Report on an inspection visit to police custody suites in Greenwich Borough Operational Command Unit

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by

HM Inspectorate of Prisons and

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1. Introduction

This report is part of a programme of inspections of police custody carried out jointly by our two inspectorates. These inspections form a key part of the joint work programme of the criminal justice inspectorates. They also contribute to the United Kingdom's response to its international obligation to ensure regular and independent inspection of all places of detention.[1] The inspections look at strategy, treatment and conditions, individual rights and health care.

The London Borough of Greenwich has one principal designated custody suite in Plumstead which is open 24 hours a day, has 24 cells and holds both adults and juveniles. A second part-time facility in Greenwich is used for various operational contingencies, for example football matches. In the year ending 31 March 2010, Plumstead received 8,671 detainees, while Greenwich received 106 detainees. As well as visiting both suites for this announced inspection, inspectors were also informed by a survey of prisoners at HMP Belmarsh who had previously been held in the borough's police cells.

Strategic oversight of the suite was provided by the Metropolitan Police Service (MPS) central custody directorate which seeks to ensure consistency across London boroughs by issuing standard operating procedures. Day to day management is devolved to the borough operational command unit (BOCU). The Metropolitan Police Authority (MPA) has responsibility for the estate and manages an active body of independent custody visitors, although there continues to be no MPA member with a lead role for custody.

Management oversight of the suites was adequate, but could be developed further: for example by way of more rigorous sampling of custody records and improved management information. In particular, there was a lack of appropriate monitoring of the use of force, both locally and London-wide. Staffing numbers were sufficient, staff were properly trained and felt well supported by managers. There was some good partnership working and particularly effective arrangements were in place to divert the mentally ill from custody.

The physical environment was reasonable, although plans to upgrade the suites had been shelved and this left Greenwich with insufficient capacity. The booking-in desks were poor and allowed little privacy. Excellent relationships were observed between staff and detainees, and efforts were made to address the particular vulnerabilities of detainees. De-escalation of volatile detainees was well managed. As we often find, some basic hygiene needs, for example showers and toilet paper, were only available on request.

Records and observations indicated that the provisions of the Police and Criminal Evidence Act were properly adhered to, although this also meant that appropriate adults were not automatically sought for 17-year-olds. Staff reported good working relationships with the United Kingdom Border Agency but were concerned by delays in moving immigration detainees out of police custody. Arrangements for managing DNA and forensic samples were good. Basic pre-release assessments were carried out but complaints procedures were confused.

The quality of health care was mixed and the BOCU needed to ensure more robust monitoring of provision. Clinical governance arrangements were unclear and infection control in clinical

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

rooms needed to be improved. However, medicine management was good and levels of staff training were high. Mental health services were good and substance misuse support was comprehensive.

Overall, this inspection of police custody in Greenwich paints a generally positive picture, although we point to a number of areas where improvements could be made. Accordingly, this report sets out a number of recommendations that we believe will assist the MPS and MPA to improve the quality of custody provision. We expect these recommendations to be considered in the wider context of priorities and resourcing, and for an action plan to be provided in due course. Some recommendations also have national implications and we will progress these directly with the appropriate authorities.

Sir Denis O'Connor
HM Chief Inspector of Constabulary

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June 2010

2. Background and key findings

2.1 HM Inspectorates of Prisons and Constabulary have a programme of joint inspections of police custody suites, as part of the UK's international obligation to ensure regular independent inspection of places of detention. These inspections look beyond the implementation of the Police and Criminal Evidence Act 1984 (PACE) codes of practice and *Safer Detention and Handling of Persons in Police Custody* 2006 (SDHP) guide, and focus on outcomes for detainees. They are also informed by a set of *Expectations for Police Custody*[2] about the appropriate treatment of detainees and conditions of detention, which have been developed by the two inspectorates to assist best custodial practice.

2.2 The Metropolitan Police Service (MPS) has 77 custody suites designated under the PACE 1984 for the reception of detainees. Twenty-five are 'overflow custody suites', used for various operational matters such as charging centres for football matches, Operation Safeguard (the housing of overspill prisoners) or immigration detention. The remaining custody suites operate 24 hours a day and deal with detainees arrested as a result of mainstream policing.

2.3 This announced inspection was conducted at the Plumstead custody suite in the London Borough of Greenwich. A second part-time custody suite at Greenwich was also visited. Inspectors examined force-wide and borough custody strategies, as well as treatment and conditions, individual rights and health care in the custody suite. A survey of prisoners at HMP Belmarsh who had formerly been detained in the suite was conducted by HM Inspectorate of Prisons researchers and HM Inspectorate of Constabulary inspectors.

2.4 Plumstead custody suite had 24 cells open 24 hours a day holding adults and juveniles. The suite had received 8,671 detainees in the year to 31 March 2010, including 111 immigration detainees. Greenwich was opened for specific police operations or when Operation Safeguard was running and had held 106 detainees in the same period.

Strategic overview

2.5 The MPS custody directorate within the Emerald territorial policing team had strategic oversight of custody in all boroughs in London. Standard operating procedures (SOPs) were issued to boroughs and aimed to assist in the delivery of a consistent level of service in custody. The Metropolitan Police Authority (MPA) had responsibility for the custody estate and the official who managed the independent custody visitors (ICV) scheme also had lead responsibility for reporting on custody matters to the MPA, but there was no member of the authority with a lead for custody. The local ICV scheme was active and the borough operational command unit (BOCU) was responsive to it.

2.6 Plans to upgrade the custody estate had been put on hold, but there was insufficient cell capacity in the BOCU to meet demand and therefore regular overspill to neighbouring BOCUs. Responsibility for day-to-day management of the custody suite and delivery of services had been devolved to BOCUs and therefore rested with the BOCU commander, who was a chief superintendent. There was a clear management structure overseeing custody and staff felt well supported, although some key formal oversight arrangements were under-developed. Very limited dip sampling of custody records was taking place and the quality of those we

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

reviewed was generally poor. There was a lack of management information to support the strategic management of provision.

2.7 Staffing numbers in custody were sufficient and a permanent custody staffing model had been introduced. Staff received approved training before working in custody and some refresher training was available.

2.8 Some good partnership work was evident. Good practice information was circulated to staff. There was no BOCU-wide collation of information on the use of force to enable trends and patterns to be analysed.

Treatment and conditions

2.9 We observed excellent relationships between staff and detainees and staff had some understanding of how juveniles and females could be particularly vulnerable in custody, although there was scope to develop this further. Access for detainees with physical disabilities was adequate, but there were no adapted cells. A hearing loop was provided. A range of materials for observing major faiths was available.

2.10 The booking in desks were poor and cramped, resulting in very limited privacy for detainees arriving in custody. Staff completed risk assessments on new arrivals and those we observed were good, but this was not always evident in written records. Staff understood the importance of rousing and carried anti-ligature knives. Handovers between shifts were good and time was built in for this to happen.

2.11 Staff were encouraged to use de-escalation techniques, even with difficult or aggressive detainees. Handcuffs were usually removed on arrival in custody.

2.12 The physical environment was reasonable and cleanliness was very good, with almost no graffiti. An outside exercise yard was rarely used. A small number of ligature points were found in cells.

2.13 Showers were rarely offered. A mattress and pillow were routinely provided and cleaned between uses, but blankets and toilet paper had to be requested. The use of cell call bells was not explained to detainees, but bells were regularly tested. Fire evacuation arrangements were adequate. The food was adequate, but reading materials and visits were rarely offered.

Individual rights

2.14 Custody sergeants checked that arrest and detention were appropriate. Custody was not used as a formal place of safety for children and young people under section 46 of the Children Act 1989. Staff reported good working relationships with the UK Border Agency (UKBA), but there could be delays in moving immigration detainees. Telephone and face-to face interpreting services were used. Rights and entitlements information was available in a range of languages. Detainees with dependency obligations were offered support. Pre-release risk assessments were carried out.

