Report on an inspection visit to the police custody suite in Harrow Borough Operational Command Unit

17 – 19 May 2010

by

HM Inspectorate of Prisons and

HM Inspectorate of Constabulary

Printed and published by:
Her Majesty's Inspectorate of Prisons
Her Majesty's Inspectorate of Constabulary

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Contents

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 Harrow has one designated custody suite with 11 cells. It is open 24 hours a day and, in the year ending 31 March 2010, received 4,861 detainees. As well as visiting Harrow for this announced inspection, inspectors were also informed by a survey of prisoners at HMP Wormwood Scrubs who had previously been held in the borough's police cells.

Strategic oversight is provided by the Metropolitan Police Service (MPS) 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, although there continues to be no MPA member with a lead role for custody. The MPA oversees Harrow's small, but effective, group of independent custody visitors.

Management arrangements were generally sound but senior staff had a wide range of responsibilities, which limited their focus on custody. There was also limited management information to call on; for example, there was a lack of appropriate monitoring of the use of force, both locally and London-wide. We were not assured that all staff working in custody were up to date with their training. There was some good partnership working with local health care providers and the local criminal justice board.

The suite was generally clean but tired, and plans to refurbish London's custody estate had been put on hold. Relationships between staff and detainees appeared relaxed, and good de-escalation skills were observed. Vulnerable detainees were well supported. There was limited privacy when booking in detainees, but risk assessments were good and records generally excellent. As we frequently find, basic hygiene needs, such as showers and toilet paper, were only available on request and needed to be offered routinely.

Custody sergeants ensured an assiduous approach to the Police and Criminal Evidence Act, although this also meant that appropriate adults were rarely sought for children of 17. Good liaison with the UK Border Agency had ensured a marked reduction in the time immigration detainees were held in police custody. Forensic samples were efficiently processed. Pre-release assessments were carried out, but complaints during detention were not facilitated.

The quality of health care was reasonable, although clinical governance required improvement and there were some weaknesses in medicines management. Services for substance users were comprehensive. Support for those with mental health issues was very good, and it was good practice that a designated police officer had been involved with developing a shared mental health protocol with providers.

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

Overall, we report positively on police custody in Harrow, although there is inevitably scope for further improvement, and we set out a number of recommendations that we hope will assist the MPS and MPA in taking matters forward. 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.

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September 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 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[3] 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 Harrow, the single custody suite for this London Borough. Inspectors examined force-wide and borough custody strategies, as well as treatment and conditions, individual rights and health care in the custody suites.

2.4 A survey of prisoners at HMP Wormwood Scrubs who had formerly been detained at the custody suite in the borough was conducted by an HM Inspectorate of Prisons researcher and HMIC inspector to obtain additional evidence (see appendix III).

2.5 Harrow had 11 cells and two detention rooms. It was open 24 hours a day and held adults and juveniles. The suites had received 4,861 detainees between April 2009 and March 2010.

Strategic overview

2.6 The MPS custody directorate within the Operation 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. The local independent custody visitors (ICV) scheme was small, but reported excellent and responsive relations with the borough.

2.7 Plans for the custody estate had been put on hold and the area needed some attention. The cells were somewhat tired and the design of the suite did not allow for privacy or the supervision arrangements envisaged under Operation Herald (workforce modernisation). It was unclear whether the capacity of the suite would be sufficient in the long term. Responsibility for day-to-day management of custody suites and delivery of services had been devolved to boroughs and rested with the borough operational command unit (BOCU) commander. Custody management meetings had recently been introduced, but there was no custody user forum with external partners. The dip sampling of custody records was not representative or intrusive enough or cross-referenced with closed-circuit television (CCTV). There was a lack of management information to support the strategic management of provision.

[2] http://www.justice.gov.uk/inspectorates/hmi-prisons/expectations.htm
[3] The use of police custody to house prisoners locked out of overcrowded prisons

2.8 The time available to the custody manager and chief inspector of operations for custodial work was limited due to their other duties. Permanent custody sergeants provided a level of consistency during the main working periods and overall staffing levels were adequate. Training for staff was available, but take-up poor and managers had no assurance that all staff working in custody were up to date.

2.9 Partnership working was reasonable, as were court cut-off times. There were links at a strategic level through the borough commander's attendance at the local criminal justice board and through personal links.

2.10 Learning from successful interventions was circulated to staff by email, but staff were unaware of the Independent Police Complaints Commission's (IPCC) 'Learning the Lessons' newsletters. There was no BOCU-wide collation of use of force to enable trends and patterns to be analysed.

Treatment and conditions

2.11 Relationships between staff and detainees were relaxed. Staff took account of detainees' individual needs and juveniles were offered appropriate support. Cells were unsuitable for detainees with disabilities and there were no hearing loops. A range of materials for observing major faiths was available and most cells were marked with the direction of prayer.

2.12 Space constraints in the booking area compromised the privacy of new arrivals and this was exacerbated by the number of bail to returns (BTRs) attending the same area. Assessments of levels of risk on arrival were thorough and information followed detainees to court. Staff were aware of the impact of more volatile detainees and moved them quickly. Shift handovers ensured key issues were communicated to oncoming staff. Good care was given to vulnerable detainees.

2.13 We saw evidence of good de-escalation skills in practice and staff had personal safety training twice a year.

2.14 The physical environment was ageing, but clean. Temperatures in cells were problematic and the suite leaked when it rained. Detainees were not given the opportunity to spend time in the fresh air. The single shower ran cold and there was no evidence that it was used. Only paper towels were available. Ligature points were found, but immediate remedial action was taken when we pointed these out. Cells were not cleaned after use, nor were mattresses and pillows. Blankets were not routinely provided. Toilet paper was available only on request. Staff explained the use of the cell call bells, tested them daily and responded to them swiftly. Fire evacuation arrangements had been tested in the previous six months. The locking away of handcuffs risked wasting valuable time in an evacuation. Smoking was not allowed, but nicotine patches were not provided.

2.15 A good range of meals was provided, but food was not checked for temperature. Reading materials were limited. Visits were allowed only in exceptional circumstances. Alternative clothing was provided when detainees' clothing was removed.

Individual rights

2.16 Custody sergeants looked critically at the appropriateness of detention and most inspector reviews were carried out in person and on time. Telephone and face-to-face interpreting services were reasonable, although there were some issues in accessing common languages.

Rights and entitlements information was available in a range of languages. There was good liaison with the UK Border Agency (UKBA) and considerable progress had been made in reducing the length of time immigration detainees were held in police custody. Detainees with dependency obligations were offered support. Staff facilitated telephone calls for detainees, often allowing more than one. Pre-release risk assessments were carried out and acted on.

2.17 PACE was adhered to. Posters advertised detainees' right to free legal advice and this service was offered routinely. The design of the booking in area meant telephone conversations were not confidential. Appropriate adult (AA) provision through Harrow Social Services was adequate, but police adhered to the PACE definition of a child so 17 year olds were not routinely provided with an AA. Detainees were bailed rather than waiting long periods for an AA. Detainee DNA samples were processed efficiently. Detainees who were charged were promptly put before the courts.

