Report on an unannounced inspection visit to police custody suites in the

Metropolitan Police Service: Met Detention South

by HM Inspectorate of Prisons
and HM Inspectorate of Constabulary

3–9 November 2015

This inspection was carried out in partnership with the Care Quality Commission.

Glossary of terms

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Any enquiries regarding this publication should be sent to HM Inspectorate of Prisons at Victory House, 6th floor, 30–34 Kingsway, London, WC2B 6EX, or hmiprisons.enquiries@hmiprisons.gsi.gov.uk, or
HM Inspectorate of Constabulary at 6th Floor, Globe House, 89 Eccleston Square, London SW1V 1PN, or haveyoursay@hmic.gsi.gov.uk

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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.

Met Detention became operational in January 2015 and it is the newly formed and overarching police custody command for the Metropolitan Police Service (MPS). It has seven police custody clusters; this was the first inspection of the southern cluster. The suites were previously inspected when they were under the governance and resource of the local borough commander rather than as a single structure answerable to a single commander overseeing the entire custody provision. The change appeared to be a positive development, providing organisational coherence and consistency throughout MPS custody operations.

Met Detention South (MDS) covered four custody suites, including Croydon and Brixton, two of the busiest suites in London. There were significant staff shortages; the commander was aware of this and attempting to address the situation. During busy times we saw custody suite operations regularly put on temporary hold, not taking new detainees, while they booked in those already waiting in queues.

The collection of management information was broadly appropriate; however, some relevant data were not being gathered. It was notable that the reasons for strip-searches were not always detailed, and we found, for example, that despite Croydon and Brixton having a similar number of detainees, significantly more strip-searches were recorded at Brixton.

Some partnership working had yielded excellent outcomes, especially for those suffering mental ill health; however, there was no evidence of initiatives to improve outcomes for children who were charged and not bailed. Partnership working was the responsibility of another strand of MPS management, which was not involved in or focused on custody issues. Data supplied by the police service showed 197 children were charged and refused bail, in the year up to the inspection.

The overall treatment of detainees by staff and their individual interactions were good. Risk assessments and pre-release risk assessments were considered and staff worked well with other specialist health and substance misuse workers. Care plans focused on risks and responses and included requirements for constant watch to take place with the cell door open for the most vulnerable. Observation levels were recorded and adhered to. Handovers between shifts contained relevant, focused information.

We saw staff use good de-escalation skills but overall, the recording and monitoring of incidents involving use of force was poor. We were told that staff often used handcuffs and leg restraints as a means of preventing self-harm. It was difficult to determine how often this occurred as the data were either not collected or were flawed. This type of restraint on a vulnerable detainee, however well intentioned, was inappropriate.

Detainees' legal rights were explained to them as they were booked-in, and custody sergeants could also provide examples of when they had refused detention. MPS did not collect data on the use of voluntary attendance and we were unable to assess if alternatives to custody were well used.

Staff advised us and we saw that cases were not always progressed expeditiously. Delaying factors included a lack of adequate appropriate adult (AA) provision. AA services were generally chaotic; we were told the interviewing officer only called an AA when the interview and solicitor were ready; the

process did not support a vulnerable detainee through custody and undermined the primary purpose of an AA.

Detainees required to attend court were subject to unnecessary and prolonged stays in police custody: either the courts closed too early, or if the detainees had to be transported elsewhere, transport did not always arrive. There was no evidence of measures to address this.

Health care was affected by difficulties in recruiting and retaining personnel, resulting in delays in detainees being seen. Custody nurses received excellent training for their role.

A new initiative at some London suites, in which custody health care professionals had, with detainees' consent, electronic access to their prescribing information from their GP, was good. It provided timely information leading to safer detention.

Access to substance misuse workers was good; they provided support and advice in the custody suites. Three of the suites had criminal justice mental health teams, which delivered immediate mental health support. Considerable efforts were made by the police, in partnership with the health service, to ensure people requiring specialist mental health interventions were appropriately diverted.

The staff's professionalism and care, demonstrated in the treatment of the detainees, were among the key strengths of MDS custody provision. Risk assessments were focused and proportionate. Similarly, in health care, custody nurses were trained and professional. The substance misuse and mental health provision was good.

Weaknesses identified were mainly in the lack of strategic partnerships, which had a negative impact on vulnerable detainees. Provision for children was poor, AA provision was not adequately organised and detainees were detained for unnecessarily prolonged periods.

Sir Thomas P Winsor
HM Chief Inspector of Constabulary

Martin Lomas
HM Deputy Chief Inspector of Prisons

January 2016

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 College of Policing's *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 A documentary analysis of custody records is conducted as part of all police custody inspections. The analysis provides case examples illustrating the level of care detainees receive, the quality of risk assessments and care arrangements, and access to services such as healthcare and legal advice.

2.4 Records are randomly selected from approximately four weeks prior to the inspection and the sample contains a minimum of five young people (aged 17 years and under). The number of records sampled from each custody suite is proportional to throughput at those suites, i.e. more records are sampled at suites with a higher throughput and fewer from suites with a lower throughput. Where this information is unavailable, proportional sampling is based on the number of cells in each suite. Due to the small sample size, samples are not representative of the wider detention throughput. As part of this inspection a total of 30 records were sampled.

2.5 This was the first time we inspected the Met Detention South (MDS) cluster; we previously inspected and reported on the individual boroughs as part of the joint HM Inspectorates of Prisons and Constabulary custody inspection programme. MDS had four custody suites. The designated custody suites and cell capacity for each was as follows:

Custody suites	Cells
Brixton	40
Croydon	40
Sutton	30
Wandsworth	30

[1] http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/inspection-criteria/

Strategy

2.6 The Metropolitan Police Service (MPS) had only recently centralised all custody facilities under the auspices of Met Detention; previously the borough commander managed custody facilities locally. Met Detention South (MDS) consisted of a cluster of four custody suites. There was a clear management structure for custody up to commander level.

2.7 The police service collected a significant amount of relevant management information. The commander chaired a monthly meeting where data relating to custody were discussed; however, other relevant data, such as the number of strip-searches, were not provided to help improve custody provision.

2.8 There was sufficient cell capacity to deal with demand; however, staffing shortages meant custody suites were busy, staff were under pressure and sometimes detainees waited a long time before being booked in. MDS custody had introduced the role of a 'grip sergeant' whose job was to oversee case progression; however the person was quickly drawn into operational matters to ease the pressure and they could not fulfil their primary role. Some support was available from officers from territorial policing but they could not access systems and were therefore often less effective.

2.9 An electronic form was available so staff could record the use of force in custody; however it was not completed comprehensively in the majority of cases and had a high error rate.

2.10 Some partnership working yielded excellent outcomes for detainees, such as robust partnership arrangements to reduce the number of mentally ill people detained under section 136 of the Mental Health Act. However, there was no evidence of any progress to ensure better outcomes for children charged and refused bail and they were often kept in police custody. Partnership working was the responsibility of another strand of MPS management, which did not appear to be strategically focused on these matters.

2.11 Not enough cases were examined to ensure the standard of systems, procedures and treatment within custody was appropriate. Meaningful lessons could not be derived from such a small sample size; the MDS attributed this shortcoming to staffing shortages.

2.12 Training was relevant for staff working in custody. The mixture of training on policy and practice was particularly good. Personal development days were built in to the shift pattern. The commander sent out a weekly note, covering topics of interest and news items.

Treatment and conditions

2.13 Detainees we spoke to said that staff were polite and generally addressed their individual needs; our observations confirmed this view. Staff dealt with detainees sensitively when asking questions about their mental and physical health.

2.14 We were concerned about the prolonged detention of children in police custody. The treatment children received while detained did not always take into account their vulnerability, although age-appropriate language was used to explain the custody process.