2.15 PACE was adhered to. Defence solicitors reported good working relationships with staff, but responses to our survey indicated delays in seeing them. Appropriate adult (AA) provision was reasonable during the working day, but less reliable out of hours. Police adhered to the PACE definition of a child, which meant 17 year olds were not routinely provided with an AA.

Arrangements for managing detainee DNA and forensics were good. Early court cut-off times were particularly problematic for the youth court and the virtual court pilot was in operation.

2.16 Detainees were not told how to make a complaint and staff were confused about the process for taking them. While more serious issues were referred to the duty inspector, detainees complaining about lower level issues were sometimes referred to the front of the police station on release.

Health care

2.17 Governance arrangements for health care were managed centrally by the MPS. Clinical governance arrangements were unclear and there was little ownership of the provision in the BOCU. Robust monitoring and policies were lacking to ensure provision was meeting needs and management arrangements were not systematic.

2.18 The clinical rooms were clean, but infection control needed to be improved. The management and stocking of medications was good. Recording of checks of defibrillators was good, staff were properly trained and first aid kits well maintained.

2.19 Our custody record analysis indicated that the average wait for a forensic medical examiner (FME) was just 42 minutes. Most FMEs had access to the national strategy for police information systems (NSPIS) custody system.

2.20 Drug and alcohol services were comprehensive and included support for those with alcohol-related problems, but needle exchange was not provided on site. Symptomatic relief was provided when needed.

2.21 Mental health services were good. There were well developed relationships between the police and providers and few Section 136 patients were taken into police custody.

Main recommendations

2.22 The Metropolitan Police Service should monitor the use of force locally and at a force-wide level, for example by ethnicity, location and officer involved.

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

2.24 Detainees should be told how to make a complaint and they should be facilitated to do so.

3. Strategy

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

3.1 The MPS had a custody directorate led by a commander within territorial policing headquarters. Day-to-day management of the custody directorate was delivered by a detective superintendent. There was an internal inspection function, with mechanisms to ensure compliance with inspection findings. Responsibility for day-to-day management of custody suites and delivery of services had been devolved to BOCUs. Accountability therefore rested with the BOCU commander, who was a chief superintendent. There was no MPA lead for custody, but a MPA official managed the ICV scheme and had lead responsibility for reporting on custody issues.

3.2 The Emerald commander sat on the programme board for SDHP and was clearly focused on ensuring an emphasis on 'professionalising custody'. He was also preparing to introduce integrated prosecution teams, and 'virtual courts' were being piloted through video links in some custody suites.

3.3 Policies were signed off at a strategic command level in the MPS and the custody directorate provided SOPs that supported delivery of force policies by custody suites in each London BOCU. The SOPs covered a broad spectrum, 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 help BOCUs deliver consistent levels of service.

3.4 The MPS's asset management plan had stalled due to the wider economic situation, which had led to 'rephasing' of the building plans prioritised by most pressing need. The borough of Greenwich was challenged by the capacity and age of its estate. There did not appear to be any immediate plans for major improvements or capacity building, but the throughput of detainees at Plumstead was putting increasing pressure on custody staff and cells and was not sustainable in the long term. Maintenance at Plumstead could usually be carried out when facilities were open, although more substantial work meant the custody suite would be closed and arrangements made to accommodate detainees elsewhere. The suite was also tired and showing its age, but reasonably well maintained and clean.

3.5 A full-time inspector was the custody suite manager, although she had a range of other responsibilities. A full-time dedicated custody manager was due to start work at the beginning of May 2010. Ten full-time permanent police sergeants (custody officers) were 'posted' into the custody role, one of whom was responsible for 'bail to returns'. The staffing model worked well and the duty scheme had good overlapping periods built in when staff could hand over to the oncoming shift. The BOCU had seven designated detention officers (DDOs), but this was due to increase to 24 by the end of 2010 as part of Project Herald (workforce modernisation). This increase meant the BOCU would no longer need to use untrained PC gaolers to augment the DDOs, which was an area of weakness that increased risks to detainees, staff and the MPS.

3.6 Apart from police constable (PC) gaolers, all staff had received nationally approved custody training delivered corporately before being deployed in the custody suite. All custody officers had received a corporate refresher training package that was delivered every 12 to 18 months.

3.7 The MPS had recruited teams of nurses for six stations to complement the level of health care provided by its doctors. The aim was to recruit 200 nurses by 2012 to ensure that each BOCU had a nurse on duty 24 hours a day. They were not yet available at Greenwich, but were expected to arrive in due course as part of the rollout of Project Herald.

3.8 The BOCU commander did not attend local criminal justice board (LCJB) meetings. The BOCU had recently provided a chief inspector to Operation Springboard, a joint initiative with the Crown Prosecution Service (CPS) involving four linked BOCUs that aimed to improve criminal justice outcomes. Greenwich therefore shared the LCJB meeting with Lewisham BOCU. A superintendent attended for Lewisham and an acting detective chief inspector (DCI) for Greenwich. The BOCU commander said the acting DCI was able to make decisions on behalf of the Greenwich senior management team (SMT), but we were surprised no SMT member attended.

3.9 Relationships with the CPS were described as good, with clear case management escalation routes when there were different opinions on how criminal cases should be progressed. The BOCU commander met with the Chief Crown Prosecutor (CCP) every month and the regional CCP regularly.

3.10 The BOCU had very positive relationships with mental health teams and as a matter of course mentally ill people did not enter the custody suite. Protocols were comprehensive and well established. Excellent use was made of available management information to problem-solve underlying issues, which benefited patients, the hospital and the police (see section on health care). We were very impressed with improvements as a result of their investment of dedicated resources.

3.11 There were no obvious concerns about detainees held on behalf of the UK Border Agency (UKBA) except that the SMT believed they were held for a day or less whereas custody staff said it was closer to four or five days. The lack of management information on detainees, particularly immigration detainees, meant it was not possible to determine the actual length of time they were held.

3.12 There was a MPA lead for the ICV scheme, which was viewed by all parties as an important independent oversight mechanism. ICVs were focused on detainee welfare and visited fairly regularly, but were meeting only 70% of their target for custody visits. This was partly due to a low number of panel members, which had recently been addressed with the recruitment of two more. Feedback reports were prepared after each visit and a MPA administrator put together summary reports for quarterly ICV panel meetings. Issues of concern identified by ICVs were addressed immediately by the custody sergeant or more longer-term issues by the custody manager, with progress reports supplied to ICVs every six weeks. ICVs reported good relationships with custody staff compared to two to three years previously.

3.13 The SMT lead for custody was the acting DCI. He attended the daily management meetings (DMMs) with the BOCU commander. Custody issues were raised on an exception reporting basis. DMMs enquired into custody issues, but mainly from the perspective of investigating incidents or crimes and therefore lacked a strategic focus. However, the SMT had developed a detailed 65-point action plan, which the BOCU commander expected the incoming dedicated custody manager to own and implement. A custody users group (CUG) met quarterly, but no SMT member attended which risked a disconnect between strategy and delivery. The custody manager attended quarterly custody manager meetings organised and managed by the custody directorate.

3.14 The culture among staff in the custody suite was positive and respectful. Quality assurance checks were carried out by the custody manager when PACE reviews on detainees were completed. The BOCU was required to dip sample 10% of custody records a month, but was not achieving this and checks were somewhat ad hoc with no cross-reference to CCTV recordings. Identified learning points were emailed to custody sergeants for their information and any positive or negative issue identified with staff were addressed with them individually.

3.15 The MPS struggled to provide comprehensive management information from within the NSPIS custody system, even though it was possible to extract this using the NSPIS 'business objects' reporting model. Consequently, individual BOCUs could not get relevant and timely management information to support strategic planning and staffing models and inform performance around investigative decisions. Despite this, Greenwich BOCU was using basic features of 'business objects' to inform custody business.

3.16 Newsletters from the custody directorate provided information and advice on detainee supervision and identified health and safety learning points gleaned from investigating successful interventions and near misses. The custody directorate also circulated the Independent Police Complaints Commission (IPCC) 'Learning the Lessons' newsletter.