2.18 Detainees were not told how to make complaints and staff advised detainees to complain after release. IPCC complaint forms were not available.

Health care

2.19 The overall approach to health service provision was reasonable and custody sergeants demonstrated a good attitude towards caring for detainees' health needs. Governance arrangements for health care were managed centrally by the MPS and health care delivered by individual forensic medical examiners (FMEs) contracted in by Forensic Health Services. Clinical governance remained the responsibility of individual FMEs, which was unsatisfactory, and the recently appointed FMS director of medical and forensic health had yet to address this.

2.20 The FME room was clean and had some new equipment. Medical equipment was appropriate for the level of care delivered and checked regularly. Staff had annual training in the use of the defibrillator. The management of medications was reasonable, although there were issues around stock control accountability. Detainees could continue medication, other than methadone, as long as this was verified by the FME. FMEs held clinical records in their private residences, but made sufficient entries in NSPIS to indicate to custody staff what health care support was necessary.

2.21 Our custody record analysis indicated that the average wait for a FME was 59 minutes, but there was one unacceptable wait of three hours. There was no coherent mechanism for reporting FME response times to allow effective monitoring of the contract. Significant concerns over a detainee's health were responded to by calling paramedics and admission to hospital where necessary.

2.22 The management of detainees with mental health issues was good and referrals were made to the crisis team when mental health concerns were identified. If detainees were not Harrow residents, the crisis team conducted only the initial mental health assessment and the case was referred to the detainee's local mental health team. The provision at Northwick Park for section 136s was just adequate and being upgraded. Mental health awareness training had not yet been introduced for front line staff.

2.23 The Westminster Drug Project provided good drug and alcohol services on site and out of hours, including referral to rapid prescribing and signposting clients to services in the community around the country. Workers shared records with clients, who could also have a copy on request.

Main recommendations

2.24 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.

2.25 Staff should adhere to the Metropolitan Police Service guidelines for the management and registration of drugs and medicines in custody. Missing medicines, particularly controlled drugs, should immediately be notified to the primary care trust accountable officer.

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 boroughs. 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 Custody Directorate had an inspection function for audit and compliance, health and safety and the implementation of SDHP guidance. The 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 (IPTs) and 'virtual courts' through video links.

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 a 'rephasing' of the building plans prioritised by most pressing need. The current capacity of the custody estate in Harrow was fortunately adequate to meet demand, but issues with age, privacy, ventilation and ongoing maintenance needs had to be addressed in the medium to long term if the premises were properly to meet need.

3.5 Maintenance of the custody suite 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 in a neighbouring borough. The custody suite was reasonably well maintained for its age.

3.6 Police sergeants in the custody suite were not permanent team members, but were 'posted' into custody roles from operational patrol teams, sometimes for just a day at a time. However, four permanent custody sergeants held individual primary responsibility for duties such as Livescan training, DNA supervision, monitoring of store supplies and CCTV. They also assisted in covering 'bail to returns' (BTRs) and mainstream custody duties between 8am and 11pm Monday to Saturday. Overall, 36 sergeants were trained to cover duties in the custody suite. All had received nationally approved custody training delivered corporately before being deployed in the custody suite. Some sergeants had also received or were due to receive a one-day refresher training course, although there was limited availability. There was no system to ensure that sergeants required to staff the custody suite were up-to-date and fully trained in all custody developments.

3.7 The BOCU also had 13 designated detention officers (DDOs), allowing two or three on each of the five custody teams. They had received corporately delivered custody training, including use of the National Strategy for Police Information Systems (NSPIS), before being deployed in the custody suite. A local training day for DDOs and custody sergeants held two weeks previously had included input from local custody management on Livescan issues, how to conduct cell checks, new practices for custody contractors working on-site, taking footwear impressions and a new youth triage system. DDOs had also received appropriate training in preparation for their change of role in October 2010 as part of Operation Herald (workforce modernisation). The new role included booking in detainees, with custody sergeants remaining responsible for risk assessment.

3.8 The BOCU also used police constable (PC) gaolers from operational shifts to cover any shortages in DDO staffing levels. They had received custody-specific training on NSPIS and shadowed a DDO for two days and a custody sergeant for one day before being deployed on their own. The borough aimed to have five trained PC gaolers on each operational team, but accepted this was difficult due to staff movement.

3.9 An inspector was custody manager, but was also responsible for driving standards, criminal exhibits and covering the role of duty officer when required. He line managed the four permanent custody sergeants, who in turn had allocated management of DDOs. Non-permanent custody sergeants and gaolers were line managed by their patrol team shift inspectors. No 'permanent' sergeants worked on Sundays or night duty shifts, which presented issues relating to ownership and shift management of the custody suite.

3.10 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 Harrow, but they were expected to arrive in due course as part of the rollout of Operation Herald.

3.11 The BOCU commander and his deputy regularly attended the local criminal justice board (LCJB) meetings. Relationships with the UK Border Agency (UKBA) were described as good, with close links with the UKBA liaison officer. A UKBA member of staff was based in the intelligence unit at Harrow police station and no issues concerning immigration detainees were identified. An IPT had recently been established at Harrow allowing Crown Prosecution Service (CPS) and borough staff to work together in the same premises.

3.12 There was a MPA lead for the ICV scheme, which was viewed by all parties as an important independent oversight mechanism. ICVs visited the custody suite regularly and were focused on detainee welfare. Feedback reports were produced 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. ICVs reported good relationships with custody staff. This was reiterated by the custody manager, who regularly attended ICV meetings.

3.13 The senior management team (SMT) lead for custody was the chief inspector operations, who was also responsible for managing professional standards, performance and a human resources change project. He attended the daily management meetings (DMMs) and fortnightly SMT meetings, chaired by the BOCU commander. Custody issues were raised on an exception reporting basis at the SMT, but were a standing agenda item at the DMM, albeit mainly from the perspective of investigating incidents or crimes so lacked strategic focus.

3.14 Due to their individual responsibilities, the chief inspector operations and custody manager met formally only once a week to discuss custody and other issues. They both visited the custody suite daily, as did other members of the SMT when carrying out reviews under PACE. The custody manager was not involved in any formal check of the custody suite, relying on staff to ensure these were fully completed. If any building work was carried out, a formal search was carried out by police search advisers (POLSA), but staff were not able to recognise potential ligature points (see section on physical conditions).

3.15 Quality assurance checks were carried out by the custody manager, who was required to dip sample about 22 custody records a month. Checks followed a set list and the details were recorded and discussed at the weekly meeting between the custody manager and chief inspector operations. Any negative issues identified with individual staff were addressed with them, but this did not involve their patrol team shift inspector. The individual checks were limited and the overall number of custody records examined represented only 5% of the annual throughput of detainees. Given that most custody staff were not dedicated to their custody roles, the BOCU therefore could not be satisfied that all relevant learning points were being identified. A recently introduced custody management meeting chaired by the custody manager and attended by permanent custody sergeants and DDOs provided a forum for discussion of generic learning points. There was no forum for meeting with external custody partners.