2.15 All custody suites were well equipped with a range of religious material so detainees could observe their religious beliefs. There was some provision for detainees with disabilities. Custody had adequate screening between booking-in terminals to ensure privacy.

2.16 Custody sergeants and designated detention officers (DDOs) booked detainees in. Custody sergeants had good oversight of DDOs' work; all the custody sergeants understood that

they had overall responsibility for risk assessments and care plans. Custody staff worked collaboratively with health care practitioners (HCP), substance misuse workers and mental health professionals. Staff managed detainees' risks in a measured and proportionate manner and did not routinely remove corded clothing or footwear from all detainees.

2.17 Data provided by the police service suggested a waiting time of 25 minutes to be booked in, however, we saw many detainees waiting longer. In some custody suites detainees waited over an hour and in some cases in excess of two hours.

2.18 Care plans identified all risks and CCTV was used appropriately as an additional means of observation. Officers who undertook constant watches for the most vulnerable with the cell door open were appropriately briefed.

2.19 Risk assessments were dynamic and staff and detainee interactions were good, particularly when rousing checks were undertaken (where people were under the influence of drugs or alcohol). Detention logs and care plans in custody records outlined the reasons for the level of observation, which was generally adhered to.

2.20 Handovers we saw were good overall. The shift pattern did not have a handover period built in and staff devised their own ways of providing information. These differing methods of communication meant some information risked being omitted. Handovers did not always include the whole team.

2.21 Pre-release risk assessments (PRRA) we saw were good; they involved the detainee and focused on ensuring their safe release from custody. Custody sergeants appropriately reviewed the initial risk assessments, addressed any ongoing concerns, offered detainees leaflets and highlighted organisations providing suitable services. They also made arrangements to take some vulnerable detainees home.

2.22 The use of force was poorly monitored and recorded and lacked accountability. Information was poor and MDS could not be confident incidents of force were appropriate or proportionate. We saw staff use good de-escalation techniques; they communicated well with detainees to minimise the force needed and achieve good outcomes.

2.23 We were told that handcuffs and leg restraints were used to manage people who were self-harming or threatening to self-harm. It was questionable whether this was appropriate care; in some cases the leg restraints remained on for too long after the detainee had become compliant.

2.24 We saw strip-searches being appropriately authorised, but noted that despite having a similar throughput compared with Croydon custody suite, Brixton appeared to carry out significantly more strip-searches. It was not clear from the data provided why this was the case. In all custody suites many detainees arrived and remained in handcuffs until they were taken to the booking-in desk, even when they were compliant.

2.25 The physical condition of the buildings was generally good. Cleanliness and general maintenance checks were undertaken.

2.26 Detainee care was generally good, although there were some inconsistencies depending on which staff member responded to a request. Some said they would supply meals on request, others said they would only provide meals at mealtimes. Some showers were not sufficiently private.

Individual rights

2.27 Custody staff booked detainees in well and authorised detention appropriately. Most officers knew the requirements of PACE code G[2]. Custody staff could provide examples of when they had refused to detain someone where circumstances did not merit it. Alternatives to custody were available in the form of Caution +3 (voluntary attendance)[3] and street bail[4]. However the MDS did not collect data on the use of Caution +3.

2.28 Staff advised us that cases were not always progressed promptly; our observations confirmed this as did our custody record analysis. Delays in case progression could be attributed to a number of factors, including solicitor delays, a lack of appropriate adults (AAs) (independent individuals who provide support to young people and vulnerable adults in custody) and delays in booking detainees in.

2.29 Immigration officers were based at three of the four custody suites and in most cases we observed immigration detainees were moved on expeditiously.

2.30 Data supplied by the police service showed that in the year up to the inspection, 197 children had been charged and detained, with no alternative accommodation found for them, which was too high. Custody staff told us no local authority secure accommodation was available across the boroughs for children who had been charged but could not be bailed. However MDS staff could not tell us how many requests for alternative accommodation had been made as not all children had to be placed in secure accommodation. A few staff reported that non-secure accommodation had been made available on a very limited number of occasions.

2.31 AA provision across MDS was extremely chaotic. Custody staff did not routinely contact an AA, which was assumed to be the role of the interviewing officer. They were only called to attend when detainees were being interviewed with a solicitor; vulnerable detainees did not have an AA to support them throughout the detention process. It was also difficult to identify which scheme was responsible and when it could be contacted. Some schemes were reported to offer cover over 24 hours but even then staff told us they could not access an AA between 11pm and 8am.

2.32 Detainees were advised of their rights and received a written notice explaining their rights and entitlements. Staff could access the information in an easy-read pictorial format, as well as in other languages. All detainees were offered free legal representation.

2.33 Some PACE reviews were inconsistent and they were often conducted too early or late. Detainees whose PACE review took place while they were asleep or being interviewed were not informed that their continued detention had been authorised.

2.34 We were advised that detainees were not routinely accepted at the local remand courts, which closed early, and detainees were held in custody for longer than necessary, sometimes overnight, until an available slot for a court appearance could be found.

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[2] PACE code G refers to the Police and Criminal Evidence Act 1984 code G, the code of practice for the statutory power of arrest by police officers.

[3] Voluntary attendance is usually used for lesser offences and involves suspects attending a police station by appointment to be interviewed about alleged offences. This makes the need for an arrest and subsequent detention unnecessary.

[4] Street bail under section 4 of the Criminal Justice Act 2003 enables a person arrested for an offence to be released on bail by a police constable on condition that they attend a police station at a later date. One of the benefits of street bail is that an officer can plan post-arrest investigative action and be ready to interview a suspect when bail is answered.

2.35 Virtual courts (in which a defendant appears in court by means of a secure video link) were available at three of the four custody suites. We knew of detainees who had been remanded by the virtual court, but were not moved on because of a lack of onward transport.

2.36 Custody staff were inconsistent in their responses when asked how they would deal with a detainee wishing to make a complaint. We saw officers advising detainees to make a complaint on their release; others said they would inform the inspector. No information regarding the complaints process was displayed in any of the custody suites.

Health care

2.37 New governance structures were developing well and an up-to-date health needs assessment was informing service development.

2.38 The health care provided was reasonably good, but was undermined by difficulties recruiting and retaining custody nurses and forensic medical examiners (FMEs), which regularly resulted in delays in detainees being seen.

2.39 The MPS could not be confident that detainees were receiving a timely service because there were no agreed response times, FME response times were inadequately monitored and there was no mechanism for handovers between FMEs.

2.40 Custody nurses' access to formal clinical and managerial supervision was underdeveloped. The situation was exacerbated after nurses had their line management transferred to the custody manager. Custody nurse practitioners received excellent training for their role and reasonable access to informal support from clinical managers.

2.41 Custody and health staff we spoke to reported most FME consultations were conducted with the door open without an individual risk assessment having been undertaken, which denied detainees adequate privacy and confidentiality; this was particularly the case at Sutton and Wandsworth where the rooms were adjacent to the booking-in area.

2.42 Stock medication was generally managed well and stored securely, except at Brixton where keys to the drug cupboard were regularly left in the cabinet or lying on a desk, which was inappropriate.

2.43 Detainees generally had good access to prescribed medication including symptomatic relief for drug and alcohol withdrawals.

2.44 A new initiative at some London suites allowed custody health care professionals to access the detainee's prescribing and allergy information electronically from their GP records with their consent, which improved the timeliness of prescribing.

2.45 DDOs and custody sergeants understood their medication administration responsibilities, but we were told of occasions and observed an instance where FMEs did not prepare the medication dose, which created delays and the risk of errors.