3.17 Information on the use of force in custody suites was not collated at a local or force-wide level. Officers and staff recorded the use of force against detainees in their custody records and police officers recorded it in their evidential pocket note books. Therefore, there was no management information accessible from a local or force-wide perspective (see main recommendation).

Recommendations

3.18 The Metropolitan Police Authority should allocate one authority member as lead for custody.

3.19 The Metropolitan Police Service should review its provision of cell capacity at Plumstead and improvement plans should be developed and instigated as soon as practicable.

3.20 The borough operational command unit should hold formal custody meetings that include senior management team attendance.

3.21 The Metropolitan Police Service should provide BOCUs with relevant management information about a range of custody related matters to enable them to critically focus on important strategic issues.

3.22 The Metropolitan Police Service should urgently address the force-wide and borough shortcomings in terms of extracting management information from NSPIS to focus critical thinking, including the structural processes and IT deficiencies that inhibit this.

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 were brought to the station in police vans and cars and, if appropriate, Serco – the contracted detainee escort provider – escorted them to and from court. Detainees we talked to had no complaints about their experience in transit or the conditions of the vehicles. Custody sergeants made sure detainees understood what was being said and took care when eliciting personal information for custody records and to inform risk assessments. The custody desk was small, with four terminals close together, so did not offer any privacy for detainees being booked in or responding to personal questions (see main recommendation). Staff wore name badges and usually addressed detainees by their first names. All detainees we spoke to said they had been treated respectfully and politely by custody staff. Women were given the opportunity to speak to a female member of staff and cells allocated for female detainees were separate from the cells for males.

4.2 Custody staff had attended the Every Child Matters training and understood the need to treat children and young people sensitively. We saw young people accompanied by a parent acting as an appropriate adult who were allowed to sit with them in the open custody suite rather than in a cell. The designated cells for children and young people were separate from other cells and close to the custody desk, but were otherwise identical to adult cells. There were no nearby shower facilities so any child or young person wanting a shower had to use one on the adult corridors.

4.3 Custody staff understood child protection procedures. However, children and young people were not kept separate from adults at the custody desk and custody sergeants said there was no formal process to ensure they did not come into contact with schedule one offenders[3]. Custody sergeants said children and young people were strip-searched only in exceptional circumstances and, if possible, in the presence of an appropriate adult. However, these searches had occasionally taken place without an appropriate adult when intelligence suggested that the safety of the young person or staff might otherwise be compromised.

4.4 None of the cells had wheelchair access and none had been adapted for use by detainees with a physical disability. One cell had a hearing loop and we spoke to one deaf detainee who had been given regular access to a signer and was very satisfied with the service provided. Copies of relevant religious faith books as well as prayer mats and compasses were available.

3 Persons convicted of an offence listed in schedule one of the Children and Young Person Act 1933 against a child or young person under the age of 18 years.

Safety

4.5 In our survey, 61% of detainees, significantly worse than the comparator of 39%, said they had felt unsafe, but detainees we spoke to during the inspection all said they felt safe and well looked after. Staff said their safety training had equipped them to do the job.

4.6 Custody sergeants assessed detainees on arrival for any potential self-harm and suicide issues, physical and mental health, and drug or alcohol dependency. Risk assessments were based on observation, previous knowledge of the detainee and current personal information. All risk assessments we saw covered the frequency of observations, the need for a health care intervention and an appropriate adult. However, the custody record of one vulnerable woman with mental health problems placed on constant watch did not adequately reflect the ongoing care taking place and omitted significant details such as her racial abuse of the doctor and her pre-release plan.

4.7 We did not see written care plans for particularly vulnerable people, but heard custody sergeants advising DDOs of the needs of detainees they were concerned about and this information could be shared with the next shift at formal handovers. The constant watch protocol was new and not yet fully embedded in practice.

4.8 Staff routinely roused detainees when appropriate and at unpredictable times. Ten cells had CCTV cover and images could be viewed on five screens from the custody desks. Pictures were grainy, but staff did not overly rely on them and regularly checked on detainees as well. The level of observations was changed if there were any concerns about a detainee's welfare and we saw DDOs talking to detainees and answering questions. Some detainees said the purpose and use of cell bells had not been explained to them. Cell bells were mostly responded to promptly, although one detainee said staff had taken five minutes to respond to his bell. All custody staff carried ligature knives, but only DDOs and PC gaolers always carried the keys to cells. Cell keys were also kept behind the custody desk.

4.9 Custody staff were given advance warning before a violent detainee arrived and were familiar with the procedures for managing such detainees in the custody suite.

Use of force

4.10 Staff received regular training in restraint and de-escalation techniques and were clear that force should be used only as a last resort. We saw staff successfully calm down a fractious detainee who could easily have become violent while other detainees were appropriately moved out of the area. Custody staff did not carry incapacitant sprays or Tasers. Health care staff were called after force was used only if the detainee complained of pain or if there were any visible signs of injury. Use of force was recorded in custody records, but not centrally (see section on strategy).

Physical conditions

4.11 The BOCU had a total of 16 cells for male detainees, four for females and four for children and young people or vulnerable adults who needed CCTV or constant watch. Cells had little natural light and only 5% of detainees in our survey, significantly worse than the comparator of 20%, said the ventilation and air quality were good. Smoking was not allowed and smokers were not offered nicotine replacement therapy.

4.12 Cleaners worked at the suite from 8am to 4pm every day. All cells were clean, in good decorative order and with little graffiti apart from some remaining on toilet seats despite efforts to remove it. DDOs checked cells before use and took a zero tolerance approach to any detainee who damaged or defaced them. Cell bells were checked before and after each cell was used and any found to be broken were repaired within two hours of an engineer being notified. The vast majority of ligature points had been carefully filled in, although there were some issues with old toilet seats.

4.13 Fire bells were tested weekly. Staff were aware of fire evacuation procedures and notices to follow the custody sergeant's instructions were displayed, but there had been no fire evacuation drills. A fire evacuation policy kept behind the custody desk was reviewed annually and had been updated in April 2010. There were enough sets of cuffs available to evacuate the custody suite safely.

Personal comfort and hygiene

4.14 All cells contained a clean mattress and pillow. There were enough blankets and these were clean and in good condition. Hygiene packs for women were available, but were not routinely offered.

4.15 All cells contained a toilet, but these were not screened and some, particularly in cells for female detainees, were clearly visible through the viewing glass. Toilet areas in cells covered by CCTV were blocked out, but this offered little privacy and one woman said she was too embarrassed to use the toilet. Toilet paper had to be requested. Detainees washed their hands at basins in the corridors and there were adequate supplies of soap and paper towels.

4.16 There were three showers, one of which was in the corridor for female detainees. All worked, but none offered much privacy and two female detainees said this would prevent them having a shower. Showers were not routinely offered and only paper towels were provided.

4.17 Detainees whose clothing was seized were given a clean track suit bottom, T-shirt and plimsolls. The clothing store contained suitable replacement clothing in a range of sizes, but no underwear. Paper suits were also available, but staff said they were rarely used. Friends and families were not encouraged to bring in a change of clothes, although this was possible for immigration detainees who often stayed for longer.

Catering

4.18 Most food was prepared by the station canteen and detainees said it was served at regular times throughout the day. There was a reasonable choice, including a good range of microwavable halal options and a slightly more limited range for vegetarians. DDOs said they would microwave more food if a detainee was still hungry after eating. One detainee said he could not eat any of the food offered due to various allergies, but we later heard a custody sergeant explaining his requirements to a DDO. Few detainees said they liked the food and most said it was not hot enough. Water and hot drinks were offered regularly.

Activities

4.19 The small exercise yard was reasonably clean, but rarely used. None of the detainees we asked had been offered the opportunity to use it and some did not know it was there. There were a few books and old magazines, but these were not particularly suitable and were not

routinely offered to detainees. Families and friends of detainees held for long periods were allowed to visit.

Recommendations

4.20 There should be a formal process to ensure that children and young people do not have contact with schedule one offenders.

4.21 Some cells should be adapted for use by detainees with physical disabilities.

4.22 Managers should ensure that custody records include more detail of significant events that occur during a detainee's detention.