3.16 The MPS could not provide 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.

3.17 Newsletters from the Custody Directorate provided information and advice on detainee supervision and identified health and safety learning points gleaned from investigating successful interventions. This information was emailed to custody-trained staff by the custody manager, but staff did not know where to find this information centrally. The Custody Directorate also circulated the Independent Police Complaints Commission (IPCC) 'Learning the Lessons' newsletter, but neither staff nor managers were aware of this.

3.18 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 2.24).

Recommendations

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

3.20 The borough operational command unit should change its staffing model to ensure that a consistently professional service is provided by staff sufficiently trained in custody.

3.21 Sufficient custody records should be sampled to ensure managers have confidence in the quality of procedures and recording taking place and this should include cross-referencing to CCTV records when appropriate.

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.

Housekeeping point

3.23 Electronic links to the Custody Directorate and IPCC newsletters should be created through the borough custody webpage on the force intranet to create an easily accessible bank of learning points for staff.

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 The vans used to transport detainees to the custody suite were clean, relatively spacious and in good condition.

4.2 The booking in process was respectful and detainees were asked how they wished to be addressed. The booking in area was relatively small and quickly filled up with newly arriving detainees, bail returners, solicitors, appropriate adults and arresting officers. Custody sergeants maintained a calm and properly controlled environment. The booking in desks were an appropriate height, but offered little privacy as they were close to where detainees and others sat. Telephone calls were made in an area slightly away from the desk and a hood around the telephone offered a small amount of privacy.

4.3 Female detainees were treated much the same as male detainees. Staff said they tried to keep juvenile detainees out of cells and we saw one allowed to sit on the bench with his appropriate adult for most of the day. Juveniles who did go into cells were usually put in detention rooms covered by closed-circuit television (CCTV) and closer to the booking in desk. The appropriate adult of one young person we spoke to was content with how the young person had been treated. Women and girls were offered the opportunity to speak to a female member of staff.

4.4 There were no adapted facilities for detainees with disabilities and no hearing loops. However, staff treated all detainees as individuals and gave one example of a detainee who had been able to keep his wheelchair with appropriate risk management to ensure it was not used to injure himself or anyone else. There was a range of materials to allow detainees to observe their faith. Most cells were marked with the direction of prayer for Muslims and staff said detainees could wash at the sinks or using a cup of water before prayers, but there was little evidence of this in custody logs and detainees said they had not been offered the opportunity to wash.

Recommendations

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

4.6 Detainees with disabilities should be held in cells adapted for their use and a hearing loop should be installed at the custody sergeants' desk.

Safety

4.7 All detainees were subject to a comprehensive risk assessment on arrival. There were appropriate arrangements for monitoring those at risk. During the inspection, several detainees were placed on constant observation, one of whom remained in the booking in area where he could be watched by custody sergeants until there were enough staff to cover his constant

observation. Levels of monitoring set by the risk assessment were adhered to and we saw some positive staff engagement with detainees. Information about risk travelled with detainees when they went to court.

4.8 No detainees shared a cell. CCTV monitors were at the booking in desk out of sight of detainees or visitors and CCTV was not used as a substitute for personal interaction. All designated detention officers (DDOs) in the cell area carried keys and an anti-ligature tool and all those we spoke to understood the importance of rousing detainees. Safety information was appropriately shared at handovers between shifts and custody sergeants and DDOs were aware of the individual circumstances and risks of the detainees in their care.

4.9 Custody sergeants were given advance warning before a potentially violent detainee arrived and took appropriate action to manage the situation. This usually included clearing the booking in area of non-essential personnel.

Use of force

4.10 New arrivals were given a rub-down search and handcuffs were removed as soon as possible. Staff were appropriately trained in use of force techniques. During the inspection, a custody sergeant allowed a detainee who had taken a dislike to the arresting officer to be searched by a different officer to defuse a potentially fraught situation. Detainee interviews and custody record analysis did not indicate that force was overused, but local monitoring was limited. DDOs and custody sergeants did not carry CS spray and Tasers were not used.

Physical conditions

4.11 Cells and detention rooms were reasonably clean apart from a small amount of graffiti. In our survey, 73% of respondents, more than the comparator of 56%, said there had been graffiti in their cell. Any detainee known to have defaced their cell in this way was charged with criminal damage. All cells had some natural light, but temperatures were hard to control and staff said they could get too hot in the summer, too cold in the winter and were liable to leaks when it rained. Smoking was not allowed and smokers were not offered nicotine replacement therapy.

4.12 Staff were expected to carry out daily checks of the facilities at the start of each day shift to identify health and safety, maintenance and cleanliness issues. The permanent custody sergeants carried out similar, but more in-depth, checks weekly. However, cells were not thoroughly checked between uses and, while DDOs removed any debris after use, mattresses and pillows were not routinely wiped down. Contract cleaners attended every morning and throughout the day if required to clean up spillages. Despite recent maintenance work, ligature points were identified in most cells and detention rooms. The BOCU took urgent remedial action when advised of this, including taking five cells and two detention rooms out of use.

4.13 Fire alarms were tested regularly. Staff were aware of fire evacuation procedures and there had been a drill in the previous six months. Cuffs for use in an evacuation were locked away, wasting valuable time in an emergency. All cell call bells were in working order, their use was explained to detainees and they were responded to reasonably quickly. .

Recommendations

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

4.15 All cells should be suitable for detaining individuals, clean and free of graffiti and ligature points.

Housekeeping point

4.16 Handcuffs required for evacuation purposes should be easily accessible to staff.

Personal comfort and hygiene

4.17 All cells contained a mattress and a pillow, but blankets were not routinely provided. Hygiene items such as razors, shower gel, toothbrushes and toothpaste were available on request. Female detainees were not routinely offered a hygiene pack.

4.18 Detainees could use the toilet in private, but toilet paper had to be requested and there were no in-cell hand washing facilities. Detainees washed and cleaned their teeth in sinks. The one shower ran cold. In our survey, no detainees said they had been offered a shower and no custody record on our analysis indicated that a shower had been taken even though two related to detainees who had been in custody between 24 and 48 hours. Only paper towels were provided.

4.19 Paper suits, jogging bottoms, T-shirts and plimsolls were available, but in limited supply and in a limited range of sizes. No replacement underwear was provided. Family and friends were allowed to bring in replacement clothing.

Recommendations

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

4.21 Detainees held overnight and those who require it should be offered a shower and clean towels.

4.22 Toilet paper should be provided routinely.

Catering

4.23 The canteen offered a good range of meals for breakfast, lunch and dinner, and additional meals, including vegetarian and halal options, could be provided for detainees who missed meal times. Hot drinks were offered regularly and food was routinely offered three times a day. The food preparation area was clean, but food temperatures were not checked before serving.