2.46 Detainees had good access to prompt support from the embedded drug and alcohol workers at each suite. Children were directed to age-appropriate substance misuse services as required.

2.47 Three of the suites had embedded criminal justice mental health teams, which provided swift and effective mental health support for detainees, supported by street triage. A liaison and diversion service had been commissioned for Sutton, the remaining suite, which was positive.

Mental Health Act assessments generally took place promptly, but the pressure on mental health beds meant some detainees stayed in police custody too long.

2.48 Children in custody in Croydon were routinely assessed by a mental health practitioner as part of an NHS England pilot programme to improve access to services.

2.49 Custody staff we spoke to had a good understanding of mental health issues and said they had received some formal mental health training, supplemented by informal training from the mental health staff on site.

Main recommendations

2.50 The Metropolitan Police Service should collate and use data more meaningfully, including use of force information (in accordance with the College of Policing's *Authorised Professional Practice - Detention and Custody* guidance), to allow them to manage and improve detainee care and welfare.

2.51 Sufficient levels of staff should be provided in custody to allow for an efficient operation. This includes inspectors, custody sergeants, detention officers and health care staff.

2.52 The Metropolitan Police Service chief officer group should engage with its counterparts in local councils, to instigate an immediate review of local authority accommodation provision under section 38(6) PACE 1984 for children and monitor performance data to ensure that children are not unnecessarily detained in police cells.

2.53 AAs should be available 24 hours a day and staff should request they attend as soon as possible to ensure the welfare and safety of vulnerable adults and children in custody.

2.54 Health care professionals should see detainees consistently and within agreed response times that are routinely monitored; there should be proper oversight of repeated calls and non-responses.

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 The Metropolitan Police Service (MPS) had centralised custody facilities in January 2015. Known as Met Detention, facilities were previously managed by local borough commanders. Met Detention South (MDS) operated a cluster of four custody facilities in Brixton, Wandsworth, Sutton and Croydon and had a clear management structure for custody up to commander level. Custody facilities generally had the capacity to manage the throughput of detainees. Staff worked a four-shift pattern, working up to 12 hours a day.

3.2 The commander chaired a monthly management meeting that considered a broad range of performance data. Senior managers from Met Detention attended the meeting. Information was provided on detainee numbers, average waiting times before being booked in to custody, overall detention times, and the number of people detained under section 136 of the Mental Health Act. The data provided at the meeting did not include some important qualitative performance information, such as the standard of risk assessments being carried out across the cluster, the proportionality of strip-searching or the provision of alternative accommodation for children (see main recommendation 2.50). The chief inspector held a regular quarterly meeting with all inspectors.

3.3 The authorised complement of staff for MDS was 15 inspectors, allowing for two custody support inspectors (CSI) to cover each custody suite at all times and a custody manager at each facility. The department operated with only 10 inspectors supported by three acting inspectors. As a result it was not always possible to ensure that the facilities were well equipped, that staff rotas were up to date and that oversight of detainees was efficient or effective. We saw that at least one inspector was simultaneously a CSI and a custody manager.

3.4 The custody facilities mostly had a 'grip sergeant' in the middle of the day who was responsible for overseeing case progression and efficiency in custody. We noticed that they were frequently drawn into a more tactical role, which included booking detainees in, because of pressure on other staff; they could therefore not fulfil their primary role effectively.

3.5 There were shortages of custody sergeants, designated detention officers and health care staff (see section on health care, governance, and main recommendation 2.51). Staff in the control room allocated individuals to a custody facility when a person was arrested; we found this inefficient as at times some of the facilities were full, or had a queue of people waiting to be booked-in, while adjacent facilities were less busy. Staffing shortages sometimes meant that detainee care was compromised in busier suites (see section on treatment and conditions, detainee care).

3.6 The custody chief inspector was dedicated full time to managing all matters across the four facilities. Staff working in custody were part of Met Detention and were managed separately from response and investigation staff.

3.7 Each territorial policing borough had committed to retain 10% of sergeants who were trained custody officers to support MDS and to ensure a number of constables were trained

as detention officers so they could be used when necessary. We found that many of the constables brought in to the custody facilities were not fully trained to use the computer system so their contribution was limited.

3.8 When force was used either on arrest or during custody, the custody sergeant or designated detention officer (DDO) was required to record it on an electronic record in the main custody record but the use of force records completed had a very high error rate and data were not accurately recorded or collated thereafter. Officers did not complete specific use of force forms. The use of force policy meant that officers recorded and justified use of force in their own notes and as a result the police service could not identify trends within custody.

3.9 All policies and procedures relating to custody matters (known as the custody toolkit) were clearly visible on the police service intranet and were accessible to all staff.

Partnerships

3.10 Outcomes for mentally ill people detained under the Mental Health Act were excellent, as a result of partnerships with mental health services and it was rare for anyone detained under section 136 of the Mental Health Act to be brought to a police station (see section on health care, mental health, paragraph 6.31).

3.11 A large number of children over the previous year had been charged with an offence, refused bail and remained in police custody rather than being transferred to local authority accommodation. There was no evidence that this problem was being pursued by MDS or the Met Police Engagement Department (see main recommendation 2.52).

3.12 There was a lack of strategic oversight of partnership accountability for better outcomes for detainees. The provision of appropriate adults (independent individuals who provide support to young people and vulnerable adults in custody) was disjointed (see section on individual rights, rights relating to detention, paragraph 5.9 and main recommendation 2.53). Interactions with HM Courts and Tribunals Service (HMCTS) and the prison escort provider Serco were inadequate and did not ensure that detainees who were remanded in custody by virtual courts (in which a defendant appears by means of a secure video link) were expeditiously transferred to the next place of detention (see section on individual rights, rights relating to PACE, paragraph 5.21).

3.13 Partnerships and work with external stakeholders took place within a different management strand of the MPS. The MDS did not appear to be strategically linked to or have any knowledge of these issues. It was not clear how the current custody commander influenced or was involved in this agenda.

3.14 There was little evidence that staff were being encouraged to use voluntary attendance (Caution +3) as an alternative to custody. We received no data on the use of Caution +3 (see section on individual rights, rights relating to detention, paragraph 5.2).

3.15 The independent custody visitor (ICV) scheme was well supported and each inspector held quarterly meetings with the ICV volunteers for their custody facility. There were regular visits to custody centres.

Learning and development

3.16 Met Detention ran its own audit programme in which custody facilities were visited and relevant checks made on the standard of the estate and some of the work processes.

3.17 MDS inspectors were responsible for dip-sampling custody records. The process was computerised and prompted an effective review of key areas of custody, including risk assessments, case progression, reviews of detention and visits to detainees. However, the MDS did not carry out sufficient dip-samples: in Wandsworth in October 2015 only 10 cases were reviewed. Custody managers and CSIs told us they did not have the capacity to fulfil this role due to staff shortages. Custody records were not reviewed in conjunction with CCTV footage from the custody facility. It was impossible for the organisation to learn effective or meaningful lessons from such a small sample.

3.18 Training was relevant to the custody role. The mixture of training on policy and practice was good. Personal development days were built in to the shift pattern, which was positive and allowed for other non-mandatory training opportunities.

3.19 The commander sent out a weekly email covering a range of issues, including current topics that staff needed to be aware of, updates on policy and lessons from adverse incidents across the country.

Recommendation

3.20 **Met Detention South should ensure that an appropriate number of custody cases are dip-sampled; this should include checking cases against CCTV recordings so that lessons can be learned.**

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 Detainees we spoke to said, and our observations confirmed, that custody staff engaged politely and courteously with detainees, particularly those who presented as vulnerable and people detained in custody for the first time. Staff dealt with detainees sensitively when asking them questions about their mental and physical health and took the time where necessary to explain the process they would go through. Custody staff had a reasonable awareness of diversity and detainees' individual needs were mostly met; however, they did not always inform women detainees about the option of speaking to a female member of staff or make them aware of the availability of hygiene products, despite there being prompts to do so as part of the electronic booking-in process. On the other hand, we observed custody staff making appropriate enquiries about detainees' caring responsibilities; they were given the opportunity to make alternative arrangements for any dependants.