4.23 The proper use of the cell bell should be explained to detainees when they enter a cell.

4.24 Ventilation in cells should be improved.

4.25 Subject to individual needs assessment, nicotine replacement should be available to detainees.

4.26 All female detainees should be offered a hygiene pack on arrival.

4.27 All cell toilets should be effectively screened.

4.28 All cells should have a supply of toilet paper.

4.29 All detainees held overnight and those who are dirty should be offered a shower, which they should be able to take with an appropriate degree of privacy.

4.30 Detainees held for over 24 hours should be offered outdoor exercise.

Housekeeping points

4.31 Replacement underwear should be made available if it is required.

4.32 Food provided for detainees should be served at the correct temperature.

4.33 Those held in custody should be offered a range of suitable reading material.

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 We observed custody sergeants taking proper account of the reports from arresting officers to ascertain that detention was lawful and appropriate and challenging this when necessary. Immigration detainees could be kept at the police station for up to five days. The custody suite was not used as a place of safety for children and young people under section 46 of the Children Act 1989, although the police station, usually the canteen, had been used to look after children before social services arrived.

5.2 Custody sergeants advised detainees of their rights and entitlements. All detainees we spoke to had been offered a free telephone call to let someone know where they were. These calls took place at the DDO desk next to the custody desk, which was adequate, but not very private.

5.3 A professional telephone interpreting service was used for detainees with little or no English and there was a register of interpreters able to attend the custody suite. Relevant information was available in a range of languages, but nothing in easy-read format for detainees with learning difficulties.

5.4 Custody sergeants routinely asked detainees about any dependants. We spoke to three detainees with dependants, one of whom was still breast-feeding her child. All had been asked about dependants, all were happy with the arrangements made and all had been able to make a telephone call to check on their children.

5.5 A pre-release risk assessment was conducted in all cases and details of support organisations were offered to all detainees before release. Custody sergeants said that, with the detainee's agreement, they would ask the arresting officer to make a referral to a support agency. Detainees could use the telephone to arrange transport and we saw one detainee with mental health problems driven home in a police car after staff had checked this arrangement with the social worker.

Rights relating to PACE

5.6 Up-to-date copies of PACE were available and given to detainees and we saw one detainee reading a copy in his cell. Detainees were not interviewed while under the influence of drink or drugs.

5.7 Detainees were offered the opportunity to get free legal advice, including from immigration specialists, through the duty solicitor scheme. Staff also facilitated contact with personal solicitors on request. Waits for legal advisers were usually between one and two hours, although 91% in our survey, significantly worse than the comparator of 63%, said they had waited four hours for a solicitor. Detainees and legal representatives could obtain copies of their custody records and were informed of this right through the rights and entitlements leaflet.

5.8 Custody sergeants tried to use parents and carers as appropriate adults for children in the first instance. The appropriate adult service was managed by Catch 22, a local voluntary organisation that offered a service to children and young people under the age of 17, vulnerable adults and those with learning difficulties. The service operated from 9am to midnight on weekdays, with the social services emergency duty team covering weekday nights and weekends. There was one trained volunteer and a back up to cover. They took part in interviews in the presence of a solicitor and only when satisfied that no family member could act as an appropriate adult. They made written records and always contacted the parent or carer of a child or young person so let them know they had been involved. Police adhered to the PACE definition of a child instead of that in the Children Act 1989, which meant those aged 17 were not routinely provided with an appropriate adult unless otherwise deemed vulnerable[4].

5.9 The management of DNA and forensic samples was good. The only minor issue identified was some confusion among staff whereby a small number of DNA samples had not been submitted as promptly as they should have been and were listed as 'missing' on the Police National Computer despite being in the BOCU freezer.

5.10 The cut-off time for the nearby Woolwich Magistrates Court was 2pm and staff said later arrivals were sometimes accommodated. However, the cut-off times for the youth court at the Camberwell Green Magistrates Court were noon on weekdays and 11am on Saturdays and the hour-long journey there meant some children and young people were delayed in appearing before it. The virtual court was used frequently. It provided services until 6.45pm and had a DDO assigned specifically to it.

Rights relating to treatment

5.11 Detainees were not routinely told of their right to complain and we were told that custody staff were instructed to send anyone wanting to make a complaint to the front office (see main recommendation). Complaints were not centrally recorded. Any complaints made in custody were recorded on the custody record and the duty inspector made aware.

Recommendations

5.12 Rights and entitlements information should be available in a range of formats to meet specific needs.

5.13 The BOCU should instigate discussions with the managers responsible for the duty solicitor scheme to ensure detainees have timely access to legal advice.

5.14 Appropriate adults should be deployed to support juveniles aged 17 and under.

Housekeeping point

5.15 The borough operational command unit should ensure that staff are clear on DNA policies and that samples are submitted promptly to the National DNA Database.

[4] Although this met the current requirements of PACE, in all other parts of the criminal justice system, and international treaty obligations, 17 year olds are treated as juveniles. The UK government has committed to bringing PACE into line as soon as a legislative slot is available.

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.

Clinical governance

6.1 Custody staff were mindful of detainees' health needs and DDOs adopted a caring approach, but 26% in our survey said the quality of health care received in custody was very bad. Female FMEs were not always on duty, but efforts were made to access one on request and female chaperones were provided. Interpreting services were widely used. Custody staff said the FME service was generally good and that they would not hesitate to report back any access problems, but some felt the introduction of agency locum doctors had caused minor problems. There was no formal structure to verify locum doctors' qualifications. Clinical governance arrangements for FMEs were not robust and it was unclear how the FMS assured itself that there were adequate structures to ensure the management, training, supervision and accountability of FMEs. Each FME was responsible for maintaining their own professional registration and ongoing professional training.

6.2 The new FME contract had been in force for a year and some staff felt it had resulted in increased delays in FMEs attending custody suites. Most FMEs responded within agreed timelines, but local transport links were often busy and congested. Custody staff did not hesitate to call an ambulance if they were concerned about a detainee's health. Not all FMEs were approved clinicians under Section 12 of the Mental Health Act and their backgrounds were from various medical specialties. One custody sergeant was the identified point of contact for FMEs, but regular meetings between them had not taken place for some time. One of the DDOs was delegated to assist the FME and ensure detainees' welfare needs, including health, were met. The DDO basic training incorporated some elements of mental health awareness training.

6.3 The FME room at Plumstead was close to the main custody area and was in good order, neat and tidy. However, it had no privacy screen for use during a physical examination and there was no sheet or blanket to cover detainees being examined. The room was visible to anyone in the custody area, including detainees, their families and legal representatives. The door was left open during consultation, we were told for security reasons, which potentially compromised privacy and medical confidentiality.

6.4 Infection control systems were not robust and there was no evidence that an infection control audit had been carried out at either station.

6.5 Cleaning schedules were not displayed in either station and there was no evidence that cleaning schedules were monitored. The taps were not elbow taps. However, both rooms appeared to be clinically clean.

6.6 A small number of the examination/swab kits were out of date and sanitary products were held in the Plumstead FME room. The FME room was checked daily by one of the DDOs.

6.7 The FME room at Greenwich was generally very clean, although there was no privacy screen and the cover on the examination couch was unsuitable. Only small amounts of over-the-

counter pain relief and sickness medicines were held. The overall management of medicines at the station was generally very good. There was no evidence of over-stocking and controlled drugs were checked at the staff changeover of every shift, although we found a small stock of five rectal Diazepam that had not been recorded.

6.8 The auditing of medication at Plumstead was well managed by senior custody staff. Medicines were held in locked cupboards, with the key kept behind the custody desk and accessible only to FMEs or custody sergeants. Staff said small amounts of medication had been missing in the past, but thought this was probably because FMEs did not record all medicines administered to detainees.

6.9 Emergency equipment, including a defibrillator, was easily located behind the custody desk. It was in date and checked at each shift change. Staff knew how to use it and received emergency life support training every six months.