Housekeeping point

4.24 Food temperatures should be checked and recorded before serving.

Activities

4.25 There was no outside exercise area, which particularly disadvantaged detainees held for longer periods of time who could not be offered any time in the fresh air. There was some

limited reading material, but nothing for juveniles or detainees with learning or sight difficulties. There were no visits rooms and visits were authorised only in exceptional circumstances.

Recommendation

4.26 Detainees held for longer periods should be offered outdoor exercise and visits.

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 checked that detention was appropriate before authorising it and had occasionally deemed it inappropriate. Police custody was not used as a place of safety for children and young people under section 46 of the Children Act 1989.

5.2 Custody sergeants followed up with investigating officers driving the enquiry to ensure that detention lasted no longer than appropriate. Most reviews by inspectors took place in person with detainees, with telephone reviews undertaken when they were called out to an incident. An extension to detention was allowed about twice a month through a superintendent's authorisation.

5.3 Detainees, including immigration detainees, were routinely advised on arrival that they were entitled to have someone concerned for their welfare informed of their whereabouts. Any delay to this because the detainee was too drunk or violent was authorised by the custody sergeant following a risk assessment. Staff facilitated telephone calls, often allowing more than one. In our survey, 80% of detainees, significantly more than the comparator of 51%, said they had been offered a free telephone call.

5.4 There had been considerable progress in reducing the number of detainees held solely on immigration matters and there was good liaison with the UK Border Agency (UKBA). There was reasonable access to telephone interpreters and two-way handsets were available. Face-to-face interpreters were also available, although the waiting time for one depended on the language involved. Staff said they had found it difficult to get a Guajarati interpreter and had therefore had to use the detainee's daughter to undertake some initial interpreting before release. Custody records did not assure us that all immigration detainees had their rights explained in a language they could understand, although in most cases they were provided with an interpreter or telephone interpretation service where this was necessary. All detainees were offered a copy of their rights and entitlements and these were available in a range of languages. Staff said it was particularly difficult to secure signing services and that detainees had been bailed pending appropriate support. Nothing was available in easy to read format.

5.5 The NSPIS custody system prompted custody staff to ask detainees about any dependents for whom they were responsible and staff took any necessary action, including making arrangements with schools and contacting social services if required.

5.6 Pre-release risk assessments were completed when deemed necessary and action taken, included offering lifts home and suggesting detainees speak to drugs workers. A leaflet detailing support organisations and agencies was available to those who might need it.

Rights relating to PACE

5.7 Up-to-date copies of PACE were available and regularly offered to detainees. There was no evidence that detainees were interviewed while under the influence of alcohol or drugs, or that they were denied adequate breaks during the interview process. A doctor was called if there was any doubt about a detainee's fitness for interview.

5.8 There was a duty solicitor scheme and posters offering free legal advice were displayed in a range of languages. Custody records indicated that all detainees were routinely offered legal advice. Detainees could not consult legal representatives by telephone in complete privacy as the consultation room had no telephone so calls had to be made from the custody area (see section on respect). This impacted particularly on immigration detainees as representatives specialising in immigration advice did not visit the custody suite in person. Detainees were usually able to speak to legal advisers within the first hour of detention and solicitors we spoke to did not raise concerns about their clients' treatment. Legal representatives could get copies of the front two sheets of the custody record and many routinely asked for these on arrival at the custody suite.

5.9 Harrow Social Services provided appropriate adults through the youth offending team and the mental health crisis team. They insisted that family and friends were contacted in the first instance, except in relation to mental health assessments, and that a legal representative be present during interview. The appropriate adult service could be available up to 10pm, but was more limited at weekends. The custody sergeant said there could be waits of up to 10 hours, in which case the possibility of bail would be explored. 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]

5.10 The management of DNA and forensic samples was good and no major issues were identified other than that the freezer was old, in poor condition and had a broken lock.

5.11 Detainees who were charged were promptly put before the courts. Detainees had to be at the local court by 2pm during the week and midday on Saturdays. Staff tried to arrange court appearances as early as possible to avoid unnecessary time spent in police custody. There were no video link facilities.

Recommendations

5.12 Detainees, including immigration detainees, should be able to consult with their legal representative in private.

5.13 Appropriate adults should be available 24 hours a day to support juveniles aged 17 and under and vulnerable adults in custody.

5.14 The borough should replace the freezers with ones that provide confidence that DNA samples and forensic exhibits are being stored at an appropriate temperature.

[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.

Rights relating to treatment

5.15 Detainees were not routinely told how to make a complaint and this information was not included in the rights and entitlements leaflets. Custody sergeants said complaints could not be taken while a detainee was in custody and that they advised anyone wanting to make a complaint to see the inspector on release. There was no comprehensive central recording of complaints in custody and no separate system for reporting and dealing with racist incidents. IPCC complaint forms were not available.[5]

Recommendation

5.16 Detainees should be told how to make a complaint and facilitated to do so before they leave custody.

[5] IPCC statutory guidance to the police service and police authorities on the handling of complaints, 2010

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 aware of the health needs of detainees and treated them respectfully and compassionately. FMEs and drug workers appeared committed to providing a high level of care and support. Most FMEs were male. Efforts were made to allow a female detainee to see a female FME if requested, but this was not always possible as only one FME was on call at any one time. Chaperones were routinely offered to female detainees and juveniles. Telephone and face-to-face interpreters were available.

6.2 Independent FMEs were contracted by the MPA Forensic Health Services (FHS), who also used agency doctors when necessary. FMEs came from a wide range of clinical backgrounds, including hospital consultants and GPs. There was no lead FME, but some acted as advisers to the commissioners advisory group and were involved in recruiting and training prospective FMEs. All FMEs were responsible for managing their ongoing professional development, professional registration and appraisal system. For most, this was done through their other work. A clinical director had recently been appointed by the MPA to oversee the management of FMEs. Complaints were now managed by the clinical director and police staff said the procedure had improved as a result.

6.3 Drug workers were managed by their parent company, Westminster Drug Project, and were fully supported in maintaining their professional development. They had access to both monthly supervision and an impressive level of internal and external professional training.

6.4 The FME room was located centrally and provided a good degree of privacy. It was a reasonable size and adequately furnished, apart from an electrical socket hanging from one of the walls. The room contained lockable medicines cabinets, an examination couch and a sink. There was no screen around the couch and no blanket to cover detainees being examined. Clinical and general waste was segregated into separate bins and removed regularly.

6.5 The overall management of medicines was good, apart from some overstocking and incorrect auditing. There were no medicine management policies or procedures, but pharmacy reference books were available. The medicines cabinets contained a comprehensive and appropriate stock of medicines. Medicines were ordered through FMS and delivered by courier to the nominated custody sergeant. FMEs also carried their own stock for use in urgent situations, particularly out of hours. Historically, FMEs had their own keys to the medicines cabinets, but some of these had been 'mislaid' and the practice was being reviewed to reduce risk (see main recommendation 2.25).