4.2 We were concerned about the prolonged detention of children in police custody. Data provided by the police service and our own observations showed that there were too many children in police custody overnight (see main recommendation 2.52 and section on individual rights, rights relating to detention, recommendation 5.13). The prolonged detention of children was further compounded by the chaotic provision of appropriate adults (AA) (independent individuals who provide support to young people and vulnerable adults in custody), lack of alternative arrangements and the absence of any obvious efforts to ensure that children spent the least amount of time in custody or were bailed where possible (see section on individual rights, rights relating to detention, from paragraph 5.8).

4.3 In our custody record analysis, for example, we found five out of the six children in the sample were detained for between 12 and 24 hours. The treatment children received while detained did not always take into account their vulnerability. Age-appropriate language was used to explain the custody process, but there was no additional recognition of their vulnerabilities: girls under 18 were not routinely assigned a named officer; there were no designated cells close to the custody desk, no age-appropriate material to keep them occupied and no additional staff interactions with the children detained.

4.4 Detainees were not always asked if they had any religious needs as part of the booking-in process, although all custody suites were well equipped with suitably stored religious books and prayer mats.

4.5 The custody suites were relatively new and had some provision for detainees with physical disabilities, such as adapted toilets and showers, designated cells with lowered cell call bells and a discrete lower booking-in desk at Croydon. However, the bed plinths were too low; thick mattresses would have made them more accessible to older detainees and those with physical disabilities.

4.6 Designated detention officers (DDOs) and sergeants understood the importance of asking transgender detainees if they preferred to be searched by a male or female officer.

4.7 Custody suites had adequate screening between bookings-in terminals to ensure privacy; however, discreet booking-in areas were not always considered for use when dealing with the most sensitive cases.

Recommendations

4.8 Women detainees should be informed that they can speak to a female officer if they wish and told of the availability of hygiene products.

4.9 Girls under 18 should be allocated a named female officer responsible for their care while in custody.

4.10 All suites should have a small supply of thick mattresses.

Safety

4.11 Custody sergeants and DDOs booked detainees in. Custody sergeants had good oversight of DDOs' work. Custody sergeants and DDOs understood their responsibility for the risk assessment and the care plan. Custody staff engaged well with detainees to complete the risk assessments and asked probing supplementary questions. We saw good collaborative working between custody staff, health care practitioners and substance misuse and mental health workers in cases where there were concerns about detainees' physical or mental well-being.

4.12 Staff appropriately took account of other sources of information during the risk assessment process, including warning markers (indicators showing that a person has previously had a problem, such as with drugs or self-harm) on the police national computer and in local intelligence systems. Where detainees did not comply with the risk assessment process custody staff appropriately gathered information from other sources and managed their risk in a measured and proportionate way. It was good to see that detainees' corded clothing and footwear were not routinely removed without an assessment; this was evident at all the suites.

4.13 The otherwise good risk assessment process was, on occasion, hampered by delays in booking detainees in. Data provided by the Metropolitan Police Service (MPS) suggested waiting times of approximately 25 minutes overall. However, at Brixton, on more than one occasion, we observed delays in excess of two hours and over an hour at Croydon in booking detainees in; detainees waiting in the queue were not triaged to identify any risks to themselves, other detainees or officers (see section on individual rights, rights relating to detention, paragraph 5.3).

4.14 In the cases we analysed, the level of observation that detainees were placed on was generally appropriate, reviewed regularly and changed when suitable; staff mostly complied with the required frequency of visits to observe the detainee. Care plans generally identified all risks and CCTV monitoring was appropriately used as an additional means of observation for detainees with additional risks. Interactions with detainees when DDOs conducted rousing checks on those who were intoxicated were good and checks were well-documented in the custody record.

4.15 We observed several officers being brought into the custody suite specifically to conduct a constant supervision of detainees who were assessed as having a high risk of suicide or self-harm. Constant supervision generally involved the officer sitting outside a cell with the cell door open. Custody sergeants appropriately briefed the officers, providing relevant

information about the circumstances and risks which had led to the heightened observation levels. We saw officers interacting appropriately with detainees on constant supervision, recording information and relaying any relevant issues to the custody sergeant.

4.16 All custody staff carried personal-issue anti-ligature knives; a set was provided to any non-custody staff who were working in the custody suite temporarily. However, other staff, such as interviewing officers, who often attended cells to unlock detainees, did not carry anti-ligature knives. Inspectors felt that staff should have been able to respond promptly and effectively to any situation in a custody suite, including one where an anti-ligature knife was required immediately.

4.17 Shift handovers across the custody suites were conducted well but not always with the whole team; the content was relevant and focused appropriately on detainees' risks and case progression. A handover period was not built in to all the shift patterns and staff devised their own ways of providing information. Some sergeants used a handover screen on the national strategy for police information systems (NSPIS) computer system; others devised their own template on which they recorded relevant information; and some used the NSPIS whiteboard. These differing methods of communication meant there was a risk of some information being omitted. Management expected all staff to use the handover screen on the NSPIS, but needed to reinforce its use to ensure it was done consistently across all suites. The handover process could have been further enhanced by custody staff visiting detainees to let them know the shift and people responsible for their care had changed.

4.18 Pre-release risk assessments were good and there were several examples of custody sergeants appropriately exploring continuing risk concerns, making referrals and involving health care practitioners and mental health workers where necessary. The pre-release risk assessments we saw involved the detainee and were focused on releasing them from custody safely. Custody sergeants appropriately reviewed initial risk assessments, addressed any ongoing issues and offered detainees support leaflets and advice on suitable services. Where necessary, arrangements were made to take detainees home. Our custody record analysis showed that all detainees being released to their home had a pre-release risk assessment completed.

Recommendations

4.19 **The Metropolitan Police Service should monitor the average waiting time from detainees' arrival in custody to detention being authorised to ensure that detainees are booked in promptly.**

4.20 **Anti-ligature knives should be available on keys for staff who undertake cell visits.**

4.21 **All custody staff should be involved in the same shift handover.**

Use of force

4.22 Arresting officers signed the custody record to confirm the type of force use prior to custody. The form used to record the use of force in custody consisted of an annex on NSPIS and merely logged whether force was used before or during custody or in other circumstances and the type of force employed; we were told it was often completed incorrectly, which made it difficult to disaggregate data that were relevant to custody. Detention logs we reviewed often contained scant information.

4.23 Governance of use of force was poor; there was no overall information about how often it was used and no analysis of use of force trends or data for training purposes and to ensure staff accountability (see main recommendation 2.50). Not all custody staff had received up-to-date officer safety training.

4.24 We were unable to review a representative sample of CCTV for a number of reasons relating to information technology access, such as poor logging of incidents. We saw some good use of de-escalation techniques and staff generally communicated with detainees to ensure the minimum amount of force was used. The limited CCTV footage we reviewed, involving the use of leg restraints and handcuffs, showed that force was used proportionately considering the level of non-compliance initially, but we were concerned that both forms of restraint remained in place for too long after detainees appeared calm and compliant.