Patient care

6.10 A published FME rota provided the name and telephone number for custody staff to call for medical assistance. FMEs could work for up to two six-hour shifts. Calls to FMEs and response times were entered on the custody record. Any complaints about health-related issues were followed up by custody staff.

6.11 Detainees were asked if they were on prescribed medication and, if necessary, officers collected personal medication from a detainee's home. They were seen by an FME and treatment was continued if appropriate. Records of administration were kept on the custody record and custody staff were alerted when a detainee needed to receive medication. Custody staff could administer medication sanctioned by the FME, but only the FME administered controlled drugs. Substance users registered with a GP or drug services could get symptomatic relief. Administration of Methadone was very limited and depended on the individual FME. Following strict guidelines and to ensure a negligible risk of overdose, detainees could not receive Methadone until at least six hours after their arrival in custody.

6.12 All FMEs said they provided custody staff with a care plan on NSPIS containing enough clinical information for them to manage the health care of detainees while in custody. Some said they would give legal representatives a copy of the detainee's clinical notes on request.

6.13 There was little consistency in the management of clinical records held by FMEs. FMEs we spoke to said they held patients' notes in their private residences in various storage facilities. The old medical record books (Book 83) were rarely used.

Substance use

6.14 Drug services were provided by the crime reduction initiative, a registered charity. A generic drug intervention programme (DIP) worker was based in the custody area on weekdays between 8am and 10pm, but only 18% in our survey said they had been offered the services of a drug worker. The DIP workers rotated through a system covering the community, custody suites and magistrates courts, so could follow the progress of substance users through the judicial process. The DIP workers went to all cells several times a day offering support to known substance users and new clients. Detainees taken into custody overnight were checked in the morning and anyone testing positive to drugs was assessed and followed up in custody and on release. The workers liaised with custody sergeants at every shift change and were alerted whenever an offence triggered a drug test. Where necessary, a care plan was

completed and detainees were signposted to community services. Needle exchange was not available to detainees released from custody, but they were given details of local GPs, Accident and Emergency departments and needle exchange facilities.

6.15 The prevalence of alcohol users was said to be greater than those dependent on other substances. Detainees with alcohol addiction were signposted to a local charity specialising in alcohol dependence. Many detainees seen by the DIP workers had a dual diagnosis. Those with dual diagnosis of mental health and substance use-related mental illness were well supported by the DIP workers, who were prepared to accompany them to specialist psychiatric appointments if requested. They could also support homeless users to identify housing needs.

Mental health

6.16 Mental health services were provided by the Oxlea NHS Foundation Trust. Joint protocols between the police, the Trust, the local authority and the London Ambulance Service had been published in 2008 and were based on best practice. They were detailed and incorporated a wide range of issues, including Section 136 access, Section 135 (mental health assessment on private premises) and risk management.

6.17 No mental health workers were based at either station, but relationships between the police and the Trust were excellent and custody staff said they received robust support when necessary. The Trust indicated that it also received timely response from the police where appropriate. A multi-agency meeting was held every six weeks to review and progress the strategy. A police mental health liaison officer attended the approved mental health professional (AMHP) meeting every three months. The Trust recognised the need to improve training for the police, especially in light of changes in mental health law, and this was due to be discussed at the next liaison meeting.

6.18 Any detainee presenting with mental health concerns was initially seen by the FME who, when appropriate, requested the expertise of an AMHP. Response times were said to be very good. Detainees displaying mental health issues were put in cells with CCTV to reduce the risk of self-harm. We were told that custody staff received some annual mental health awareness training. Where necessary, police officers were used to provide a constant watch.

6.19 Custody staff could not recall the last time the station had been used as a place of safety under Section 136 of the Mental Health Act 1983. Access to the Trust Section 136 suite was swift and effective.

Recommendations

6.20 Clinical governance arrangements should be improved, including clear lines of accountability for checking the identity, qualifications, appraisal systems, training and supervision of all forensic medical examiners.

6.21 There should be clear infection control procedures and these should be adhered to.

6.22 Forensic medical examiners should record all medicines administered to detainees and this should include entries in the controlled drug audit book.

6.23 Forensic medical examiners should ensure that all clinical records are stored in accordance with the Data Protection Act and Caldicott guidance.[5]

6.24 Injecting drug users released into the community should be offered clean needles by drug workers.

Housekeeping points

6.25 The custody sergeant identified as the link between forensic medical examiners and custody staff should reintroduce their regular meetings.

6.26 The practice of leaving the door to the health care room open during patient consultation should be reviewed.

6.27 Privacy screens should be provided in Plumstead and Greenwich health care rooms.

6.28 Forensic sampling kits should be subject to stock rotation.

6.29 Sanitary products should be held in the clothing store.

6.30 The examination couch at Greenwich should be recovered.

6.31 Controlled drug checks should include rectal Diazepam medication.

[5] The Caldicott review (1997) stipulated certain principles and working practices that health care providers should adopt to improve the quality of, and protect the confidentiality of, service users' information.

7. Summary of recommendations

Main recommendations — To the Metropolitan Police Service

7.1 The Metropolitan Police Service should collate the use of force in accordance with the Association of Chief Police Officers policy and National Police Improvement Agency guidance. (2.22, see paragraph 2.8)

7.2 Booking in desks should allow effective and private communication between detainees and staff. (2.23, see paragraph 2.10)

7.3 Detainees should be told how to make a complaint and they should be facilitated to do so. (2.24, see paragraph 2.16)

Recommendation — To the Metropolitan Police Authority

7.4 The Metropolitan Police Authority should allocate one authority member as lead for custody. (3.18, see paragraph 3.1)

Recommendations — To the Metropolitan Police Service

Strategy

7.5 The Metropolitan Police Service should review its provision of cell capacity at Plumstead and improvement plans should be developed and instigated as soon as practicable. (3.19, see paragraph 3.4)

7.6 The borough operational command unit should hold formal custody meetings that include senior management team attendance. (3.20, see paragraph 3.13)

7.7 The Metropolitan Police Service should urgently address the force-wide and borough shortcomings in terms of extracting management information from NSPIS to focus critical thinking, including the structural processes and IT deficiencies that inhibit this. (3.22, see paragraphs 3.11 and 3.15)

Treatment and conditions

7.8 There should be a formal process to ensure that children and young people do not have contact with schedule one offenders. (4.20, see paragraph 4.3)

7.9 Some cells should be adapted for use by detainees with physical disabilities. (4.21, see paragraph 4.4)

7.10 Managers should ensure that custody records include more detail of significant events that occur during a detainee's detention. (4.22, see paragraph 4.6)

7.11 The proper use of the cell bell should be explained to detainees when they enter a cell. (4.23, see paragraph 4.8)

7.12 Ventilation in cells should be improved. (4.24, see paragraph 4.11)

7.13 Subject to individual needs assessment, nicotine replacement should be available to detainees. (4.25, see paragraph 4.11)

7.14 All female detainees should be offered a hygiene pack on arrival. (4.26, see paragraph 4.14)

7.15 All cell toilets should be effectively screened. (4.27, see paragraph 4.15)

7.16 All cells should have a supply of toilet paper. (4.28, see paragraph 4.15)

7.17 All detainees held overnight and those who are dirty should be offered a shower, which they should be able to take with an appropriate degree of privacy. (4.29, see paragraph 4.16)

7.18 Detainees held for over 24 hours should be offered outdoor exercise. (4.30, see paragraph 4.19)

Individual rights

7.19 Rights and entitlements information should be available in a range of formats to meet specific needs. (5.12, see paragraph 5.3)

7.20 The BOCU should instigate discussions with the managers responsible for the duty solicitor scheme to ensure detainees have timely access to legal advice. (5.13, see paragraph 5.8)

7.21 Appropriate adults should be deployed to support juveniles aged 17 and under. (5.14, see paragraph 5.8)

Health care

7.22 Clinical governance arrangements should be improved, including clear lines of accountability for checking the identity, qualifications, appraisal systems, training and supervision of all forensic medical examiners. (6.20, see paragraph 6.1)

7.23 There should be clear infection control procedures and these should be adhered to. (6.21, see paragraph 6.4)

7.24 Forensic medical examiners should record all medicines administered to detainees and this should include entries in the controlled drug audit book. (6.22, see paragraph 6.28)