6.6 Medication brought in by detainees on arrival was removed and stored with the detainee's property. However, there were no arrangements to ensure it was securely locked away, which was in breach of current legislation and national guidance. Detainees could use their own medication only once it had been seen and approved by an FME. Where necessary, medicines were dispensed into Henley bags and labelled by the FME with clear instructions for

administration by custody staff. Any medicines administered by custody staff were recorded on NSPSIS.

6.7 Controlled drugs were regulated and a register of their administration was held. Diazepam (5mg) tablets and Dihydrocodeine (30) tablets were recorded in the controlled drugs register, but Diazepam (10mg) rectal tubes were not. There were significant discrepancies in the stock levels of Diazepam and Dihydrocodeine tablets, with 14 of the former and 13 of the latter missing. The responsible custody officer was aware of this and dealing with it. One box of antibiotics had the expiry date removed (see main recommendation 2.25).

6.8 Emergency and resuscitation equipment was limited and did not contain oxygen or resuscitation drugs, but did include a defibrillator. Staff had been trained in its use and undertook annual updates. The equipment was checked every day at shift handover. An additional first aid box was held in the FME room.

Patient care

6.9 Detainees could ask to see a health care professional at any point and would be asked the reason why to determine the level of urgency. The FMEs covered two adjacent boroughs and we were told another station had been added to the workload. This was having a negative effect on response times due to heavy traffic in the area. Custody staff and FMEs were concerned about protracted response times, but there was no evidence that these were monitored by the police, and custody staff did not know what the contracted expected response time was. Records indicated a maximum response time of three hours, but the average response time was 59 minutes. If a detainee began to display obvious signs of physical or mental health need, the custody officer called the FME and noted it on the custody record. Anyone in great physical discomfort was taken to the nearest accident and emergency department or an ambulance would be called.

6.10 FMEs provided symptomatic relief for substance users. Methadone or heroin users could wait up to six hours for relief unless they displayed signs of gross withdrawal. Methadone was not routinely prescribed, although one FME said he would do so if this had been verified by the detainee's GP or drug worker. The six-hour period would also be imposed to ensure safety.

6.11 The FME made an entry in the custody record following any contact with a detainee. This provided sufficient information to allow custody staff to manage the detainee as safely as possible. FMEs also kept their own more comprehensive clinical records. Those we spoke to recorded and stored clinical records in different ways, but arrangements were not monitored and no checks were made to ensure records were stored securely or that processes were in place for safe archiving. Recording of health care interventions was therefore inconsistent.

6.12 Drugs workers completed a comprehensive assessment that was signed by the detainee. A copy of the confidentiality form was given to the client, who could request to see their file at any time. Only brief information was shared with custody staff, who entered it in the custody record.

Substance use

6.13 The Westminster Drugs Project (WDP) provided a comprehensive client-centred substance misuse service, including alcohol. Juveniles were seen and assessed in the presence of an appropriate adult and referred to adolescent services. WDP had developed information-sharing protocols with the police, courts and local prisons, ensuring a good level of continuity of

substance users. A dedicated drug worker had made excellent links with local remand prisons and went there every week following up clients and attending continuity of care meetings. The meetings included representatives from prison counselling, assessment, referral, advice and throughcare teams, prison health care and other substance misuse agencies. Stable clients were referred to their own GPs and local mental health services. WDP also provided a rapid prescribing scheme and other services where necessary, including ethnic minority counselling services and alcohol services. Out-of-borough clients were assessed and referred to their home substance misuse team.

6.14 Injecting drug users were not given clean needles or syringes, but were told where to get them. There were limited alcohol services and alcohol users were signposted to supportive community services and given written information and advice. Drug workers offered a comprehensive on-site and out-of-hours service. The team of four workers carried out a sweep of all cells twice a day to ensure anyone with drug or alcohol problems was offered advice and support. Detainees requiring advice and support out of hours were given an appointment for noon the following day at the WDP base. The police issued a standard letter to the detainee on release giving appointment information and contact details. They also faxed the detainee's details to WDP to confirm.

Mental health

6.15 Arrangements for the care and treatment of detainees with mental health problems were provided by a specialist provider, the Central & North West London NHS Foundation Trust. The mental health crisis team was based at Northwick Park Hospital. The team manager said they receive about four referrals a month from FMEs for mental health assessment.

6.16 There were very good links between the various crisis teams operating in the trust. All referrals for initial mental health assessment were made through the FME, some of whom were Mental Health Act section 12 approved. An onward referral to the mental health crisis team was then made if appropriate. Trust staff reported good working relationships with FMEs and said referrals were always appropriate. There was some concern about occasional significant delays in the crisis team attending the custody suite. The approved mental health practitioner coordinated the mental health assessment process, including the provision of an appropriate adult if required, and this was carried out in good time.

6.17 General mental health assessments were carried out according to an agreed protocol. Ongoing packages of treatment and care were put in place for Harrow borough residents, while others were referred to their local borough team for general assessment. FMEs said levels of mental health awareness varied among custody staff. Some additional training was under discussion, but had not yet been implemented.

6.18 Monthly meetings about dual diagnosis were held with Compass, the borough's alcohol service provider.

6.19 An out-of-hours emergency team conducted Mental Health Act assessments. Routine assessments were not carried out after 11pm, but FMEs could get support from local accident and emergency departments through the Trust crisis line. There were regular joint meetings between the mental health team and the police regarding section 136 and accident and emergency liaison. A designated police link officer attended the meeting. A small court diversion team made referrals to the crisis team as necessary.

6.20 Arrangements for the care and treatment of detainees with mental health problems were good. A designated police officer had been involved in shared mental health protocol development.

6.21 Relationships between the police and mental health staff were very good and detention of people under section 136 was rare. There were agreed protocols for section 136 suites, which appeared to work well. Police remained on site for one hour or by negotiation, until assessment was complete. Custody staff and the FME said patients were only detained in the custody suite while under the influence of drugs or alcohol, pending regaining fitness for assessment. The section 136 suite in Northwick Park Hospital was used an average of twice a week. The accommodation was only adequate, but a new suite with better facilities was expected to be ready for use by June 2010.

Recommendations

6.22 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.

6.23 Detainees should be able to see a doctor of the same gender on request.

6.24 Forensic medical examiner response times should be recorded locally and reported centrally to ensure the effective monitoring and management of the contract.

6.25 Health care professionals should ensure that all clinical records are stored in accordance with the Data Protection Act and Caldicott guidance on the use and confidentiality of personal health information and there should be clear protocols on how long clinical records should be kept.