4.25 We were repeatedly told that strategies to manage self-harming or suicidal detainees included the using handcuffs and leg restraints; we believed this did not constitute providing good care to detainees in crisis in the first instance. We were concerned about the prolonged use of these restraints, particularly in two cases. In one, a vulnerable detainee was handcuffed while under constant supervision for 2.5 hours due to her demeanour, which was linked to her mental vulnerability. In a second case, a detainee who was confrontational towards staff and said he would harm himself and others, led to him being handcuffed. Staff attempted to interact with him and the handcuffs were removed but the detainee remained in leg restraints for over six hours during which an inspector carried out a review. The inspector did not mention the prolonged use of leg restraints to the custody staff or the detainee and it was not clear why the restraints had not been removed after the detainee had become compliant. Health practitioners were not involved to assess the detainees' physical or mental well-being.

4.26 We saw appropriate authorisation for strip-searches, however, data supplied by the police service highlighted that in Brixton the number of searches was significantly higher than at Croydon, which had a similar throughput of detainees: there were 1,702 strip-searches in 2014–2015 compared with 710 in Croydon over the same period. We found no reason why this should have been the case. The police service needed to be confident that strip-searching at Brixton custody suite was justified and conducted in a proportionate manner based on good risk assessments and intelligence.

4.27 Custody sergeants and officers did not ensure handcuffs were removed from compliant detainees while they were waiting to be booked in; we saw too many compliant detainees in handcuffs for long periods, which was excessive.

Recommendations

4.28 **The Metropolitan Police Service should be confident that strip-searching in all cases has a recorded rationale, and investigate why strip-searches are carried out more frequently at Brixton than at other custody suites.**

4.29 **Detainees should be admitted to the custody suite promptly; handcuffs should be removed from detainees after arrival, unless a risk assessment indicates otherwise.**

Physical conditions

4.30 Custody suites provided an appropriate environment. Cleaning and maintenance arrangements were generally good. Communal and cell areas were generally clean with little evidence of graffiti. Cells were checked between occupants and cleaners visited suites twice a day and cleaned cells that were unoccupied.

4.31 DDOs conducted comprehensive daily cell checks and regularly took cells out of action if faults or defects, such as ligature points, were discovered. Faults and defects were mostly dealt with promptly; one notable exception was a cell at Brixton that had been out of use since 18 August 2015 because the CCTV was not working.

4.32 During the inspection, we identified a potential ligature point in the ceramic toilets at Wandsworth. In all suites but Sutton, cells contained embedded sinks, including hand dryers with a metal grille for air flow, which we also considered could have been used as a ligature point.

4.33 In cells covered by CCTV, toilet areas were obscured on monitors to ensure privacy. Detainees were generally informed if cells were monitored and clear signage was displayed in cells advising them of CCTV monitoring. Cell call bells were routinely explained to detainees when they were in cells and they generally received a prompt response.

4.34 Suites had fire evacuation policies and evacuation plans were displayed. We were informed that all suites had had a fire evacuation drill within the previous 12 months.

Recommendation

4.35 **The police service should take action to address the potential ligature points in the toilets at Wandsworth and embedded sinks at Brixton, Croydon and Wandsworth.**

Detainee care

4.36 Overall, detainee care while in the cell was adequate. In our analysis of 30 custody records, 25 detainees were offered at least one meal while in custody, none were offered exercise and three were offered a shower. There were some improvements required, mattresses and pillows were provided but were not always cleaned between uses. Some cells were cold and clean blankets were not offered to all detainees, not even at night. With the exception of Croydon where there was no underwear, there were sufficient stocks of replacement clothing. Toilet paper was mostly available on request. Women detainees were not routinely offered hygiene products (see paragraph 4.1 and recommendation 4.8).

4.37 Food storage and preparation areas were generally clean. The provision of meals was inconsistent. In our custody record analysis and through our own observation we noted that a minority of staff, particularly at Brixton and Croydon, stuck rigidly to set meal times, which meant that some detainees who arrived in the evening or late at night were not offered a meal until breakfast the next day. Otherwise, a range of microwave meals, porridge and drinks were offered regularly.

4.38 Custody suites had a range of reading material, generally donated by staff and independent custody visitors but they were not promoted well and were usually only provided on request. Too few reading materials were available in languages other than English and there

were no easy-read publications or material specifically for children. Visiting facilities were not available and we were told visits were not permitted.

4.39 All custody suites had small exercise yards and showers that were generally clean but some had doors that did not provide sufficient privacy. Access to exercise and showers was infrequent, generally only on request and subject to staff availability (see section on strategy, strategic management, paragraph 3.5).

Recommendations

4.40 All suites should hold a stock of suitable reading material in a range of languages and in an easy-read format, as well as books that are suitable for children.

4.41 Visits should be arranged, particularly for children, vulnerable detainees and those who remain in custody for longer periods.

4.42 Detainees should have access to exercise and showers, particularly if they remain in custody for longer periods.

4.43 Mattresses and pillows should be cleaned between uses.

4.44 All detainees should be offered a blanket.

4.45 Replacement underwear should be available in all custody suites.

Section 5. Individual rights

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

Rights relating to detention

5.1 Custody sergeants were responsible for asking arresting officers to provide a full explanation of the circumstances of and the reasons for the arrest before authorising detention. Sergeants told us that a minority of operational officers did not always have a good understanding of the necessity criteria contained in the Police and Criminal Evidence Act (PACE) 1984 code G; we also observed this to be the case. Sergeants told us they were confident about refusing detention when the circumstances did not merit it, and provided us with details of such cases.

5.2 Custody staff told us, and we observed, that voluntary attendance (known locally as Caution +3) was sometimes used as an alternative to custody. Custody staff were unclear about how often voluntary attendance was used as they were not involved in the process. The facilities could be used discreetly without a person having to enter the booking-in or cell areas. The police service could not supply us with any data in relation to voluntary attendance as its use was not monitored (see section on strategy, partnerships 3.14). Street bail as an alternative to custody was also available, and we saw this being put to good use in one case, when a vulnerable young woman had received street bail to attend the custody suite the following morning with her appropriate adult (AA) (independent individuals who provide support to young people and vulnerable adults in custody).

5.3 All custody staff were aware of the need to keep detention periods to a minimum. Custody sergeants were clear about their obligations to ensure that cases were progressed promptly; however we observed some significant delays in detainees being booked in at the busier suites (see section on treatment and conditions, safety, paragraph 4.13). Custody sergeants in most cases became involved in the booking-in process, which did not allow them to oversee case progression. We observed detainees being held in custody for lengthy periods due to a number of factors, which included the non-availability of AAs, solicitors and interviewing officers. Data from 1 April to 30 September 2015 showed that the average length of detention ranged from 12 hours 34 minutes at Sutton to 15 hours and four minutes at Brixton. The average length of detention in our custody record analysis was 16 hours 59 minutes; only four out of 30 detainees in our sample were held for less than six hours. These unacceptably lengthy periods of detention did not convince us that detainees were dealt with as expeditiously as possible.

5.4 Custody staff reported a good relationship with Home Office immigration enforcement officers, a number of whom were based in the custody suites, except at Sutton. We were told that a large number of immigration detainees were regularly held and that those who were to be transferred to immigration removal centres (IRC) were usually moved within 12 to 24 hours; however on a few occasions longer delays had been experienced. At Brixton we saw one immigration detainee being moved to an IRC within four hours of a warrant of detention being served on him. Data supplied by the police service confirmed that 403 immigration detainees had been held in the year up to the inspection with an overall average detention time of just over 16 hours 45 minutes.

5.5 Professional telephone interpreting services were available to assist staff dealing with foreign national detainees. Staff told us that a good face-to-face interpreter service was available for interviews.

5.6 Staff assured us that the custody suites were never used as a place of safety for children under section 46 of the Children Act 1989[5].