7.25 Forensic medical examiners should ensure that all clinical records are stored in accordance with the Data Protection Act and Caldicott guidance. (6.23, see paragraph 6.13)

7.26 Injecting drug users released into the community should be offered clean needles by drug workers. (6.24, see paragraph 6.14)

Housekeeping points

Treatment and conditions

7.27 Replacement underwear should be made available if it is required. (4.31, see paragraph 4.17)

7.28 Food provided for detainees should be served at the correct temperature. (4.32, see paragraph 4.18)

7.29 Those held in custody should be offered a range of suitable reading material. (4.33, see paragraph 4.19)

Individual rights

7.30 The borough operational command unit should ensure that staff are clear on DNA policies and that samples are submitted promptly to the National DNA Database. (5.15, see paragraph 5.9)

Health care

7.31 The custody sergeant identified as the link between forensic medical examiners and custody staff should reintroduce their regular meetings. (6.25, see paragraph 6.2)

7.32 The practice of leaving the door to the health care room open during patient consultation should be reviewed. (6.26 see paragraph 6.3)

7.33 Privacy screens should be provided in Plumstead and Greenwich health care rooms. (6.27 see paragraph 6.3)

7.34 Forensic sampling kits should be subject to stock rotation. (6.28 see paragraph 6.6)

7.35 Sanitary products should be held in the clothing store. (6.29, see paragraph 6.6)

7.36 The examination couch at Greenwich should be recovered. (6.30, see paragraph 6.7)

7.37 Controlled drug checks should include rectal Diazepam medication. (6.31, see paragraph 6.7)

Appendix I: Inspection team

Sean Sullivan	HMIP team leader
Anita Saigal	HMIP inspector
Paddy Craig	HMIC inspector
Ian Thomson	HMIP inspector
Bridget McEvilly	HMIP health care inspector
Anne McCaffrey	CQC inspector
Catherine Nichols	HMIP researcher
Laura Nettleingham	HMIP researcher

Appendix II: Custody record analysis

Background

As part of the inspection of Greenwich police custody, a sample of the custody records of detainees held at Plumstead police custody suite were analysed for the following three random dates: Tuesday 16 February, Friday 19 February and Sunday 21 February.

Greenwich police station is solely used as overflow for police operations and held 22 detainees during May 2010. Therefore, only three custody records were viewed. Custody records were held electronically on NSPIS. A sample of 31 records was analysed from across the borough of Greenwich:

Custody suite	Number of records analysed
Plumstead	28
Greenwich	3
Total	31

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

Demographic information

- Six of the detainees were female and 25 were male.
- One person under the age of 17 was included in the sample.
- There were 17 detainees in our sample with a white British/other ethnic background and 13 with a black or ethnic minority background. For one detainee, this was not known.
- There were 14 foreign nationals in the sample and all were given their foreign national rights.
- Three detainees had been held for more than 24 hours. Seven (23%) had been in custody overnight, including those who had arrived during the night and were not released until the morning. Twelve (39%) detainees had been held for less than six hours.

Risk assessments

Initial risk assessment statements were largely clear and contained helpful information.

- Fourteen detainees (45%) were brought in to custody intoxicated. Apart from one, all were seen by a doctor according to the notes in their detainee logs. One detainee was seen by a drugs and alcohol worker.
- Two detainees had previously self-harmed. This information was recorded in the detention log. In one case, the initial entry log did not identify any self-harm or risk, but was mentioned in later entries and no information was recorded in the risk assessment.
- Four detainees in our sample had reported mental health problems. It was noted that an appropriate adult was required for one detainee and was present for both the rights and interview.
- Four detainees in our sample reported being on medication on arrival in custody. Three of these detainees were seen by a health care professional and the other detainee was held in custody for only just over two hours.

- Two detainees were given medication while in custody. Neither detainee reported being on medication on arrival.
- Three detainees in our sample came in to custody with an injury and all were seen by a doctor. One detainee required further assistance and was taken to hospital and subsequently returned to police custody. A fourth detainee was strip searched shortly after arrival and allegedly received an injury from officers during this process. No other details were noted in the detention log.
- In five (16%) risk assessments, it was noted to be a detainee's first time in custody.

Removal of clothing

None of the detainees in the sample had had clothing removed.

Young people

There was one young person in our sample aged 15 years. It was noted that an appropriate adult was required and was present when the young person was read their rights and entitlements and during the interview. The detainee was in custody for just over two hours.

Women

Of the six female detainees in the sample:

- According to the initial risk assessment in the log, all were offered the chance to speak alone with a female member of staff and all six declined.
- A further prompt in the risk assessment asks all detainees if they have any dependents. Only one female detainee identified a young dependent, but did not report any issues with ensuring dependents were looked after.

Interpreters

- Three detainees required the use of an interpreter. One detainee was in custody for approximately 45 hours and spoke reasonable English. An interpreter was requested following the detainee's first night in custody. Rights and entitlements were re-read and the interpreter was present for the interview and a later virtual court session.
- Another detainee had an interpreter present for both the reading of rights and entitlements and the interview. On arrival into custody, a professional telephone interpreting service was used during the booking in process.
- One detainee had his rights read and was seen by a doctor before an interpreter was requested, who was then present for the interview. There was no indication from the detention log that rights were re-read once the interpreter had arrived.

Inspector reviews

Inspector reviews were held in line with requirements usually at the required times. However, in a number of cases, inspectors were conducting reviews while the detainee was asleep. On a few occasions, the entry log records the detainee awake in his cell, only minutes after the review has occurred.

Services

- Four detainees had made a telephone call during their time in custody. Three detainees requested to make a call, but these were not granted usually due to custody being busy at the time of request. One detainee requested to make an international call, which was not granted as the detainee could not provide a correct number. In 24 cases, detainees were not offered a telephone call.
- All detainees were routinely offered legal advice, but only 12 (39%) detainees accepted. One detainee initially declined legal advice, but subsequently made a request when attending court. There was no entry in the detention log that a duty solicitor was present, but it was noted that a member of staff would organise this.
- Sixteen (52%) detainees were seen by the FME.
- The longest wait was approximately two hours 48 minutes.
- The average wait for an FME was approximately 42 minutes.
- Fourteen (45%) detainees in our sample were offered at least one meal in custody. Eleven detainees were not offered a meal in custody. All but four of these detainees were in custody for less than six hours.
- No detainees in the custody sample had been given outside exercise.
- No detainees had a shower while in custody. Four detainees had gone to court and not been offered a shower. One detainee held for over 45 hours and was not offered a shower.
- Two detainees had been provided with reading materials.
- No evidence of cell sharing was found.
- In several custody records, there was clear evidence that entries were made in the wrong detainee record, information was recorded incorrectly and entries were inconsistent in that it was difficult to follow the detainee's time in custody (e.g. detainee declining solicitor and then duty solicitor being contacted).
- One detainee provided false identity on arrival so it was difficult to ascertain the detainee's age. It was questionable as to whether this detainee would need an appropriate adult as he could have been under the age of 17. It was not clear from the record whether this was established before interview.

Appendix III: Summary of detainee questionnaires and interviews

Prisoner survey methodology

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

Choosing the sample size

The survey was conducted on 19 April 2010. A list of potential respondents to have passed through Plumstead or Greenwich police stations was created, listing all those who had arrived from Greenwich, Woolwich or Bexley Magistrates courts within the past two months. This happened in conjunction with a survey for Bexley police borough.

Selecting the sample

In total, 150 respondents were approached. Sixty-three respondents reported either being held in police stations outside Greenwich and Bexley and one could speak no English and so it was impossible to determine the police station they had been in. Five prisoners could not be located. On the day, the questionnaire was offered to 81 respondents. There were three refusals, one questionnaire returned blank and seven non-returns. All of those sampled had been in custody within the last two months. Forty-one questionnaires were returned completed from prisoners who had been through the borough of Greenwich.