Housekeeping points

6.26 The electrical sockets in the medical room should be secured to the wall.

6.27 There should be a screen around the couch and a blanket for those being examined.

Good practice

6.28 *A designated police officer had been involved in shared mental health protocol development.*

7. Summary of recommendations

Main recommendations

To the Metropolitan Police Service

7.1 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. (2.24, see paragraph 2.10)

7.2 Staff should adhere to the Metropolitan Police Service guidelines for the management and registration of drugs and medicines in custody. Missing medicines, particularly controlled drugs, should immediately be notified to the primary care trust accountable officer. (2.25, see paragraph 2.20)

Recommendations

To the Metropolitan Police Service

Strategy

7.3 The Metropolitan Police Authority should allocate one authority member as lead for custody. (3.19, see paragraph 3.1)

7.4 The borough operational command unit should change its staffing model to ensure that a consistently professional service is provided by staff sufficiently trained in custody. (3.20, see paragraph 3.9)

7.5 Sufficient custody records should be sampled to ensure managers have confidence in the quality of procedures and recording taking place and this should include cross-referencing to CCTV records when appropriate. (3.21, see paragraph 3.15)

7.6 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 paragraph 3.16)

Treatment and conditions

7.7 Booking in areas should allow enough privacy to enable effective communication between staff and detainees. (4.5, see paragraph 4.2)

7.8 Detainees with disabilities should be held in cells adapted for their use and a hearing loop should be installed at the custody sergeants' desk. (4.6, see paragraph 4.4)

7.9 Subject to individual needs assessment, nicotine replacement should be available to detainees. (4.14, see paragraph 4.11)

7.10 All cells should be suitable for detaining individuals, clean and free of graffiti and ligature points. (4.15, see paragraph 2.14 and 4.12)

7.11 All female detainees should be offered a hygiene pack on arrival. (4.20, see paragraph 4.17)

7.12 Detainees held overnight and those who require it should be offered a shower and clean towels. (4.21, see paragraph 4.18)

7.13 Toilet paper should be provided routinely. (4.22, see paragraph 4.18)

7.14 Detainees held for longer periods should be offered outdoor exercise and visits. (4.26, see paragraph 4.25)

Individual rights

7.15 Detainees, including immigration detainees, should be able to consult with their legal representative in private. (5.12, see paragraph 5.8)

7.16 Appropriate adults should be available 24 hours a day to support juveniles aged 17 and under and vulnerable adults in custody. (5.13, see paragraph 5.9)

7.17 The borough should replace the freezers with ones that provide confidence that DNA samples and forensic exhibits are being stored at an appropriate temperature. (5.14, see paragraph 5.10)

7.18 Detainees should be told how to make a complaint and facilitated to do so before they leave custody. (5.16, see paragraph 5.15)

Health care

7.19 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. (6.22, see paragraph 2.19)

7.20 Detainees should be able to see a doctor of the same gender on request. (6.23, see paragraph 6.1)

7.21 Forensic medical examiner response times should be recorded locally and reported centrally to ensure the effective monitoring and management of the contract. (6.24, see paragraph 6.9)

7.22 Health care professionals should ensure that all clinical records are stored in accordance with the Data Protection Act and Caldicott guidance on the use and confidentiality of personal health information and there should be clear protocols on how long clinical records should be kept. (6.25, see paragraph 6.11)

Housekeeping points

Strategy

7.23 Electronic links to the Custody Directorate and IPCC newsletters should be created through the borough custody webpage on the force intranet to create an easily accessible bank of learning points for staff. (3.23, see paragraph 3.17)

Treatment and conditions

7.24 Handcuffs required for evacuation purposes should be easily accessible to staff. (4.16, see paragraph 4.13)

7.25 Food temperatures should be checked and recorded before serving. (4.24, see paragraph 4.23)

Health care

7.26 The electrical sockets in the medical room should be secured to the wall. (6.26, see paragraph 6.4)

7.27 There should be a screen around the couch and a blanket for those being examined. (6.27, see paragraph 6.4)

Good practice

Health care

7.28 A designated police officer had been involved in shared mental health protocol development. (6.28, see paragraph 6.20)

Appendix I: Inspection team

Sara Snell	HMIP team leader
Anita Saigal	HMIP inspector
Fiona Shearlaw	HMIC inspector
Angela Johnson	HMIP inspector
Kellie Reeve	HMIP inspector
Bridget McEvilly	HMIP health care inspector
Jan Fooks-Bale	CQC inspector
Adam Altoft	HMIP researcher
Sherrelle Parke	HMIP researcher

Appendix II: Custody record analysis

Background

As part of the inspection of Harrow police custody, a sample of custody records for detainees held at the only police custody suite in the borough were analysed between 1 and 8 April 2010. Custody records were held electronically on NSPIS. A total of 30 records were analysed for the borough of Harrow. The analysis looked at the level of care and access to services such as showers, exercise and telephones. Any additional information of note was also recorded.

Demographic information

- Five (17%) of the detainees were female and 25 (83%) were male.
- Four (13%) people under the age of 17 were included in the sample.
- There were 13 (43%) detainees in our sample from a white background and 17 (57%) from a black or ethnic minority background.
- Two (7%) detainees had been held for more than 24 hours. One of the two stayed for almost 38 hours. Eight detainees (26%) had been in custody overnight, including those who had arrived before or during the night and were not released until the morning (between midnight and 6am). Six (20%) detainees had been held for less than six hours.

Risk assessments

Initial risk assessment statements were mostly well detailed and contained helpful information. However, some had conflicting information. For example, one young person required and received an appropriate adult (for both interview and when they received their rights), but the appropriate adult box was ticked as 'no' on the risk assessment.

- Nine detainees (30%) in our sample were brought into custody intoxicated. Of these, six were seen by a doctor according to the notes in their detainee logs. No detainees in the sample were seen by a drugs and/or alcohol worker.
    - Three (10%) detainees had current or previous self-harm or suicide issues.
    - Five (17%) detainees 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. A 'mental health team' of three doctors visited this detainee while in custody.
- Twelve (40%) detainees reported being on medication on arrival in custody. Seven of these detainees were seen by a health care professional.
    - Five (17%) detainees came in to custody with an injury and three of these were seen by a health care professional. Three detainees in our sample required a hospital visit during their time in custody.
    - In six (20%) risk assessments, it was noted to be a detainee's first time in custody.

Removal of clothing

Only two of the detainees in the sample had had clothing removed.

Foreign nationals

There were seven (23%) foreign nationals in the sample and all were given their foreign national rights. However, two of the seven were given their foreign national rights without having an interpreter present, even though this had been identified as a need in both cases. For one of the two, it was noted that custody staff had attempted to contact an interpreter, but there was no subsequent record detailing whether the interpreter attended custody or whether there was an interpreter in attendance for the detainee's interview.

Young people

There was varying treatment of the four young people in our sample (aged under 17 years).

- All young people had an appropriate adult (AA) present when being given their rights and while being interviewed.
- One young person was held for over 29 hours and an initial request for a telephone call was not granted due to the custody suite being busy at the time of request
- Two young people in the sample were released into the care of social services.

Women

- Of the five female detainees in the sample:
    - According to the detention log, all were offered the chance to speak to a female member of staff in private and all five declined. However, this automated text was occasionally also left on detention logs for male detainees.
    - A further prompt asks all detainees if they have any dependents. None of the detainees in our sample reported any issues with ensuring dependents were being looked after.