5.7 Custody staff told us they had not known local authorities to provide secure accommodation where a child had been charged and could not be bailed (see section on strategy, partnerships, paragraph 3.11). Some staff were aware of a few occasions when safe accommodation[6] had been provided on request. We were advised of a case at Croydon where a young person with a developmental disability was released to social services for an emergency placement.

5.8 The police service supplied data showing that 197 children under the age of 18 had been charged and had bail refused in the year up to the inspection but they could not confirm how many requests had been made to local authorities asking for alternative accommodation. The data supplied showed that the number of children under 18 years of age who had been charged and had bail refused, and subsequently remained in detention, had been decreasing year on year over the previous three years; however, it remained too high.

5.9 We were concerned that AAs were not being used appropriately; they were not asked to attend as soon as a vulnerable detainee was identified. Custody staff were aware of the need to contact an AA when dealing with vulnerable adults and children under the age of 18, but in three of the four custody suites the responsibility for making contact rested with interviewing officers rather than custody staff. Across all the suites, custody staff told us that AAs were normally only asked to attend when interviews with detainees were due to take place, rather as soon as practicable to support the child or vulnerable adult throughout the custody experience and our observations confirmed this (see section on treatment and conditions, respect, paragraph 4.2). We were told of a case involving a 13-year-old in custody who had breached a youth rehabilitation order, who was held in custody overnight to appear at court the following morning. There was no evidence in his custody record of any contact with an AA throughout his stay.

5.10 In our custody record analysis, we saw evidence of five children being held overnight (see section on treatment and conditions, respect, paragraph 4.2). It was apparent that for three of these children, officers attempted to progress their cases throughout the night, for example, interviewing witnesses and collecting evidence. In one case, a 17-year-old girl arrived at Croydon with her AA. She had never been in custody before and disclosed that she had self-harmed earlier in the day. The custody record noted that no one was available on the late shift to deal with the girl, so her AA was sent home and asked to attend again the following morning; the girl was held in custody overnight. The records did not explain why the girl was not allowed to return home with her AA. The AA returned to the station the following morning and within two hours of their arrival, the girl was released after having spent just over 16 hours in custody.

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

6 Under PACE code C Note 16D the availability of secure accommodation is only a factor in relation to a child aged 12 or over when other local authority accommodation would not be adequate to protect the public from serious harm from them.

5.11 Family or friends were contacted in the first instance to act as an AA and custody staff were aware of the Home Office guidance document to assist AAs when carrying out this role, which we saw being appropriately issued. In the absence of family members, a number of AA schemes operated across the four custody suites but it was difficult to establish what their responsibilities were or confirm their hours of operation. Some schemes, for example, were reported to offer a 24-hour service, but custody staff still told us they were routinely unable to access AAs between 11pm and 8am, which meant detainees had to be bailed or held in custody overnight; they were consequently held for longer than necessary.

Recommendations

5.12 **The Metropolitan Police Service should ensure that operational officers are fully aware of and comply with the requirements of the necessity criteria as detailed in PACE code G.**

5.13 **The police service should monitor how long detainees are held to ensure they are dealt with expeditiously and released as soon as the need for detention no longer applies.**

Rights relating to PACE

5.14 During the booking-in process, custody sergeants and designated detention officers (DDOs) advised detainees of their three main rights[7] and in the majority of cases, they routinely received a written notice setting out their rights and entitlements. Custody staff could provide the notices in foreign languages for non-English speaking detainees but not all staff knew that an easy-read pictorial version of the detainees' rights and entitlements notice was available for detainees needing help with understanding or reading.

5.15 We saw staff inform detainees they could read the PACE codes of practice notice during the booking-in process, but they did not always explain what they were. None of the suites had sufficient copies of the up-to-date PACE code C notice and we did not see these routinely offered or handed out to detainees. Posters informing detainees of their right to free legal advice in a range of languages were displayed in all the suites.

5.16 All detainees were offered free legal representation and told if they declined they could change their mind at any time. With the exception of detainees in Sutton, those wishing to speak to legal advisers could do so over the telephone in the privacy of legal advice booths. Only Sutton had no legal advice booths. There were sufficient consultation and interview rooms at all the suites and we saw legal advisers who asked for it being given a copy of their client's custody record front sheet or full record. In our custody record analysis, all detainees were offered access to free legal advice; 12 accepted the offer. Logs demonstrated that solicitors had been contacted promptly after a request for one.

5.17 We saw staff tell detainees they could inform someone of their arrest, which staff helped arrange. In our custody record analysis, nine detainees had asked for someone to be informed, and in all but one case it was recorded that the person was contacted or an attempt made to contact them.

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[7] The right to have someone informed of their arrest; the right to consult a solicitor and access free independent legal advice; and the right to consult the PACE codes of practice.

5.18 Custody support inspectors (CSIs) who were responsible for two of the four custody suites, either Brixton and Wandsworth or Croydon and Sutton carried out reviews of detainees' cases. We saw some inconsistent face-to-face PACE reviews that ranged from good to poor. In our custody record analysis, 25 detainees had required a PACE review; 15 were conducted on time; eight were undertaken early and two were later than the required review times. Custody staff and inspectors told us, and we observed that reviews were often conducted early or late as it was not unusual for the inspectors to be responsible for reviewing over 60 detainees, particularly at a weekend.

5.19 In our custody record analysis there was evidence that 14 reviews took place while the detainee was asleep and two while the detainee was being interviewed, but records in only one case showed that the detainee had been informed a review had taken place and been reminded of their rights and entitlements. Custody sergeants confirmed that the information that a review had been conducted while a detainee was sleeping or 'in interview' was not exchanged during handovers and therefore could easily have been overlooked. These detainees were not told that their continued detention had been authorised or the reasons for it, which was a significant oversight.

5.20 The management of refrigerators and freezers in custody was inadequate. In some areas staff demonstrated that samples were collected regularly and were well monitored. However, in Brixton and Sutton we found some old volunteer DNA samples and a large number of forensic samples, some of which were dated September 2013.

5.21 Custody staff told us that the local remand courts would not normally accept detainees after 2.30pm to 3pm on week days, which was too early. We saw one of the courts refuse to accept a detainee at 2.10pm, despite staff having first notified them that he was in custody at 11am. Brixton, Croydon and Sutton offered a virtual court facility (through which a defendant appears in court by means of a secure video link) for Camberwell Green Magistrates' Court, which was available for detainees charged with certain qualifying offences. Custody staff told us and we observed that detainees being dealt with through the virtual court were often not dealt with until later in the day. Detainees who were remanded or sentenced by the virtual court regularly had to remain in police custody for longer than necessary as they were not picked up for transfer to prison on the same day, but were held overnight in most cases for transfer the following afternoon, which was unacceptable.

Recommendations

5.22 Reviews of detention should be conducted as detailed in the PACE code C.

5.23 The Metropolitan Police Service should review its policies and procedures for managing the refrigerators and freezers in the custody suites to ensure samples are submitted promptly.

5.24 Senior police managers should work with HM Courts and Tribunals Service and Prison Escort and Custody Services to ensure that early closure times at local remand courts and the working practices of the virtual court at Camberwell Green Magistrates' Court do not result in inappropriately long stays in police custody.

Rights relating to treatment

5.25 Custody staff had different responses when asked how they would handle a complaint. Some said they would advise detainees to make a complaint at the police station front desk on release; we saw a detainee who said he wanted to make a complaint being given this advice when he was being released from custody in Brixton. Other staff said they would contact the CSI immediately; the CSI would decide whether they would note the complaint while the detainee was still in custody or make an arrangement for them to be seen at a later date. No information on the complaints process was displayed in the custody suites but details were included in the rights and entitlements notice that custody staff offered to the majority of detainees.

