Housekeeping points

Strategy

7.39 Custody managers and custody support inspectors should be more involved in 'pace-setter' meetings. (3.13)

Treatment and conditions

7.40 Staff should ask detainees if they wish to undertake any religious observance, and items for religious observance should be stored appropriately. (4.16)

7.41 Emergency practice evacuations should take place regularly and be recorded. (4.46)

7.42 Mattresses and pillows should be routinely wiped down between uses. (4.60)

7.43 A small supply of toilet paper should be available in every cell, subject to a risk assessment. (4.61)

7.44 Detainees should be informed that they are not under observation on closed-circuit television while using the toilet. (4.62)

7.45 Female detainees should be routinely offered hygiene packs. (4.63)

7.46 Wherever possible, meals should be provided at recognised mealtimes, or at other times if needed. (4.64)

7.47 A range of reading materials should be available and routinely offered, including books and magazines suitable for children and for detainees whose first language is not English. (4.65)

Individual rights

7.48 All the information in the rights and entitlements leaflet should be written in a font size that is easily readable. (5.26)

7.49 Staff should ensure that detainees are always informed, on waking, if a review of their detention has taken place while they were asleep. (5.27)

Health care

7.50 Training opportunities for health care professionals (HCPs) should be expanded to ensure that they are able to meet service needs and continuing professional development requirements. (6.20)

7.51 Medicines storage and recording should comply with national guidance and include running stock balances, refrigerator temperature checks and a suitable audit trail for the controlled drug medication cupboard keys. (6.21)

7.52 Policies should mirror NHS standards and professional requirements. (6.22)

7.53 Health promotion literature should be available. (6.35)

Good practice

Health care

7.54 The presence of a DIP worker at the Brent custody suite enabled good joint working with custody and health care staff, and resulted in early responses to detainees' substance use needs. (6.43)

Section 8. Appendices

Appendix I: Inspection team

Maneer Afsar	HMIP team leader
Gary Boughen	HMIP inspector
Peter Dunn	HMIP inspector
Vinnett Pearcy	HMIP inspector
Fiona Shearlaw	HMIP inspector
Paul Davies	HMIC staff officer
Nicola Rabjohns	HMIP health services inspector
Jan Fooks-Bale	Care Quality Commission inspector
Joe Simmonds	HMIP researcher
Rachel Prime	HMIP researcher