Interpreters

- Five (17%) detainees required the use of an interpreter.
    - Two detainees had an interpreter present when their rights were given and during police interviews.
    - In one case, it was clear that officers had some difficulty deciding whether a detainee required an interpreter or not. He was later given his foreign national rights using telephone interpreting services.

Inspector reviews

Inspector reviews were held in line with requirements, usually at the required times. In a number of cases, inspectors were conducting reviews while the detainee was asleep.

Services

- Twelve detainees (40%) were able to make a telephone call during their time in custody. Some detainees in the sample were able to make more than one call, including one detainee who was allowed to contact his employer. Seventeen detainees (57%) were not offered a telephone call and one detainee requested a telephone call but was refused.

- All detainees were routinely offered legal advice and 20 (67%) detainees chose to use a legal professional.
- Twelve (40%) detainees were seen by the FME.
    - The longest wait was approximately three hours.
    - In three cases, the FME was already on site.
    - In the nine cases where staff had to call an FME to attend, the average wait was 59 minutes.
- Nineteen (63%) detainees in our sample were offered at least one meal in custody.
- Eleven (37%) detainees were not offered a meal. Of those, five had been in for over eight hours, two of whom were in custody for over 18 hours.
- There were no detainees in the custody sample who had been given outside exercise.
- No detainees had a shower in custody. Two had been held over 24 hours, but under 48 hours.
- Three detainees had been given reading materials, including a Koran, a book and a newspaper.
- No evidence of cell sharing was found.

Additional points of note

In a few cases, the 30-minute and 60-minute observational checks were left for longer, but this was infrequent in our sample. There were a few updated risk assessments written in logs, where the 'time warning' was complete and had changed as risk reduced.

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 Harrow, 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 11 May 2010. The survey for Harrow was conducted alongside a survey for the police boroughs of Brent, and Kensington and Chelsea. A list of potential respondents who may have passed through these three police boroughs was created, listing all those who had arrived from Harrow, Brent, Hendon, Uxbridge or West London Magistrates courts within the past month.

Selecting the sample

On the day, the questionnaire was offered to 79 respondents who had passed through Harrow, Kensington and Chelsea, and Brent police boroughs. There were four refusals, five questionnaires returned blank and six non-returns. All of those sampled had been in custody within the last three months[6]. Twenty questionnaires were returned completed from prisoners who had been through the borough of Harrow.

Completion of the questionnaire was voluntary. Interviews were carried out with any respondents with literacy difficulties. No respondents who had been through the borough of Harrow 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.

[6] Researchers routinely select a sample of prisoners held in police custody suites within the last two months. Where numbers are insufficient to ascertain an adequate sample, the time limit is extended up to six months. The survey analysis continues to provide an indication of perceptions and experiences of those who have been held in these police custody suites over a longer period of time.

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 27 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.

Police custody survey
Section 1: About you

Q2 What police station were you last held at?
Harrow police station

Q3 What type of detainee were you?

Police detainee	14
Prison lock-out (i.e. you were in custody in a prison before coming here)	0
Immigration detainee	1
I don't know	3

Q4 How old are you?

16 years or younger	0	*40-49 years*	3
17-21 years	2	*50-59 years*	2
22-29 years	5	*60 years or older*	0
30-39 years	8		

Q5 Are you:

Male	20
Female	0
Transgender/transsexual	0

Q6 What is your ethnic origin?

White - British	7
White - Irish	1
White - other	1
Black or black British - Caribbean	2
Black or black British - African	0
Black or black British - other	0
Asian or Asian British - Indian	0
Asian or Asian British - Pakistani	3
Asian or Asian British - Bangladeshi	0
Asian or Asian British - other	2
Mixed heritage - white and black Caribbean	1
Mixed heritage - white and black African	0
Mixed heritage- white and Asian	0
Mixed heritage - other	0
Chinese	0
Other ethnic group	3

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

Yes	9
No	11

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

None	1
Church of England	6
Catholic	5
Protestant	0

	Other Christian denomination	0
	Buddhist	1
	Hindu	1
	Jewish	0
	Muslim	5
	Sikh	0

Q9 How would you describe your sexual orientation?

	Straight/heterosexual	19
	Gay/lesbian/homosexual	0
	Bisexual	0

Q10 Do you consider yourself to have a disability?

	Yes	4
	No	14
	Don't know	2

Q11 Have you ever been held in police custody before?

	Yes	13
	No	7

Section 2: Your experience of this custody suite

Q12 How long were you held at the police station?

	1 hour or less	0
	More than 1 hour, but less than 6 hours	1
	More than 6 hours, but less than 12 hours	2
	More than 12 hours, but less than 24 hours	7
	More than 24 hours, but less than 48 hours (2 days)	5
	More than 48 hours (2 days), but less than 72 hours (3 days)	3
	72 hours (3 days) or more	2

Q13 Were you given information about your arrest and your entitlements when you arrived there?

	Yes	13
	No	5
	Don't know/can't remember	2

Q14 Were you told about the Police and Criminal Evidence (PACE) codes of practice (the 'rule book')?

	Yes	8
	No	8
	I don't know what this is/I don't remember	4

Q15 If your clothes were taken away, were you offered different clothing to wear?

	My clothes were not taken	12
	I was offered a tracksuit to wear	3
	I was offered an evidence suit to wear	2
	I was offered a blanket	0

Q16 Could you use a toilet when you needed to?

	Yes	18
	No	2
	Don't know	0

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

	Yes	*No*
Toilet paper	9	11
Sanitary protection	*3*	*8*

Q18 Did you share a cell at the police station?

Yes	2
No	18

Q19 How would you rate the condition of your cell:

	Good	*Neither*	*Bad*
Cleanliness	4	6	10
Ventilation/air quality	4	2	11
Temperature	1	6	10
Lighting	9	3	5

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

Yes	14
No	5

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

Yes	6
No	14

Q22 Were you held overnight?

Yes	19
No	1

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

Not held overnight	1
Pillow	8
Blanket	10
Nothing	8

Q24 Were you offered a shower at the police station?

Yes	0
No	20

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

Yes	0
No	20

Q26 Were you offered anything to:

	Yes	*No*
Eat?	15	5
Drink?	16	3

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

I did not have any food or drink	3
Yes	10
No	7

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

I do not smoke	5
I was allowed to smoke	0
I was not offered anything to cope with not smoking	15
I was offered nicotine gum	0
I was offered nicotine patches	0
I was offered nicotine lozenges	0

Q29 Were you offered anything to read?

Yes	2
No	18

Q30 Was someone informed of your arrest?

Yes	7
No	8
I don't know	2
I didn't want to inform anyone	3

Q31 Were you offered a free telephone call?

Yes	16
No	4

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

My telephone call was not denied	17
Yes	0
No	2

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

	Yes	*No*
Who was taking care of your children	7	11
Contacting your partner, relative or friend	6	12
Contacting your employer	2	15
Where you were going once released	5	10

Q34 Were you interviewed by police officials about your case?