Recommendation

5.26 Detainees should be able to make a complaint while they 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 New governance structures were developing well and were informed by an independent audit of Metropolitan Police Service (MPS) custody suites in 2014. They focused on environmental and clinical infection control, medicines management, maintenance of clinical equipment and a health needs assessment carried out in 2015. A newly commissioned service was planned from April 2017.

6.2 Custody nurse practitioners (CNPs) employed by Met Detention South (MDS) provided primary health services supported by contracted forensic medical examiners (FMEs). Criminal justice mental health workers from two providers were embedded in three suites and substance misuse workers from four providers were based in all four suites. Partnership working between providers and custody staff was good, but there were no regular operational meetings between providers.

6.3 The health care provided was reasonably good, but the MPS had severe and chronic difficulties recruiting and retaining CNPs, which are replicated across the health service. This regularly caused delays in detainees being seen. The FME on duty received requests to attend to a detainee directly. There were no agreed times within which a health care professional was expected to attend, no formal monitoring of response times and no handover between FMEs, which meant we could not be confident that detainees were receiving a prompt service. Data showed that the average response time for a health professional across the four suites between November 2014 and October 2015 was 169 minutes, ranging from 137 minutes at Sutton to 188 minutes at Croydon, which was excessive.

6.4 All four suites should have had CNPs on site at all times, but only seven of the 16 posts (44%) were filled (see main recommendation 2.51). Nurses from Bromley and Sutton suites had covered Brixton, the busiest suite, since August 2015. Custody staff were positive about CNPs when they were available. The lack of CNPs increased the demand on FMEs. There had been instances when there was no FME or CNP, which meant an FME from another area had to offer support or detainees requiring medical input had to be taken to another suite. In our custody record analysis, a health assessment was requested for a detainee who was not seen prior to their release, which was six hours later.

6.5 A director of nursing supported by three nurse managers provided clinical leadership for CNPs. The management team was fully staffed from early November 2015 but had been understaffed for extended periods in the previous year. Consequently some clinical governance processes, including clinical supervision and audits, were underdeveloped, although access to informal support was good. Station custody managers had taken over the management of CNPs to allow nurse managers to concentrate on clinical activities and governance; however, we were concerned that this could have led to a further weakening of oversight and support. A medical director provided satisfactory leadership and governance on medical matters and governance.

6.6 The health team had a wide knowledge base and reasonable gender balance. CNPs received excellent initial induction training and had good access to mandatory training supplemented by two practice development days annually. CNPs received an annual allowance to fund

additional training. Health policies did not include all aspects of governance and clinical practice.

6.7 The police complaint system was used for health care complaints and was insufficiently confidential as complaints may contain medical information; however lessons learned from complaints and significant incidents were shared with the team and informed service delivery.

6.8 Professional interpretation was used appropriately for detainees with limited English. Health and custody staff told us that most CNP and FME clinical consultations occurred with the door open and a designated detention officer (DDO) outside without any recorded risk assessment, which compromised detainee confidentiality particularly at Sutton and Wandsworth, where the clinical room was near the booking-in desk.

6.9 All suites had satisfactory appropriately stocked clinical rooms and were generally tidy. Appropriate action was ongoing to achieve compliance with infection control standards.

6.10 Custody staff had annual first aid training and easy access to automatic external defibrillators. Only health staff had access to oxygen tanks. First aid kits were standardised and checked regularly, however we found some expired items in sealed kits with a note incorrectly indicating that they would not expire for several months. Ambulance response times for emergencies were reported to be good.

Recommendations

6.11 All providers of health, mental health and substance misuse services in the police custody suites should meet regularly to discuss operational and strategic issues.

6.12 Health staff should have access to an appropriate range of regularly reviewed and evidence-based clinical and corporate health-specific policies.

6.13 Detainees should be able to complain about health services through a well-advertised, confidential health complaints system.

6.14 Health consultations should always occur in private unless a recorded risk assessment indicates this is not appropriate.

6.15 Custody staff should have access to adequate and up-to-date stocks in the first aid kits.

Patient care

6.16 The custody sergeant or DDO referred detainees to health professionals based on need or a detainee's request. We observed respectful interactions between clinical staff and detainees.

6.17 Nurses completed an electronic custody health assessment plan (CHAP) and summarised consultations on the national strategy for police information systems (NSPIS) computer system. FMEs completed an entry on NSPIS and maintained their own records, which they took off site for storage and we were not confident there was adequate oversight to ensure information governance and storage requirements were consistently met. Clinical records we examined were appropriate.

6.18 Standardised stock medication was well organised, checked regularly, within its expiry date and stored securely in appropriate drug cupboards. Either CNPs or, in their absence,

custody sergeants checked diazepam and dihydrocodeine stocks every day. The stock count in each suite was correct; however, we were concerned that this gave custody sergeants an inappropriate additional responsibility and allowed non-clinical staff authorised access to medication cupboards. There were no systems in place to reconcile the use of other stock used. The security of drug cupboard keys was satisfactory at most sites, but poor at Brixton, where we repeatedly observed them left in the drug cupboard door or unattended on a desk.

6.19 Custody staff tried to retrieve medication from detainees' homes where appropriate; health staff checked the medicine prior to administration. Pharmacy support for medication not held in stock was available 24 hours. A new initiative at some London suites, including Croydon, allowed health staff to access the detainee's GP prescribing and allergy records directly with their consent, which improved outcomes as prescribing was confirmed promptly.

6.20 Detainees on methadone prescriptions for opiate addiction could continue their prescription. Symptomatic relief for drug and alcohol withdrawal was prescribed. Nicotine replacement therapy was not available, which might have exacerbated the distress of detention for those who smoked.

6.21 CNPs or FMEs administered medication when they were on site; when they were not available health staff placed a dose in a bag with details of the drug and administration times alongside an electronic prescription on NSPIS. DDOs or custody sergeants then supervised the detainee taking the medication, usually with another staff member witnessing the process. Custody staff we spoke to understood their responsibilities and the local policy. However, we were told of occasions, and witnessed one instance, when medication was due to be administered but the prescribing FME had not prepared the medication. Most staff said they would call the FME to attend again to address this concern; however we observed custody staff administering medication from boxes, which created a significant risk of error and breached local policy.

Recommendations

6.22 All clinical records should be stored securely in line with the Data Protection Act and Caldicott guidelines on confidentiality.

6.23 Detainees who smoke should have prompt access to nicotine replacement therapy.

6.24 Medication management processes, including the security of keys, medication administration, reconciliation of stock, counting of controlled drugs and access to drug cupboards, should consistently meet current professional standards and be verified by regular audits.

Good practice

6.25 *The initiative enabling health staff at some suites to check detainees' GP prescribing and allergy records electronically at any time supported effective continuity of care.*

Substance misuse

6.26 Support for detainees with substance misuse issues was good. Custody staff reported, and we observed, that a high proportion of detainees presented with substance misuse problems. A different substance misuse service provided embedded services at each suite, including drug testing on arrest, and offered support to all adult drug and alcohol users who agreed to be assessed or were already known to their services. There was good joint working with custody and mental health staff and CNPs. Appropriate prompt community referrals were made with detainees' consent. Liaison with prison services was effective. Detainees were informed of local needle exchange programmes if they were required. Children with substance misuse issues were referred to or directed to local age-appropriate services.

Mental health

6.27 Custody staff reported that a significant number of detainees had current or previous mental illnesses;[8] 20% (six) of the detainees in our custody record analysis had a history of mental health problems. Three of the suites had embedded criminal justice mental health services; at Sutton services were to be introduced later in 2015. Custody staff were very positive about the service. Joint working between the police and local mental health services at local and strategic levels was effective.