Completion of the questionnaire was voluntary. Interviews were carried out with any respondents with literacy difficulties. Two respondents were interviewed.

Methodology

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

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

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

Comparisons

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

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

The current survey responses were analysed against comparator figures for all prisoners surveyed in other police areas. This comparator is based on all responses from prisoner surveys carried out in 25 police areas since April 2008.

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

Summary

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

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

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

Survey results

Section 1: About you

Q2 What police station were you last held at?
Plumstead

Q3 What type of detainee were you?

Police detainee	38 (93%)
Prison lock-out (i.e. you were in custody in a prison before coming here)	1 (2%)
Immigration detainee	0 (0%)
I don't know	2 (5%)

Q4 How old are you?

16 years or younger	0 (0%)	*40-49 years*	3 (7%)
17-21 years	2 (5%)	*50-59 years*	1 (2%)
22-29 years	21 (51%)	*60 years or older*	0 (0%)
30-39 years	14 (34%)		

Q5 Are you:

Male	41 (100%)
Female	0 (0%)
Transgender/transsexual	0 (0%)

Q6 What is your ethnic origin?

White - British	24 (59%)
White - Irish	2 (5%)
White - other	3 (7%)
Black or black British - Caribbean	5 (12%)
Black or black British - African	4 (10%)
Black or black British - other	1 (2%)
Asian or Asian British - Indian	1 (2%)
Asian or Asian British - Pakistani	0 (0%)
Asian or Asian British - Bangladeshi	0 (0%)
Asian or Asian British - other	0 (0%)
Mixed heritage - white and black Caribbean	0 (0%)
Mixed heritage - white and black African	0 (0%)
Mixed heritage- white and Asian	0 (0%)
Mixed heritage - other	0 (0%)
Chinese	0 (0%)
Other ethnic group	1 (2%)

Q7 Are you a foreign national (i.e. you do not hold a British passport, or you are not eligible for one)?

Yes	6 (15%)
No	34 (85%)

Q8 What, if any, would you classify as your religious group?

None	10 (25%)
Church of England	16 (40%)
Catholic	10 (25%)
Protestant	0 (0%)
Other Christian denomination	1 (3%)
Buddhist	0 (0%)

Hindu 1 (3%)
Jewish 0 (0%)
Muslim 2 (5%)
Sikh 0 (0%)

Q9 How would you describe your sexual orientation?
Straight/heterosexual 39 (98%)
Gay/lesbian/homosexual 0 (0%)
Bisexual 1 (3%)

Q10 Do you consider yourself to have a disability?
Yes 9 (23%)
No 30 (75%)
Don't know 1 (3%)

Q11 Have you ever been held in police custody before?
Yes 37 (93%)
No 3 (8%)

Section 2: Your experience of this custody suite

Q12 How long were you held at the police station?
1 hour or less 0 (0%)
More than 1 hour, but less than 6 hours 2 (5%)
More than 6 hours, but less than 12 hours 0 (0%)
More than 12 hours, but less than 24 hours 10 (25%)
More than 24 hours, but less than 48 hours (2 days) 11 (28%)
More than 48 hours (2 days), but less than 72 hours (3 days) 16 (40%)
72 hours (3 days) or more 1 (3%)

Q13 Were you given information about your arrest and your entitlements when you arrived there?
Yes 24 (60%)
No 13 (33%)
Don't know/can't remember 3 (8%)

Q14 Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')?
Yes 17 (41%)
No 19 (46%)
I don't know what this is/I don't remember 5 (12%)

Q15 If your clothes were taken away, were you offered different clothing to wear?
My clothes were not taken 18 (49%)
I was offered a tracksuit to wear 12 (32%)
I was offered an evidence suit to wear 3 (8%)
I was offered a blanket 4 (11%)

Q16 Could you use a toilet when you needed to?
Yes 37 (95%)
No 2 (5%)
Don't Know 0 (0%)

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

	Yes	*No*
Toilet paper	16 (40%)	24 (60%)

Q18 Did you share a cell at the police station?

Yes	0 (0%)
No	40 (100%)

Q19 How would you rate the condition of your cell:

	Good	*Neither*	*Bad*
Cleanliness?	8 (20%)	18 (44%)	15 (37%)
Ventilation/air quality?	2 (6%)	12 (38%)	18 (56%)
Temperature?	1 (3%)	10 (29%)	23 (68%)
Lighting?	9 (27%)	10 (30%)	14 (42%)

Q20 Was there any graffiti in your cell when you arrived?

Yes	20 (50%)
No	20 (50%)

Q21 Did staff explain to you the correct use of the cell bell?

Yes	6 (15%)
No	35 (85%)

Q22 Were you held overnight?

Yes	38 (93%)
No	3 (7%)

Q23 If you were held overnight, which items of clean bedding were you given?

Not held overnight	3 (6%)
Pillow	7 (15%)
Blanket	25 (53%)
Nothing	12 (26%)

Q24 Were you offered a shower at the police station?

Yes	1 (3%)
No	39 (98%)

Q25 Were you offered any period of outside exercise while there?

Yes	1 (3%)
No	39 (98%)

Q26 Were you offered anything to:

	Yes	*No*
Eat?	33 (83%)	7 (18%)
Drink?	29 (83%)	6 (17%)

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

I did not have any food or drink	3 (8%)
Yes	10 (27%)
No	24 (65%)

Q28 If you smoke, were you offered anything to help you cope with the smoking ban there?

I do not smoke	8 (21%)
I was allowed to smoke	1 (3%)
I was not offered anything to cope with not smoking	30 (77%)
I was offered nicotine gum	0 (0%)
I was offered nicotine patches	0 (0%)
I was offered nicotine lozenges	0 (0%)

Q29 Were you offered anything to read?

Yes	2 (5%)
No	38 (95%)

Q30 Was someone informed of your arrest?

Yes	18 (45%)
No	19 (48%)
I don't know	0 (0%)
I didn't want to inform anyone	3 (8%)

Q31 Were you offered a free telephone call?

Yes	18 (46%)
No	21 (54%)

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

My telephone call was not denied	18 (51%)
Yes	3 (9%)
No	14 (40%)

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

	Yes	*No*
Who was taking care of your children	3 (12%)	22 (88%)
Contacting your partner, relative or friend	19 (53%)	17 (47%)
Contacting your employer	8 (31%)	18 (69%)
Where you were going once released	3 (13%)	20 (87%)

Q34 Were you interviewed by police officials about your case?

Yes	39 (98%)	
No	1 (3%)	If No, go to Q36

Q35 Were any of the following people present when you were interviewed?

	Yes	*No*	*Not needed*
Solicitor	27 (71%)	8 (21%)	3 (8%)
Appropriate adult	2 (9%)	7 (32%)	13 (59%)
Interpreter	1 (4%)	8 (35%)	14 (61%)

Q36 How long did you have to wait for your solicitor?

I did not requested a solicitor	6 (15%)
2 hours or less	2 (5%)
Over 2 hours but less than 4 hours	1 (3%)
4 hours or more	31 (78%)

Q37 Were you officially charged?

Yes	36 (90%)
No	4 (10%)
Don't know	0 (0%)

Q38 How long were you in police custody *after* being charged?

I have not been charged yet	4 (10%)
1 hour or less	2 (5%)
More than 1 hour, but less than 6 hours	2 (5%)
More than 6 hours, but less than 12 hours	11 (28%)
12 hours or more	21 (53%)

Section 3: Safety

Q40 Did you feel safe there?

Yes	15 (39%)
No	23 (61%)

Q41 Had another detainee or a member of staff victimised (insulted or assaulted) you there?

Yes	19 (50%)
No	19 (50%)

Q42 If you have felt victimised, what did the incident involve? (Please tick all that apply to you.)

I have not been victimised	19 (36%)	*Because of your crime*	7 (13%)
Insulting remarks (about you, your family or friends)	5 (9%)	*Because of your sexuality*	0 (0%)
Physical abuse (being hit, kicked or assaulted)	6 (11%)	*Because you have a disability*	1 (2%)
Sexual abuse	1 (2%)	*Because of your religion/religious beliefs*	1 (2%)
Your race or ethnic origin	2 (4%)	*Because you are from a different part of the country than others*	3 (6%)
Drugs	8 (15%)		
Please describe:			7 (100%)

Q43 Were you handcuffed or restrained while in the police custody suite?