Yes	18	
No	2	If No, go to Q36

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

	Yes	*No*	*Not needed*
Solicitor	14	4	0
Appropriate Adult	3	2	4
Interpreter	3	3	4

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

I did not requested a solicitor	3
2 hours or less	2
Over 2 hours but less than 4 hours	5
4 hours or more	9

Q37 Were you officially charged?

Yes	18
No	2
Don't know	0

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

I have not been charged yet	2
1 hour or less	2
More than 1 hour, but less than 6 hours	2
More than 6 hours, but less than 12 hours	6
12 hours or more	8

Section 3: Safety

Q40 Did you feel safe there?

Yes	6
No	12

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

Yes	7
No	11

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

I have not been victimised	11	*Because of your crime*	2
Insulting remarks (about you, your family or friends)	3	*Because of your sexuality*	0
Physical abuse (being hit, kicked or assaulted)	4	*Because you have a disability*	1
Sexual abuse	0	*Because of your religion/religious beliefs*	0
Your race or ethnic origin	1	*Because you are from a different part of the country than others*	1
Drugs	3		

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

Yes	8
No	10

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

Yes	5
No	13

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

Yes	1
No	17

Section 4: Health care

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

Yes	6
No	12

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

Not taking medication	12
Yes	1
No	5

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

Yes	3
No	13
Don't know	2

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

	Yes	*No*
Doctor	7	11
Nurse	0	11
Paramedic	0	11
Psychiatrist	0	11

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

Yes	5
No	11
Don't know	2

Q52 Did you have any drug or alcohol problems?

Yes	7
No	11

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	11
Yes	2
No	4

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

I didn't have any drug/alcohol problems	11
Yes	0
No	7

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	9	0	1	1	1	4

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

No	13
Yes	5

Please specify:

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

No	15
Yes	3

Prisoner survey responses for Harrow 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

		Harrow police	Police custody comparator
	Any percent highlighted in green is significantly better		
	Any percent highlighted in blue is significantly worse		
	Any percent highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
Number of completed questionnaires returned		20	885
SECTION 1: General information			
2	Are you a police detainee?	**78%**	**89%**
3	Are you under 21 years of age?	**10%**	**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)?	**55%**	**34%**
6	Are you a foreign national?	**45%**	**14%**
7	Are you Muslim?	**27%**	**11%**
8	Are you homosexual/gay or bisexual?	**0%**	**2%**
9	Do you consider yourself to have a disability?	**20%**	**19%**
10	Have you been in police custody before?	**65%**	**91%**
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?	**50%**	**65%**
12	Were you given information about your arrest and entitlements when you arrived?	**65%**	**73%**
13	Were you told about PACE?	**40%**	**52%**
14	If your clothes were taken away, were you given a tracksuit to wear?	**62%**	**44%**
15	Could you use a toilet when you needed to?	**90%**	**90%**
16	If you did use the toilet, was toilet paper provided?	**45%**	**51%**
17	Did you share a cell at the station?	**10%**	**2%**
18	Would you rate the condition of your cell, as 'good' for:		
18a	Cleanliness?	**20%**	**30%**
18b	Ventilation/air quality?	**23%**	**20%**
18c	Temperature?	**7%**	**13%**
18d	Lighting?	**54%**	**42%**
19	Was there any graffiti in your cell when you arrived?	**73%**	**56%**
20	Did staff explain the correct use of the cell bell?	**30%**	**21%**
21	Were you held overnight?	**94%**	**91%**
22	If you were held overnight, were you given **no** clean items of bedding?	**40%**	**31%**
23	Were you offered a shower?	**0%**	**9%**
24	Were you offered a period of outside exercise?	**0%**	**6%**
25a	Were you offered anything to eat?	**75%**	**80%**
25b	Were you offered anything to drink?	**83%**	**81%**
26	Was the food/drink you received suitable for your dietary requirements?	**58%**	**43%**
27	For those who smoke: were you offered **nothing** to help you cope with the ban there?	**75%**	**78%**
28	Were you offered anything to read?	**10%**	**13%**
29	Was someone informed of your arrest?	**35%**	**44%**
30	Were you offered a free telephone call?	**80%**	**51%**
31	If you were denied a free call, was a reason given?	**0%**	**15%**
32	Did you have any concerns about:		
32a	Who was taking care of your children?	**39%**	**15%**

Key to tables

		Harrow police	Police custody comparator
	Any percent highlighted in green is significantly better		
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	Percentages which are not highlighted show there is no significant difference		
32b	Contacting your partner, relative or friend?	**33%**	**53%**
32c	Contacting your employer?	**12%**	**21%**
32d	Where you were going once released?	**34%**	**31%**
34	If you were interviewed were the following people present:		
34a	Solicitor	**78%**	**73%**
34b	Appropriate adult	**35%**	**7%**
34c	Interpreter	**31%**	**6%**
35	Did you wait over four hours for your solicitor?	**56%**	**65%**
37	Were you held 12 hours or more in custody after being charged?	**44%**	**63%**
SECTION 3: Safety			
39	Did you feel unsafe?	**67%**	**40%**
40	Has another detainee or a member of staff victimised you?	**39%**	**42%**
41	If you have felt victimised, what did the incident involve?		
41a	Insulting remarks (about you, your family or friends)	**17%**	**22%**
41b	Physical abuse (being hit, kicked or assaulted)	**22%**	**14%**
41c	Sexual abuse	**0%**	**2%**
41d	Your race or ethnic origin	**7%**	**6%**
41e	Drugs	**17%**	**15%**
41f	Because of your crime	**11%**	**18%**
41g	Because of your sexuality	**0%**	**1%**
41h	Because you have a disability	**7%**	**3%**
41i	Because of your religion/religious beliefs	**0%**	**3%**
41j	Because you are from a different part of the country than others	**7%**	**5%**
42	Were you handcuffed or restrained whilst in the police custody suite?	**44%**	**48%**
43	Were you injured whilst in police custody, in a way that you feel is not your fault?	**28%**	**26%**
44	Were you told how to make a complaint about your treatment?	**7%**	**14%**
SECTION 4: Health care			
46	Were you on any medication?	**33%**	**45%**
47	For those who were on medication: were you able to continue taking your medication?	**19%**	**39%**
48	Did someone explain your entitlement to see a health care professional if you needed to?	**17%**	**36%**
49	Were you seen by the following health care professionals during your time in police custody?		
49a	Doctor	**39%**	**50%**
49b	Nurse	**0%**	**15%**
49c	Paramedic	**0%**	**4%**
49d	Psychiatrist	**0%**	**4%**
50	Were you able to see a health care professional of your own gender?	**28%**	**28%**
51	Did you have any drug or alcohol problems?	**39%**	**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?	**33%**	**40%**
53	Were you offered relief medication for your immediate symptoms?	**0%**	**33%**
54	For those who had been seen by health care, would you rate the quality as good/very good?	**17%**	**29%**
55	Do you have any specific physical health care needs?	**28%**	**33%**
56	Do you have any specific mental health care needs?	**17%**	**24%**