6.28 Detainees could refer themselves or were referred by custody staff based on the risk assessment or observations. Mental health practitioners checked if detainees were known to mental health services, shared relevant risk information with custody staff and liaised effectively with external services, including probation, prison and community mental health services. Out-of-hours support was available from the crisis team. There were effective systems to escalate any problems accessing assessments to achieve a prompt solution.

6.29 Access to Mental Health Act assessments was generally good, although all staff reported regular delays in the availability of beds in mental health facilities. Some NSPIS records we examined showed good levels of information sharing following Mental Health Act assessments, but in others it was poor. We found one instance where a detainee waited 23 hours from the time it was agreed they needed to be moved to mental health facilities before they were transferred.

6.30 Mental health practitioners at Croydon assessed all children routinely as part of an NHS England pilot to improve their access to appropriate services. In other suites children were seen if necessary and referred to specialist services as required.

6.31 The use of police custody as a place of safety for those detained under section 136 was actively discouraged within MPS. A clear policy highlighted the exceptional circumstances in which it might have been appropriate and only 20 detainees had been detained in police custody under section 136 since April 2014. A mental health street triage pilot and effective links with community mental health services assisted this process.

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8 Section 136 of the Mental Health Act 1983 enables a police officer to remove, from a public place, someone who they believe to be suffering from a mental disorder and in need of immediate care and control, and take them to a place of safety – for example, a health or social care facility, or the home of a relative or friend. In exceptional circumstances (for example if the person's behaviour would pose an unmanageably high risk to others), the place of safety may be police custody. Section 136 also states that the purpose of detention is to enable the person to be assessed by a doctor and an approved mental health professional (for example a specialist social worker or nurse), and for the making of any necessary arrangements for treatment or care.

6.32 Custody staff we spoke to demonstrated a good understanding of mental health issues and said they received additional informal input from health staff, which they found helpful.

Recommendations

6.33 The outcome of Mental Health Act assessments and any guidance to inform the detainee's care plan should be consistently and promptly recorded on the detainee's custody record.

6.34 NHS commissioners should ensure detainees who require admission to mental health facilities are transferred promptly.

Section 7. Summary of recommendations

Main recommendations

7.1 The Metropolitan Police Service should collate and use data more meaningfully, including use of force information (in accordance with the College of Policing's detention and custody authorised professional practice guidance), to allow them to manage and improve detainee care and welfare. (2.50)

7.2 Sufficient levels of staff should be provided in custody to allow for an efficient operation. This includes inspectors, custody sergeants, detention officers and health care staff. (2.51)

7.3 The Metropolitan Police Service chief officer group should engage with its counterparts in local councils, to instigate an immediate review of local authority accommodation provision under section 38(6) PACE 1984 for children and monitor performance data to ensure that children are not unnecessarily detained in police cells. (2.52)

7.4 AAs should be available 24 hours a day and staff should request they attend as soon as possible to ensure the welfare and safety of vulnerable adults and children in custody. (2.53)

7.5 Health care professionals should see detainees consistently and within agreed response times that are routinely monitored; there should be proper oversight of repeated calls and non-responses. (2.54)

Recommendations

Strategy

7.6 Met Detention South should ensure that an appropriate number of custody cases are dip-sampled; this should include checking cases against CCTV recordings so that lessons can be learned. (3.20)

Treatment and conditions

7.7 Women detainees should be informed that they can speak to a female officer if they wish and told of the availability of hygiene products. (4.8)

7.8 Girls under 18 should be allocated a named female officer responsible for their care while in custody. (4.9)

7.9 All suites should have a small supply of thick mattresses. (4.10)

7.10 The Metropolitan Police Service should monitor the average waiting time from detainees' arrival in custody to detention being authorised to ensure that detainees are booked in promptly. (4.19)

7.11 Anti-ligature knives should be available on keys for staff who undertake cell visits. (4.20)

7.12 All custody staff should be involved in the same shift handover. (4.21)

7.13 The Metropolitan Police Service should be confident that strip-searching in all cases has a recorded rationale, and investigate why strip-searches are carried out more frequently at Brixton than at other custody suites. (4.28)

7.14 Detainees should be admitted to the custody suite promptly; handcuffs should be removed from detainees after arrival, unless a risk assessment indicates otherwise. (4.29)

7.15 The police service should take action to address the potential ligature points in the toilets at Wandsworth and embedded sinks at Brixton, Croydon and Wandsworth. (4.35)

7.16 All suites should hold a stock of suitable reading material in a range of languages and in an easy-read format, as well as books that are suitable for children. (4.40)

7.17 Visits should be arranged, particularly for children, vulnerable detainees and those who remain in custody for longer periods. (4.41)

7.18 Detainees should have access to exercise and showers, particularly if they remain in custody for longer periods. (4.42)

Individual rights

7.19 The Metropolitan Police Service should ensure that operational officers are fully aware of and comply with the requirements of the necessity criteria as detailed in PACE code G. (5.12)

7.20 The police service should monitor how long detainees are held to ensure they are dealt with expeditiously and released as soon as the need for detention no longer applies. (5.13)

7.21 Reviews of detention should be conducted as detailed in the PACE code C. (5.22)

7.22 The Metropolitan Police Service should review its policies and procedures for managing the refrigerators and freezers in the custody suites to ensure samples are submitted promptly. (5.23)

7.23 Senior police managers should work with HM Courts and Tribunals Service and Prison Escort and Custody Services to ensure that early closure times at local remand courts and the working practices of the virtual court at Camberwell Green Magistrates' Court do not result in inappropriately long stays in police custody. (5.24)

7.24 Detainees should be able to make a complaint while they are still in custody. (5.26)

Health care

7.25 All providers of health, mental health and substance misuse services in the police custody suites should meet regularly to discuss operational and strategic issues. (6.11)

7.26 Health staff should have access to an appropriate range of regularly reviewed and evidence-based clinical and corporate health-specific policies. (6.12)

7.27 Detainees should be able to complain about health services through a well-advertised, confidential health complaints system. (6.13)

7.28 Health consultations should always occur in private unless a recorded risk assessment indicates this is not appropriate. (6.14)

7.29 Custody staff should have access to adequate and up-to-date stocks in the first aid kits. (6.15)

7.30 All clinical records should be stored securely in line with the Data Protection Act and Caldicott guidelines on confidentiality. (6.22)

7.31 Detainees who smoke should have prompt access to nicotine replacement therapy. (6.23)

7.32 Medication management processes, including the security of keys, medication administration, reconciliation of stock, counting of controlled drugs and access to drug cupboards, should consistently meet current professional standards and be verified by regular audits. (6.24)

7.33 The outcome of Mental Health Act assessments and any guidance to inform the detainee's care plan should be consistently and promptly recorded on the detainee's custody record. (6.33)

7.34 NHS commissioners should ensure detainees who require admission to mental health facilities are transferred promptly. (6.34)

Housekeeping points

Treatment and conditions

7.35 Mattresses and pillows should be cleaned between uses. (4.43)

7.36 All detainees should be offered a blanket. (4.44)

7.37 Replacement underwear should be available in all custody suites. (4.45)

Good practice

7.38 The initiative enabling health staff at some suites to check detainees' GP prescribing and allergy records electronically at any time supported effective continuity of care. (6.25)

Section 8. Appendix: Inspection team

Maneer Afsar	HMIP team leader
Vinnett Pearcy	HMIP inspector
Kellie Reeve	HMIP inspector
Fiona Shearlaw	HMIP inspector
Clive Burgess	HMIC lead staff officer
Anthony Davies	HMIC staff officer
Majella Pearce	HMIP health services inspector
Kathleen Byrne	Care Quality Commission inspector
Andrea Josephs-Crosby	Care Quality Commission inspector
Helen Ranns	HMIP researcher
Joe Simmonds	HMIP researcher