Yes	20 (53%)
No	18 (47%)

Q44 Were you injured while in police custody, in a way that you feel was not your fault?

Yes	8 (21%)
No	30 (79%)

Q45 Were you told how to make a complaint about your treatment here if you needed to?

Yes	2 (5%)
No	36 (95%)

Section 4: Health care

Q47 When you were in police custody were you on any medication?

Yes	20 (51%)
No	19 (49%)

Q48 Were you able to continue taking your medication while there?

Not taking medication	19 (50%)
Yes	7 (18%)
No	12 (32%)

Q49 Did someone explain your entitlements to see a health care professional, if you needed to?

Yes	15 (38%)
No	23 (59%)
Don't know	1 (3%)

Q50 Were you seen by the following health care professionals during your time there?

	Yes	*No*
Doctor	25 (64%)	14 (36%)
Nurse	0 (0%)	20 (100%)
Paramedic	0 (0%)	20 (100%)
Psychiatrist	0 (0%)	21 (100%)

Q51 Were you able to see a health care professional of your own gender?

Yes	18 (46%)
No	16 (41%)
Don't know	5 (13%)

Q52 Did you have any drug or alcohol problems?

Yes	21 (54%)
No	18 (46%)

Q53 Did you see, or were offered the chance to see a drug or alcohol support worker?

I didn't have any drug/alcohol problems	18 (46%)
Yes	7 (18%)
No	14 (36%)

Q54 Were you offered relief or medication for your immediate symptoms?

I didn't have any drug/alcohol problems	18 (46%)
Yes	5 (13%)
No	16 (41%)

Q55 Please rate the quality of your health care while in police custody:

	I was not seen by health care	*Very good*	*Good*	*Neither*	*Bad*	*Very bad*
Quality of health care	13 (34%)	0 (0%)	5 (13%)	5 (13%)	5 (13%)	10 (26%)

Q56 Did you have any specific <u>physical</u> health care needs?

No	22 (63%)
Yes	13 (37%)

Q57 Did you have any specific <u>mental</u> health care needs?

No	29 (81%)
Yes	7 (19%)

Prisoner survey responses for Greenwich Police 2010

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

Key to tables

		Greenwich 2010	Police custody comparator
	Any percent highlighted in green is significantly better		
	Any percent highlighted in blue is significantly worse		
	Any percent highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
Number of completed questionnaires returned		41	844
SECTION 1: General information			
2	Are you a police detainee?	**92%**	**89%**
3	Are you under 21 years of age?	**4%**	**9%**
4	Are you transgender/transsexual?	**0%**	**1%**
5	Are you from a minority ethnic group (including all those who did not tick White British, White Irish or White other categories)?	**30%**	**34%**
6	Are you a foreign national?	**15%**	**14%**
7	Are you Muslim?	**4%**	**11%**
8	Are you homosexual/gay or bisexual?	**2%**	**2%**
9	Do you consider yourself to have a disability?	**22%**	**19%**
10	Have you been in police custody before?	**92%**	**90%**
SECTION 2: Your experience of this custody suite			
For the most recent journey you have made either to or from court or between prisons:			
11	Were you held at the police station for over 24 hours?	**69%**	**65%**
12	Were you given information about your arrest and entitlements when you arrived?	**60%**	**74%**
13	Were you told about PACE?	**42%**	**53%**
14	If your clothes were taken away, were you given a tracksuit to wear?	**65%**	**43%**
15	Could you use a toilet when you needed to?	**96%**	**90%**
16	If you did use the toilet, was toilet paper provided?	**37%**	**51%**
17	Did you share a cell at the station?	**0%**	**3%**
18	Would you rate the condition of your cell as 'good' for:		
18a	Cleanliness?	**20%**	**30%**
18b	Ventilation/air quality?	**5%**	**20%**
18c	Temperature?	**2%**	**14%**
18d	Lighting?	**28%**	**43%**
19	Was there any graffiti in your cell when you arrived?	**50%**	**56%**
20	Did staff explain the correct use of the cell bell?	**14%**	**21%**
21	Were you held overnight?	**92%**	**91%**
22	If you were held overnight, were you given **no** clean items of bedding?	**31%**	**31%**
23	Were you offered a shower?	**2%**	**9%**
24	Were you offered a period of outside exercise?	**2%**	**6%**
25a	Were you offered anything to eat?	**83%**	**80%**
25b	Were you offered anything to drink?	**83%**	**81%**
26	Was the food/drink you received suitable for your dietary requirements?	**29%**	**43%**
27	For those who smoke: were you offered **nothing** to help you cope with the ban there?	**78%**	**76%**
28	Were you offered anything to read?	**4%**	**13%**
29	Was someone informed of your arrest?	**45%**	**44%**
30	Were you offered a free telephone call?	**47%**	**51%**

Key to tables

		Greenwich 2010	Police custody comparator
	Any percent highlighted in green is significantly better		
	Any percent highlighted in blue is significantly worse		
	Any percent highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
31	If you were denied a free call, was a reason given?	**19%**	**14%**
32	Did you have any concerns about:		
32a	Who was taking care of your children?	**13%**	**15%**
32b	Contacting your partner, relative or friend?	**52%**	**53%**
32c	Contacting your employer?	**31%**	**21%**
32d	Where you were going once released?	**14%**	**32%**
34	If you were interviewed were the following people present:		
34a	Solicitor	**72%**	**73%**
34b	Appropriate adult	**8%**	**7%**
34c	Interpreter	**4%**	**6%**
35	Did you wait over four hours for your solicitor?	**91%**	**63%**
37	Were you held 12 hours or more in custody after being charged?	**58%**	**63%**
SECTION 3: Safety			
39	Did you feel unsafe?	**61%**	**39%**
40	Has another detainee or a member of staff victimised you?	**50%**	**42%**
41	If you have felt victimised, what did the incident involve?		
41a	Insulting remarks (about you, your family or friends)	**13%**	**22%**
41b	Physical abuse (being hit, kicked or assaulted)	**15%**	**14%**
41c	Sexual abuse	**2%**	**2%**
41d	Your race or ethnic origin	**4%**	**6%**
41e	Drugs	**22%**	**15%**
41f	Because of your crime	**17%**	**18%**
41g	Because of your sexuality	**0%**	**1%**
41h	Because you have a disability	**2%**	**3%**
41i	Because of your religion/religious beliefs	**2%**	**3%**
41j	Because you are from a different part of the country than others	**9%**	**5%**
42	Were you handcuffed or restrained whilst in the police custody suite?	**52%**	**48%**
43	Were you injured whilst in police custody, in a way that you feel is not your fault?	**22%**	**26%**
44	Were you told how to make a complaint about your treatment?	**4%**	**14%**
SECTION 4: Health care			
46	Were you on any medication?	**51%**	**44%**
47	For those who were on medication were you able to continue taking your medication?	**35%**	**39%**
48	Did someone explain your entitlement to see a health care professional if you needed to?	**38%**	**36%**
49	Were you seen by the following healthcare professionals during your time in police custody:		
49a	Doctor?	**64%**	**49%**
49b	Nurse?	**0%**	**15%**
49c	Paramedic?	**0%**	**5%**
49d	Psychiatrist?	**0%**	**4%**
50	Were you able to see a health care professional of your own gender?	**47%**	**28%**
51	Did you have any drug or alcohol problems?	**53%**	**55%**
For those who had drug or alcohol problems:			
52	Did you see, or were offered the chance to see a drug or alcohol support worker?	**32%**	**40%**
53	Were you offered relief medication for your immediate symptoms?	**24%**	**33%**
54	For those who had been seen by health care, would you rate the quality as good/very good?	**20%**	**29%**
55	Do you have any specific physical health care needs?	**37%**	**33%**
56	Do you have any specific mental health care needs?	**19%**	**24%**